ARC 0707C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Iowa Administrative Code.

The purpose of these amendments is to change billing codes in accordance with guidance from the Centers for Medicare and Medicaid Services (CMS) and the Health Insurance Portability and Accountability Act (HIPAA), which states that no state Medicaid department can use atypical billing codes. Most of the codes used to bill waiver services to the Iowa Medicaid Enterprise (IME) are atypical and therefore need to be changed to standardized health care procedure coding system (HCPCS) or current procedural terminology (CPT) codes. Those standardized codes have different unit descriptions than those currently contained in Chapter 78. For example, the atypical billing code unit definition is one hour; the new conversion code has a unit definition of 15 minutes.

These amendments also standardize service definitions. The standardization of service definitions was undertaken in order to provide continuity amongst the waiver programs. The description of each waiver service will now be the same for all waiver programs, unless a waiver has a very specific exception.

New subrules 78.37(15) and 78.37(19) are necessary to redefine services available through assisted living facilities.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0567C** on January 23, 2013. The Notice was a companion to the Notice of Intended Action to amend Chapter 79 that was published as **ARC 0568C** on the same date (see Adopted and Filed **ARC 0708C** herein).

The Department received four responses from interested parties.

The first respondent was concerned about how the amendments would impact CHORE services and how the services will be paid for in the future.

The Department response is that the CHORE service is available only under the elderly waiver; under no other waiver does Medicaid pay for yard work or minor home repairs for waiver members. Members under the other waivers are fully responsible for funding their own yard and home maintenance. Services available through any waiver are not, and never were, intended to pay for 100 percent of the needs of every waiver member. While the CHORE service does help support elders in remaining in their own homes, it has come to the Department's attention that there are abuses in the use of this service, such as removal of trees from rental properties and excessive monthly raking and stick removal. This tightening of the rules helps ensure that the Iowa Medicaid Enterprise (IME) is paying for necessary services, without paying for unnecessary services. No changes to the amendments were made as the result of this comment.

The second respondent requested that the Department redefine the proposed definitions of the units of service to the following: a half day (1.01 to 4 hours per day), a full day (4.01 to 8 hours per day), and an extended day (8.01 to 12 hours per day). The current rules define 1 to 4 hours as a half day, 4 to 8 hours as a full day, and 8 to 12 hours as an extended day. The reason stated for this request was a concern that the provider could experience loss of service revenue under the proposed amendments.

The Department's response is that the definitions of half-day, full-day, and extended-day services have been adopted for all waiver services that offer these time frames. The intention of these amendments is to limit the amount of money paid by the IME when no service is provided. In regard to service planning, each provider and case manager will need to more closely plan for each member. Each member's plan may be comprised of any combination of the time frame options (15 minutes, half day, full day, or extended day). Also, at the end of the month, the provider may contact the case manager to alter the service plan to match actual service provision, if applicable. The purpose of the waiver is to provide services to meet the needs of the member in the most efficient manner. No changes to the amendments were made as the result of this comment.

The third respondent shared a concern that whenever the unit of service time is reduced, there is more overhead to track and more data to maintain, which is the reason why a day of service is less expensive than two half days, two half days are less expensive than six hours, and six hours are less expensive than 24 quarter hours. This is not something that providers can get around. It is a law of economics that is played out in the real world in many different situations. It is recognized even in the proposed rule making in the prevocational services provision where the daily rate is $49.18 and the hourly rate is $13.47. Using a six-hour-day assumption, the hourly cost for prevocational services would be $8.20 per hour. In actuality, the cost is $13.47, which is more than 64 percent higher. Given the premise that four 15-minute units will take more clock time to provide and cost more to document than one consecutive hour of time, the respondent suggested adding 20 percent to 30 percent to the 15-minute rates that were calculated from hourly rates. As an alternative, there could be a time study to determine a fair rate for providers and a rate that recognizes the need for cost neutrality inside of the state budget.

