

HUMAN SERVICES DEPARTMENT[441]**Adopted and Filed Emergency After Notice**

Pursuant to the authority of Iowa Code section 249A.4 and 2013 Iowa Acts, Senate File 446, the Department of Human Services adopts a new Chapter 74, "Iowa Health and Wellness Plan," and amends Chapter 88, "Managed Health Care Providers," Iowa Administrative Code.

The Iowa Health and Wellness Plan will provide medical assistance to low-income Iowans aged 19 to 64 whose countable income does not exceed 133 percent of the federal poverty level (FPL) for their family size, who are not eligible for any other full Medicaid group or Medicare, who are not pregnant, and whose dependent children are covered by minimum essential coverage.

These amendments do not include the contributions or premiums required beginning in calendar year 2015 and described under the state legislation. They also do not include the ability to waive these contributions or premiums. The Department is currently finalizing the details of these provisions with the Centers for Medicare and Medicaid Services (CMS). Once CMS approval is obtained, the administrative rules will be amended accordingly. These amendments do not address the specific delivery for dental services, medical home or accountable care organizations. Once CMS has approved these items and details are developed, they will be added to the rules.

As of October 1, 2013, low-income adults have been able to enroll in a new Medicaid coverage group for benefits that will begin January 1, 2014. Since the IowaCare 1115 demonstration waiver is ending December 31, 2013, many people currently enrolled in the IowaCare program will be transitioned to the Iowa Health and Wellness Plan.

Notice of Intended Action on these amendments was published in the Iowa Administrative Bulletin as **ARC 0972C** on August 21, 2013.

The Department has received identical comments from two respondents. A synopsis of the comments received and the corresponding Department responses are as follows:

Comments: The respondents recommended that four provisions be changed: (1) Nonemergency medical transportation should be a covered benefit; (2) early and periodic screening, diagnosis, and treatment (EPSDT) services for 19 to 21 year olds should be a covered benefit; (3) copayments for nonemergency use of the emergency room should be lowered (proposal exceeds federal minimum); and (4) retroactive eligibility should be allowed. Additionally, the respondents expressed concerns over the imposition of monthly premium payments for those with income below 100 percent of the federal poverty level (FPL) if certain key wellness/preventive activities are not met. The respondents stated that federal law prohibits assessment of premiums for individuals with income below 150 percent of the FPL and that imposing these premiums could lead to hardship and disenrollment. The respondents provided detailed recommendations for easing the burden of completing key activities, helping participants complete them, and simplifying the premium structure.

The respondents stated that introducing two new components of the Medicaid program in Iowa (the Iowa Wellness Plan and the Marketplace Choice Plan) will be a significant, complex administrative challenge and will be more difficult than simply expanding the Medicaid program and that the process will require significant outreach, education, and procedural safeguards to ensure that eligible individuals receive the coverage and services to which they are entitled. The respondents recommended developing a continuous eligibility process to increase efficiency and reduce administrative burden.

Department response: In response to the concerns about imposing premiums for very poor beneficiaries, the waiver applications were amended to include a hardship provision for those who cannot afford their premiums for both waivers. The Department requested CMS to waive retroactive eligibility to remain consistent with the enabling legislation (2013 Iowa Acts, Senate File 446), which does not provide for retroactivity. The Department also requested CMS to waive coverage of nonemergency medical transportation and EPSDT for the same reason, because the enabling legislation does not provide such services. This policy also ensures consistent benefits across the Iowa Wellness Plan, the Marketplace Choice Plan, and qualified health plan (QHP) coverage through the Health

Insurance Marketplace. Thus, no additional benefit modifications are being made to these amendments as a result of the comments received.

The Department proposed to charge a \$10 copayment to beneficiaries for nonemergency use of the emergency room. The waiver authority aligns the waiver with the Iowa Health and Wellness Plan legislation. Moreover, the Department wants to determine whether the \$10 copayment will impact beneficiary care utilization behavior and whether the copayment reduces inappropriate emergency room use. Therefore, the \$10 copayment provision remains in these amendments.

