ARC 0359C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 141, subsection 11, 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," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Chapter 82, "Intermediate Care Facilities for the Mentally Retarded," Chapter 83, "Medicaid Waiver Services," and Chapter 88, "Managed Health Care Providers," Iowa Administrative Code.

These amendments implement directives included in 2012 Iowa Acts, Senate File 2336, enacted by the Eighty-Fourth General Assembly, that affect payment for Medicaid habilitation services; home health services; services provided under the elderly, intellectual disability, or brain injury waiver; targeted case management; and services provided in a psychiatric medical institution for children or a community-based intermediate care facility for persons with an intellectual disability (ICF/ID).

Items 1 through 10, 13, 14, 15, and 19 through 25 reflect that 2012 Iowa Acts, Senate File 2336, section 58, removes statutory requirements for county governments to pay the nonfederal share of medical assistance costs for the following services provided in the fiscal year beginning July 1, 2012:

- Habilitation.
- Targeted case management.
- Services provided under the home- and community-based services intellectual disability waiver or brain injury waiver.
- Care in a community-based intermediate care facility for persons with an intellectual disability (ICF/ID).

With the elimination of county funding for these services, the county role in provider certification, ICF/ID placement, and determination of need for waiver services is also eliminated. These amendments remove requirements on waiver applicants and county governments and streamline eligibility determination.

Item 12 increases home health agency reimbursement rates by 2 percent effective July 1, 2012, as mandated by 2012 Iowa Acts, Senate File 2336, section 33. The basis of reimbursement for private duty nursing and personal care services is corrected to read "Interim fee schedule with retrospective cost-related settlement." Increased income will help providers meet the cost of providing services.

Item 16 increases the cap on home- and community-based services elderly waiver costs from $1,117 to $1,300 for the nursing facility level of care as mandated by 2012 Iowa Acts, Senate File 2336, section 37. This change allows waiver members to receive additional services.

The final item of these amendments adds psychiatric medical institutions for children (PMICs) as covered mental health services under the Iowa Plan for Behavioral Health as directed by 2012 Iowa Acts, Senate File 2336, section 12. The transition of PMICs to the Iowa Plan is a benefit to Medicaid members because it will provide increased integration of mental health services for children with mental health conditions.

Inclusion of PMICs in the managed care plan will provide increased flexibility in payment methods and services and options for PMIC care. The transition will enhance discharge planning for children leaving PMICs to receive community-based services also managed by the Iowa Plan. This change will increase the opportunities for coordination of care and services and the permanency of community placement for children. This change was recommended by the workgroup appointed pursuant to 2011 Iowa Acts, chapter 121.

Notice of Intended Action for these amendments was published in the Iowa Administrative Bulletin as **ARC 0193C** on July 11, 2012. The amendments were also Adopted and Filed Emergency and published as **ARC 0191C** on the same date and became effective July 1, 2012.

Written comments were received by the Department regarding Item 11, which proposed a provider rate increase to the Elderly Waiver Consumer Directed Attendant Care Assisted Living Program. The

rate increase was meant for the elderly waiver dollar cap per month, but did not extend to an increase in the monthly rate for assisted living. Therefore, the amendment in Item 11 herein restores the rate for assisted living to $1117 per month or $36.71 per day. Additional comments urged the Department to continue to work cooperatively with counties and regions. The amendments in Items 2 to 4 were changed to reflect these comments.

Subsequent to publication of Adopted and Filed Emergency **ARC 0191C**, rule 441—83.69(249A) in Item 19, subrule 83.82(4) in Item 22, and rule 441—83.89(249A) in Item 24 were affected by changes to Chapter 83 that were Adopted and Filed and published in the Iowa Administrative Bulletin as **ARC 0306C** on September 5, 2012. As a result, the item statements for Items 19, 22 and 24 have been rewritten to rescind the Emergency amendments and adopt in lieu thereof new rule 441—83.69(249A), subrule 83.82(4), and rule 441—83.89(249A), respectively, to harmonize the Emergency amendments with the interim amendments.

The Council on Human Services adopted these amendments on September 12, 2012.

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

There is an impact on private-sector jobs. The increase in reimbursement to home health agencies and the increase in the level-of-care dollar cap for the elderly waiver may result in increased wages for providers and a possible increase in jobs.

These amendments are intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2336.

