ARC 1355C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 75, "Conditions of Eligibility," Iowa Administrative Code.

This rule making reinstates the rule governing the Iowa Medicaid "lock-in" program that was inadvertently omitted from recently adopted 441—Chapter 76.

Federal Medicaid regulations allow for the "lock-in" of beneficiaries who overutilize Medicaid services, restricting the beneficiaries to obtaining services from designated providers; see 42 CFR § 431.54. Iowa Code section 249A.4(7)"a" also provides that the Department may restrict Medicaid recipients' selection of providers to control overuse of care and services and that the Department "shall promulgate rules for determining the overuse of services, including rights of appeal by the recipient." Consistent with the federal regulations and the Iowa Code, Iowa's state plan for medical assistance, approved by the Centers for Medicare and Medicaid Services as a condition of federal funding, provides an exception to recipients' free choice of providers for lock-in; see Iowa State Plan for Medical Assistance, sec. 4.10(b)(1).

As of September 2013, the Department had a long-standing administrative rule at 441—76.9(249A) establishing and governing the Iowa Medicaid lock-in program. In amending its rules to comply with the federal Affordable Care Act, the Department intended to move its lock-in rule from Chapter 76 (on enrollment procedures) to Chapter 75 (on eligibility for services). However, the lock-in rule was inadvertently omitted from new Chapter 76 (see **ARC 1069C**, IAB 10/2/13, effective 10/1/13) and not included in revised Chapter 75 (see **ARC 1134C**, IAB 10/30/13, effective 10/2/13). Thus, the Notice of Intended Action (**ARC 0908C**, IAB 8/7/13) and Adopted and Filed Emergency After Notice (**ARC 1069C**, IAB 10/2/13) for new Chapter 76 made no mention of the fact that the lock-in rule was omitted.

This rule making reinstates the lock-in rule and places the rule in Chapter 75. The term "recipient" is updated to "member" throughout and cross references are updated. No other substantive changes are made to the rule as it existed prior to October 1, 2013.

Notice of Intended Action for this rule was published in the Iowa Administrative Bulletin as **ARC 1265C** on January 8, 2014. This rule was also Adopted and Filed Emergency and published as **ARC 1266C** on the same date.

The Department received comments on the proposed rule from three respondents. Each comment received by the Department was similar in nature, varying only in the specific group of persons the individual respondents wanted to add to the rules.

As a direct result of the comments, the Department agreed that subrule 75.30(2) should be broadened to allow for inclusion of various provider groups, including those represented by the respondents.

Specifically, the Department agreed to revise subrule 75.30(2) to read as follows:

"**75.30(2)** Provider selection. The member may select the provider(s) from which services will be received. The designated providers will be identified on the department's eligibility verification system (ELVS). Only prescriptions written or approved by the designated primary provider(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 75.30(3)."

The Council on Human Services adopted this rule on February 12, 2014.

This rule does not provide for waivers in specified situations because lock-in is based on individual determinations of overuse. Requests for 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.

This rule is intended to implement Iowa Code section 249A.4.

This rule will become effective April 9, 2014, at which time the Adopted and Filed Emergency rule is hereby rescinded.

The following amendment is adopted.

Adopt the following **new** rule 441—75.30(249A):

441—75.30(249A) Member lock-in. In order to promote high-quality health care and to prevent harmful practices such as duplication of medical services, drug abuse or overuse, and possible drug interactions, members that utilize medical assistance services or items at a frequency or in an amount which is considered to be overuse of services as defined in subrule 75.30(7) may be restricted (locked-in) to receive services from a designated provider(s).

75.30(1) A lock-in or restriction shall be imposed for a minimum of 24 months with longer restrictions determined on an individual basis.

75.30(2) Provider selection. The member may select the provider(s) from which services will be received. The designated providers will be identified on the department's eligibility verification system (ELVS). Only prescriptions written or approved by the designated primary provider(s) will be reimbursed. Other providers of the restricted service will be reimbursed only under circumstances specified in subrule 75.30(3).

75.30(3) Payment will be made to a provider(s) other than the designated (lock-in) provider(s) in the following instances:

a. Emergency care is required and the designated provider is not available. Emergency care is defined as care necessary to sustain life or prevent a condition which could cause physical disability.

b. The designated provider requires consultation with another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 75.30(5).

c. The designated provider refers the member to another provider. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written or approved by the primary physician(s). Referred physicians may be added to the designation as explained in subrule 75.30(5).

75.30(4) When the member fails to choose a provider(s) within 30 days of the request, the division of medical services will select the provider(s) based on previously utilized provider(s) and reasonable access for the member.

75.30(5) Members may change a designated provider(s) when a change is warranted, such as when the member has moved, the provider no longer participates, or the provider refuses to see the patient. The worker for the member shall make the determination when the member has demonstrated that a change is warranted. Members may add additional providers to the original designation with approval of a health professional employed by the department for this purpose.

75.30(6) When lock-in is imposed on a member, timely and adequate notice shall be sent and an opportunity for a hearing given in accordance with 441—Chapter 7.

75.30(7) Overuse of services is defined as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of service in an amount, duration, or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient.

a. Determination of overuse of service shall be based on utilization data generated by the Surveillance and Utilization Review Subsystem of the Medicaid Management Information System. The system employs an exception-reporting technique to identify the members most likely to be program overutilizers by reporting cases in which the utilization exceeds the statistical average.

b. In addition to referrals from the Surveillance and Utilization Review Subsystem described in paragraph 75.30(7)*"a,"* referrals for utilization review shall be made when utilization data generated by the Medicaid Management Information System reflects that utilization of Medicaid member outpatient visits to physicians, advanced registered nurse practitioners, federally qualified health centers, rural health centers, other clinics, and emergency rooms exceeds 24 visits in any 12-month period. This utilization review shall not apply to Medicaid members who are enrolled in the MediPASS program or a health maintenance organization or who are children under 21 years of age or residents of a nursing facility. For the purposes of this paragraph, the term "physician" does not include a psychiatrist.

c. An investigation process of Medicaid members determined in paragraph 75.30(7)*"a"* or *"b"* to be subject to a review of overutilization shall be conducted to determine if actual overutilization exists by verifying that the information reported by the computer system is valid and is also unusual

based on professional medical judgment. Medical judgments shall be made by physicians, pharmacists, nurses and other health professionals either employed by, under contract to, or as consultants for the department. These medical judgments shall be made by the health professionals on the basis of the body of knowledge each has acquired which meets the standards necessary for licensure or certification under the Iowa licensing statutes for the particular health discipline.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 3/5/14.