Due to continuing departmental review, combined with multiple ongoing rule-making efforts, cross references in 74.5(3), 74.6(1)“f,” 74.6(2), and 441—74.7(249A,85GA,SF446) to 441—74.9(249A,85GA, SF446) were updated for accuracy. In addition, wording relating to mandatory coverage groups was added in 74.2(1)“a” and in paragraph “2” of rule 441—74.8(249A,85GA,SF446) for clarity.

The Council on Human Services adopted these amendments on September 26, 2013.

Pursuant to Iowa Code section 17A.5(2)“b”(1), the Department finds that the normal effective date of these amendments, 35 days after publication, should be waived and the amendments made effective October 2, 2013. The normal effective date can be waived since legislation permits emergency rule making. The Legislature provided in 2013 Iowa Acts, Senate File 446, section 7(6), that the Department may adopt emergency rules for the medical assistance program as necessary to comply with federal requirements.

These amendments do not provide for waivers in specific situations because all members should be subject to the same rules. The Department has an exception to policy process that may be pursued should a member feel that the member has exceptional circumstances justifying an exception. 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, there will be potential for an impact on private sector jobs. The number of new jobs cannot be estimated, but it is anticipated that there will be an increased need for medical providers to service this population of previously uninsured people. Pent-up demand for services in the initial years and ongoing care needs will sustain the need for medical providers. The new federal funding to pay providers will create a mechanism to support job growth.

These amendments are intended to implement Iowa Code section 249A.4 and 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187.

These amendments became effective October 2, 2013.

The following amendments are adopted.

ITEM 1. Adopt the following new 441—Chapter 74:

CHAPTER 74

IOWA HEALTH AND WELLNESS PLAN

PREAMBLE

This chapter defines and structures the Iowa Health and Wellness Plan, effective January 1, 2014, and administered by the department pursuant to 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187. Implementation of the Iowa Health and Wellness Plan is subject to approval by the Secretary of the United States Department of Health and Human Services of any waivers of the requirements of Title XIX of the Social Security Act to provide for federal funding of the plan. This chapter shall be construed to comply with all requirements for federal funding under Title XIX of the Social Security Act or under the terms of any applicable waiver granted by the Secretary. To the extent this chapter is inconsistent with any applicable federal funding requirement under Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—74.1(249A,85GA,SF446) Definitions.

“*Accountable care organization*” means a risk-bearing, integrated health care organization characterized by a payment and care delivery model that ties provider reimbursement to quality metrics and reductions in the total cost of care for an attributed population of patients.

“*Countable income*” means “modified adjusted gross income” (MAGI) or “household income,” as applicable, determined pursuant to 42 U.S.C. § 1396a(e)(14).

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

“*Enrollment period*” means the 12-month period for which eligibility is initially established.

“*Essential health benefits*” means the essential health benefits defined by the Secretary of the United States Department of Health and Human Services pursuant to Section 1302(b) of the Patient Protection and Affordable Care Act, Public Law 111-148.

“*Exempt individuals*” shall be defined pursuant to 42 CFR § 440.315.

“*Federal poverty level*” means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

“*Health insurance marketplace*” or “*exchange*” means an American health benefit exchange established pursuant to 42 U.S.C. § 18031.

“*Iowa Health and Wellness Plan*” means the medical assistance program set forth in this chapter.

“*Iowa wellness plan*” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level.

“*Marketplace choice plan*” means the benefits and services provided to Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level.

“*Member*” means an individual who is receiving assistance under the Iowa Health and Wellness Plan described in this chapter.

“*Minimum essential coverage*” means health insurance defined in Section 5000A(f) of Subtitle D of the Internal Revenue Code.

“*Modified adjusted gross income*” means the financial-eligibility methodology prescribed in 42 U.S.C. § 1396a(e)(14).

“*Qualified employer-sponsored coverage*” shall be defined pursuant to 42 U.S.C. § 1396e-1(b).

“*Qualified health plan*” shall be defined pursuant to Section 1301 of the Patient Protection and Affordable Care Act, Public Law 111-152.