These amendments will become effective December 1, 2012, at which time the Adopted and Filed Emergency amendments are hereby rescinded.

The following amendments are adopted.

ITEM 1. Rescind subparagraph **77.37(10)"d"(3)**.

ITEM 2. Amend paragraph **77.37(11)"b"** as follows:

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

ITEM 3. Amend subrule 77.37(12) as follows:

77.37(12) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. to *c.* No change.

d. During the course of the review, if a team member encounters a situation that places a ~~consumer~~ member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a ~~consumer~~ member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department~~, the county of residence, and the central point of coordination~~ shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the ~~consumer~~ member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the ~~consumers~~ members deemed to be at risk as a result of the provider's inaction.

e. to *g.* No change.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from ~~an~~ a home- and community-based services intellectual disability waiver service.

i. and *j.* No change.

ITEM 4. Amend subparagraph **77.37(23)"f"(3)** as follows:

(3) Period and conditions of certification.

1. to 3. No change.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a ~~consumer~~ member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a ~~consumer~~ member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department~~, the county of residence, and the central point of coordination~~ shall ~~be notified~~ immediately ~~to~~ discontinue funding for that provider's service. If this action is appealed and the ~~consumer~~ member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the ~~consumers~~ members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. to 10. No change.

ITEM 5. Rescind subparagraph **77.39(8)"d"(3)**.

ITEM 6. Amend subrule 77.39(9) as follows:

77.39(9) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. ~~Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.~~

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

~~(3) The prospective provider's coordination of service design, development, and application with the applicable local county central point of coordination and other interested parties.~~

c. No change.

ITEM 7. Amend subrule 77.39(10) as follows:

77.39(10) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. to *c.* No change.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a ~~consumer~~ member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department~~, the county of residence, and the central point of coordination~~ shall ~~be notified~~ immediately ~~to~~ discontinue funding for that provider's service.

(2) If this action is appealed and the ~~consumer~~ member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the ~~consumers~~ members deemed to be at risk as a result of the provider's inaction.

e. to *g.* No change.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. and *j.* No change.

ITEM 8. Rescind paragraph **77.41(1)"c."**

ITEM 9. Rescind and reserve subrule **78.27(12)**.

ITEM 10. Amend paragraph **78.43(1)"d"** as follows:

d. Members who are ~~at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are~~ eligible for targeted case management ~~and, therefore,~~ are not eligible for case management as a waiver service.

ITEM 11. Amend subrule **79.1(2)**, provider category "HCBS waiver services," numbered paragraph "15," as follows:

Provider category	Basis of reimbursement	Upper limit
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	No change.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Provider's rate in effect 11/30/09. If no 11/30/09 rate: ~~$1,300~~ $1,117 per calendar month. When prorated per day for a partial month, ~~$42.74~~ $36.71 per day.
Individual	Fee agreed upon by member and provider	No change.

ITEM 12. Amend subrule **79.1(2)**, provider category "Home health agencies," as follows:

Provider category	Basis of reimbursement	Upper limit
Home health agencies		

Provider category	Basis of reimbursement	Upper limit
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect ~~11/30/09~~ 6/30/12 or maximum Medicaid rate in effect ~~11/30/09 less 5%~~ 6/30/12 plus 2%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost-related settlement	Medicaid rate in effect ~~11/30/09 less 5%~~ 6/30/12 plus 2%.
3. Administration of vaccines	Physician fee schedule	Physician fee schedule rate.

ITEM 13. Amend rule 441—82.7(249A) as follows:

441—82.7(249A) Initial approval for ~~ICF/MR~~ ICF/ID care.

82.7(1) *Referral through targeted case management.* Persons seeking ~~ICF/MR~~ ICF/ID placement shall be referred through targeted case management. The case management program shall ~~identify any appropriate alternatives to the placement and shall inform the person of the alternatives. A referral shall be made by targeted case management to the central point of coordination having financial responsibility for the person. The department is the central point of coordination for persons with state case status.~~:

a. Identify appropriate service alternatives;

b. Inform the person of the alternatives; and

c. Refer a person without appropriate alternatives to the department.

82.7(2) *Approval of ~~ICF/MR~~ placement by ~~central point of coordination~~ department.* ~~The central point of coordination shall approve ICF/MR placement, offer a home- or community-based alternative, or refer the person back to the targeted case management program for further consideration of service needs within 30 days of receipt of a referral. Initial placement must be approved by the central point of coordination with responsibility for the person.~~

a. Within 30 days of receipt of a referral, the department shall:

(1) Approve ICF/ID placement;

(2) Offer a home- or community-based alternative; or

(3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice.