The Department response is that the CMS mandate requires that each state Medicaid program use only nationally standardized billing codes. For most of the codes used in HCBS services, the only nationally standardized code available for use is defined as 15 minutes. The IME does not have the authority to alter the time frame definition of a standardized code.

The direction from CMS is clear in regard to the use of shorter time frames: the service definition time should be more narrowly defined in order to more closely match the time of service provision to the time paid by Medicaid. Previously, if a service was defined as an hour, any portion of that hour (no matter how small or large) was billed as an hour. So if a provider gave 13 minutes of service, then a full hour was paid. Under the new code definitions, if 13 minutes was provided then only 15 minutes is paid.

Each provider is already responsible for tracking the start and end times of service provision as required by rule 441—79.3(249A). Adherence to these amendments does not require that a provider watch the clock continuously during the time of service provision, but to be aware of when service started and stopped. The IME is not requiring more documentation for these new code definitions as some assume. As always, the documentation created for the service should substantiate the entire time span of that service. There is no need to document each 15 minutes separately; nor has any such need been communicated by the IME to any provider that has asked for clarification. One documentation narrative has been, and will continue to be, used for each episode of service provision. No changes to the amendments were made as the result of this comment.

The fourth respondent shared three comments. The first comment was that these amendments would put the burden on the member to begin paying one-half of travel expenses that were previously allowed. The Department's response is that there will be no additional burden on the member because the IME will still pay for necessary transportation. If the member needs transportation both to and from a site, then the IME would pay for two one-way trips for that day. But if the member only needs transportation one way, then the IME is not paying the additional cost for a round trip that does not occur. Before, the IME paid for a round trip even if the member needed transportation only one way. This rule making more closely aligns the IME payment with the amount of service provided.

The second comment from this respondent was a concern that these amendments would conflict with subrule 78.37(11), which allows reimbursement per "one mile" or "per one way trip." The Department response is that subrule 78.37(15) speaks to covered consumer-directed attendant care (CDAC) services whereas subrule 78.37(11) speaks to the coverage under the transportation service. These are two distinctly different services under the elderly waiver. The member may have both services in the member's service plan, but one trip cannot be paid by both CDAC and the transportation service. The actual costs of transportation (gas, mileage, depreciation) have never been covered under CDAC because CDAC is a hands-on service. But CDAC does cover the time spent by the CDAC provider to transport a member (see 78.37(15)"f"(12) in Item 15 regarding coverage of transportation under CDAC). While the arrangement of the rule regarding CDAC is altered in this rule making, there is no actual change in benefit to the member. These amendments add a provision to more clearly define those services that are excluded as CDAC to clear up confusion that has occurred in the past.

The final comment from this respondent was a concern that these amendments would require a provider that provides 7 or fewer minutes of service to round to 0 minutes, which would mean that

the provider is providing services without any reimbursement. The Department's response is that the IME has chosen to use the rounding rule to more closely align IME payment to the actual time of service provision. Without the rounding rule, the IME pays the provider for 15 minutes when as little as 1 minute of service occurred, i.e., the provider is paid for up to 14 minutes of service that did not occur. Under these amendments, both the IME and the provider share in financial responsibility for the service. If the service is less than 8 minutes, then the provider is responsible. If the service is 8 or more minutes, then the IME pays for a full 15 minutes.

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These amendments are identical to those published under Notice of Intended Action.

The Council on Human Services adopted these amendments on April 10, 2013.

These amendments do not provide for waivers in specified situations because CMS has not indicated that any state can be exempt from the guidelines described in this preamble. The Department does not see any reason why any provider type would be exempt from adherence to CMS guidelines. 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 July 1, 2013.

EDITOR'S NOTE: Pursuant to recommendation of the Administrative Rules Review Committee published in the Iowa Administrative Bulletin, September 10, 1986, the text of these amendments [amendments to Ch 78] is being omitted. These amendments are identical to those published under Notice as **ARC 0567C**, IAB 1/23/13.

[Filed 4/10/13, effective 7/1/13]

[Published 5/1/13]

[For replacement pages for IAC, see IAC Supplement 5/1/13.]