441—74.2(249A,85GA,SF446) Eligibility factors. Except as more specifically provided in this chapter, Iowa Health and Wellness Plan eligibility shall be determined according to the requirements of 441—Chapter 75.

74.2(1) Persons covered. Subject to the additional requirements of this chapter and of 441—Chapter 75, medical assistance under the Iowa Health and Wellness Plan shall be available to persons 19 through 64 years of age who:

- a. Are not eligible for medical assistance in a mandatory group under 441—Chapter 75;
- b. Have countable income at or below 133 percent of the federal poverty level for their household size; and
- c. Are not entitled to or enrolled in Medicare benefits under Part A or Part B of Title XVIII of the Social Security Act; and
- d. Are not pregnant.

74.2(2) Parents or caretakers of dependent children. All dependent children under the age of 21 living with a parent or other caretaker relative must be enrolled in Medicaid, in the Children’s Health Insurance Program (CHIP), or in other minimum essential coverage as a condition of the parent’s or other caretaker relative’s eligibility for Iowa Health and Wellness Plan benefits.

74.2(3) Citizenship. To be eligible for Iowa Health and Wellness Plan benefits, a person must meet the citizenship requirements in 441—Chapter 75.

441—74.3(249A,85GA,SF446) Application. Medicaid application policies and procedures described in 441—Chapter 76 shall apply to applications for the Iowa Health and Wellness Plan.

441—74.4(249A,85GA,SF446) Financial eligibility.

74.4(1) Countable income. Individuals are financially eligible for the Iowa Health and Wellness Plan if their countable income is no more than 133 percent of the federal poverty level, as of the date of a decision on initial or ongoing eligibility.

74.4(2) Household size. For financial eligibility purposes, household size shall be determined according to the modified adjusted gross income (MAGI) methodology.

441—74.5(249A,85GA,SF446) Enrollment period.

74.5(1) Iowa Health and Wellness Plan eligibility shall be effective on the first day of the month following the month of application or the first day of the month all eligibility requirements are met, whichever is later. The enrollment period shall continue for 12 consecutive months unless the member is disenrolled in accordance with the provisions of rule 441—74.8(249A,85GA,SF446).

74.5(2) Care provided before enrollment. No payment shall be made for medical care received before the effective date of enrollment.

74.5(3) Reinstatement. Enrollment for the Iowa Health and Wellness Plan may be reinstated without a new application in accordance with 441—subrule 76.12(2).

441—74.6(249A,85GA,SF446) Reporting changes.

74.6(1) Reporting requirements. As a condition of ongoing enrollment, a member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member turns 65.
- d. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
- e. The member's dependent child loses minimum essential coverage.
- f. The member's countable income increases in a manner that must be reported according to the requirements of rule 441—76.15(249A).
- g. The member is confirmed pregnant.

74.6(2) Untimely report. When a change is not timely reported as required by this rule, any program expenditures for care or services provided when the member was not eligible shall be considered an overpayment and be subject to recovery from the member in accordance with rule 441—75.28(249A).

74.6(3) Effective date of change. After enrollment, changes reported during the month that affect the member's eligibility shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or
- b. The enrollment period has expired and the member is not eligible for a new enrollment period.

441—74.7(249A,85GA,SF446) Reenrollment. A new eligibility determination is required for consecutive 12-month enrollment periods. The reenrollment process will follow the requirements in 441—subrule 76.14(2).

441—74.8(249A,85GA,SF446) Terminating enrollment. Iowa Health and Wellness Plan enrollment shall end when any of the following occur:

1. The enrollment period ends and coverage for the next enrollment period has not been renewed.
2. The member becomes eligible for medical assistance in a mandatory coverage group under 441—Chapter 75.
3. The member is found to have been ineligible for any reason.
4. The member dies.
5. The member turns 65.
6. The member abandons Iowa residency.
7. The member becomes entitled or enrolled in Medicare Part A or Part B or both.
8. The member's dependent child loses minimum essential coverage.
9. The member's countable income exceeds 133 percent of the federal poverty level.