82.7(3) *Approval of level of care.* Medicaid payment shall be made for ~~intermediate care facility for the mentally retarded~~ ICF/ID care upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the Iowa Medicaid enterprise (IME) medical services unit. The IME medical services unit shall review ~~ICF/MR~~ ICF/ID admissions and transfers only when documentation is provided which verifies a referral from targeted case management that includes an approval by the ~~central point of coordination~~ department.

82.7(4) *Appeal rights.* Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7. ~~The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to 441—paragraph 25.13(2)"j." If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department according to the procedures in 441—Chapter 7.~~

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

ITEM 14. Rescind and reserve subrule **82.14(2)**.

ITEM 15. Amend rule **441—82.14(249A)**, implementation sentence, as follows:

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

ITEM 16. Amend subparagraph **83.22(2)"c"(2)** as follows:

(2) Services must be the least costly available to meet the service needs of the ~~consumer~~ member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs are limited as follows:

Skilled level of care	Nursing level of care
$2,631	~~$1,117~~ $1,300

ITEM 17. Amend subrule 83.61(2) as follows:

83.61(2) *Need for services.*

a. No change.

b. Applicants not receiving services as set forth in paragraph 83.61(2)*"a"* shall have a department service worker or ~~a~~ case manager ~~paid by the county without Medicaid funds~~:

(1) to (3) No change.

c. to *f.* No change.

g. At initial enrollment, the service worker, department ~~QMRP~~ QIDP, case manager ~~paid by the county without Medicaid funds,~~ or Medicaid case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing assessments:

(1) The assessment shall be based, in part, on information on the completed Case Management Comprehensive Assessment, Form 470-4694.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

~~(3) Rescinded IAB 3/7/01, effective 5/1/01.~~

~~(4)~~ (3) Service plans for ~~consumers~~ applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care ~~or the designee of the county board of supervisors~~. The service worker, department ~~QMRP~~ QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. No change.

ITEM 18. Amend subrule 83.67(6) as follows:

83.67(6) *Approval of plan.* The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

a. No change.

b. The department ~~or county~~ has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department ~~or county~~ and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department ~~or county~~ has final authority regarding the services and service cost.

~~*d.* If a notice of decision is not received from a county within 30 days from the date of request for services, the request shall be sent to the department of human services with documentation verifying the original submission of the request to the county. The department shall send a letter to the county central point of coordination and county board of supervisors requesting a response within 10 days. If no response is received within 10 days, the department will make the decision, as stated in paragraph *"b."*~~

ITEM 19. Rescind rule 441—83.69(249A) and adopt the following **new** rule in lieu thereof:

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

ITEM 20. Rescind and reserve rule **441—83.70(249A)**.

ITEM 21. Amend paragraph **83.82(2)"a"** as follows:

a. The ~~consumer~~ applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed ~~prior to~~ before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the ~~consumer~~ applicant and, with the team, identify the ~~consumer's~~ applicant's ~~"~~need for service~~"~~ based on the ~~consumer's~~ applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for ~~consumers~~ applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for ~~consumers~~ applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee~~, or for a consumer at the ICF/MR level of care, the designee of the county of legal settlement's board of supervisors,~~ to make a decision regarding the need for supported community living beyond intermittent.

ITEM 22. Rescind subrule 83.82(4) and adopt the following **new** subrule in lieu thereof:

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) In the event that more than one application is received at one time, applicants shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

ITEM 23. Amend subrule 83.87(2) as follows:

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services.

Service plans for ~~consumers~~ members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care~~, or when a county voluntarily chooses to participate, by the county board of supervisors' designee or the bureau's designee~~. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

ITEM 24. Rescind rule 441—83.89(249A) and adopt the following **new** rule in lieu thereof:

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

ITEM 25. Rescind and reserve rule **441—83.90(249A)**.

ITEM 26. Amend paragraph **88.65(3)"a"** as follows:

a. The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

(1) to (16) No change.

(17) Inpatient psychiatric services in psychiatric medical institutions for children as set forth in 441—Chapter 85, Division II.

[Filed 9/12/12, effective 12/1/12]
[Published 10/3/12]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/3/12.