10. The member becomes pregnant.

11. The Iowa Health and Wellness Plan is discontinued according to the requirements in rule 441—74.14(249A,85GA,SF446).

441—74.9(249A,85GA,SF446) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member in accordance with rule 441—75.28(249A).

74.9(1) The department shall recover Medicaid funds expended on behalf of a member from the member's estate in accordance with rule 441—75.28(249A).

74.9(2) Funds received from third parties, including Medicare, by a provider other than a state mental health institute shall be reported to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

441—74.10(249A,85GA,SF446) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. Coverage decisions and actions by participating marketplace choice plans shall be appealed through the plans' grievance and appeal processes. Members will not be entitled to an appeal hearing if the sole basis for denying or limiting services is discontinuance of the program pursuant to rule 441—74.14(249A,85GA,SF446).

441—74.11(249A,85GA,SF446) Financial participation.

74.11(1) Copayment. Payment for nonemergency use of a hospital emergency department shall be subject to a \$10 copayment by the member, which shall be subtracted from the Iowa Health and Wellness Plan payment otherwise due to the provider. This copayment will be waived during the first year of the Iowa Health and Wellness Plan.

74.11(2) Reserved.

441—74.12(249A,85GA,SF446) Benefits and service delivery. Covered benefits and the service delivery method shall be determined by the member's countable income and health status.

74.12(1) *Iowa wellness plan services.* Iowa Health and Wellness Plan members with countable income that does not exceed 100 percent of the federal poverty level shall be enrolled in the Iowa wellness plan unless the member is determined by the department to be an exempt individual. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for Iowa wellness plan services.

a. Covered Iowa wellness plan services are essential health benefits, all other benefits required pursuant to 42 U.S.C. § 1396u-7(b)(1)(B), prescription drugs and dental services consistent with 441—Chapter 78, and habilitation services consistent with rule 441—78.27(249A).

b. The Iowa Health and Wellness Plan provider network shall include all providers enrolled in the medical assistance program, including all participating accountable care organizations.

c. Members enrolled in the Iowa wellness plan shall be subject to enrollment in managed care, other than PACE programs, pursuant to 441—Chapter 88. In addition to reimbursement for managed care pursuant to 441—Chapter 88, the department may provide care coordination fees, performance incentive payments, or shared savings arrangements for medical homes and accountable care organizations serving members enrolled in the Iowa Health and Wellness Plan.

d. When the member does not choose a primary medical provider, the department shall assign the member to a primary medical provider in accordance with the Medicaid managed health care mandatory enrollment provisions specified in 441—subrule 88.3(7) for mandatory enrollment counties and in accordance with quality data available to the department.

74.12(2) *Marketplace choice plan services.* Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level shall be enrolled in a marketplace choice plan unless the member is determined by the department to be an exempt individual. Marketplace choice coverage shall be provided through designated qualified health plans available on the health insurance marketplace. Covered services not provided by the marketplace choice plan will

be provided by the medical assistance program. Individuals who have been determined eligible for the marketplace choice plan, but who have not yet been enrolled in a marketplace choice plan, shall receive fee-for-service coverage under the Iowa wellness plan until they choose or are assigned to a marketplace choice plan.

a. Upon enrollment, a member shall choose a qualified health plan from those designated by the department to provide coverage to Iowa Health and Wellness Plan members.

b. When the member does not select a qualified health plan pursuant to notice of the need to do so, the department will select a plan, enroll the member, and notify the member of the assigned plan.

c. The department shall pay premiums to designated qualified health plans participating on the health insurance marketplace to buy coverage for eligible Iowa Health and Wellness Plan members. The department shall begin payment of the member's premiums for the first month of enrollment through the Iowa Health and Wellness Plan. The qualified health plan shall provide the member with an insurance card identifying the member as an enrollee of the plan. The department shall provide the member with a medical assistance eligibility card identifying the member as eligible for the marketplace choice plan.

d. Covered services are all benefits, including essential health benefits, provided by the designated qualified health plan on the health insurance marketplace, including prescription drugs. Dental services shall be provided through a contract with a commercial dental plan with covered services consistent with 441—Chapter 78. Services not covered by the qualified health plan, but covered pursuant to the marketplace choice 1115 waiver or the marketplace choice state plan will be covered by the Medicaid program.

74.12(3) *Exempt individuals.* An Iowa Health and Wellness Plan member who has been determined by the department to be an exempt individual shall be given the choice of the benefits and service delivery method provided by the Iowa wellness plan or receiving benefits and services pursuant to 441—Chapter 78.

74.12(4) *Qualified employer-sponsored coverage.* An individual who has access to cost-effective employer-sponsored coverage shall be subject to enrollment in the health insurance premium payment program pursuant to 441—Chapter 75.

441—74.13(249A,85GA,SF446) Claims and reimbursement methodologies.

74.13(1) *Claims for services not provided by a qualified health plan.* Claims for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's qualified health plan shall be submitted to the Iowa Medicaid enterprise as required by 441—Chapter 80.

74.13(2) *Payment for services not provided by a qualified health plan.* Payment for services provided under the Iowa wellness plan or for covered marketplace choice services not provided by the member's qualified health plan shall be provided in accordance with 441—Chapter 79 or as provided in a contract between the department and the provider.

74.13(3) *Payment for services provided by the marketplace choice plan.* Payment for services provided under the marketplace choice plan shall be made in accordance with the rates filed with the Iowa insurance division.

441—74.14(249A,85GA,SF446) Discontinuance of program.

74.14(1) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation, in a manner that reduces the percentage of federal assistance to the state, or if federal law or regulation affecting eligibility or benefits for the Iowa Health and Wellness Plan is modified, the department may implement an alternative plan as specified in the medical assistance state plan or waiver for coverage of the affected population, subject to prior, statutory approval of implementation of the alternative plan.

74.14(2) If the methodology for calculating the federal medical assistance percentage for eligible individuals, as provided in 42 U.S.C. § 1396d(y), is modified through federal law or regulation resulting in a reduction of the percentage of federal assistance to the state below 90 percent but not below 85 percent, the medical assistance program reimbursement rates for inpatient and outpatient hospital

services shall be reduced by a like percentage in the succeeding fiscal year, subject to prior, statutory approval of implementation of the reduction.

These rules are intended to implement 2013 Iowa Acts, Senate File 446, sections 166 to 173 and 185 to 187, and Iowa Code chapter 249A.

ITEM 2. Amend subrule 88.2(1) as follows:

88.2(1) *Contracts with HMOs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with an HMO licensed under the provisions of commerce department rules of the insurance division, 191—Chapter 40. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with HMOs.

a. to c. No change.

ITEM 3. Amend subrule 88.22(1) as follows:

88.22(1) *Contracts with PHPs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred. The department may also include the scope of services described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, or part thereof, in contracts with PHPs.

a. to c. No change.

ITEM 4. Amend subrule 88.48(1) as follows:

88.48(1) *Managed services.* Provision of the following services by any provider other than the patient manager requires authorization from the patient manager in order to be payable by Medicaid except that mental health and substance abuse services for all managed health care recipients are provided under the Iowa Plan program and do not require authorization (see rule 441—88.61(249A)):

a. to j. No change.

These services require authorization even if the need for the service is considered urgent. However, in case of urgent medical conditions, the patient manager shall arrange for necessary care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

Services or parts thereof described in 441—Chapter 74, known as the Iowa Health and Wellness Plan, require authorization by the patient manager as otherwise required by this division.

ITEM 5. Adopt the following **new** subrule 88.65(7):

88.65(7) *Iowa wellness plan service benefits.* Services described in 441—Chapter 74 that otherwise constitute covered services pursuant to this rule shall be included in Iowa Plan services for members enrolled in the Iowa Plan who are also Iowa wellness plan members.

[Filed Emergency After Notice 10/2/13, effective 10/2/13]

[Published 10/30/13]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/30/13.