ARC 1618C

HUMAN SERVICES DEPARTMENT[441]

Notice of Intended Action

Twenty-five interested persons, a governmental subdivision, an agency or association of 25 or more persons may demand an oral presentation hereon as provided in Iowa Code section 17A.4(1)*"b."*

Notice is also given to the public that the Administrative Rules Review Committee may, on its own motion or on written request by any individual or group, review this proposed action under section 17A.8(6) at a regular or special meeting where the public or interested persons may be heard.

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to amend Chapter 74, "Iowa Health and Wellness Plan," and Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Iowa Administrative Code.

On January 1, 2014, the Iowa Health and Wellness Plan began providing medical assistance to low-income Iowans between the ages of 19 and 64 who meet the following eligibility criteria: income not exceeding 133 percent of the Federal Poverty Level (FPL) for family size, not eligible for any other full Medicaid group or Medicare, not pregnant, and dependent children of the applicant or member covered by minimum essential coverage.

These amendments clarify the policies and processes of the program. Amendments include: how the Healthy Behaviors Program works, how premiums will be charged, the medically exempt determination process, the appeals process, and the standards for Accountable Care Organizations to become Medicaid providers.

Any interested person may make written comments on the proposed amendments on or before September 9, 2014. Comments should be directed to Harry Rossander, Bureau of Policy Coordination, Department of Human Services, Hoover State Office Building, Fifth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by e-mail to policyanalysis@dhs.state.ia.us.

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.

The following amendments are proposed.

ITEM 1. Amend the following definitions in rule **441—74.1(249A,85GA,SF446)**:

"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. An accountable care organization shall be qualified pursuant to rule 441—77.51(249A).

"Enrollment period" means the 12-month period for which Iowa Health and Wellness plan 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~~ at 42 U.S.C. § 18022.

ITEM 2. Rescind the definition of "Exempt individuals" in rule **441—74.1(249A,85GA,SF446)**.

ITEM 3. Adopt the following **new** definitions in rule **441—74.1(249A,85GA,SF446)**:

"Caretaker relative" means a relative listed in 441—subrule 75.55(1).

"Medical home" means a provider contracted with the department through Form 470-5177, Agreement for Participation as a Patient Manager in the Iowa Health and Wellness Plan (Wellness Plan).

"Medically exempt individual" means an individual exempt from mandatory enrollment in an alternative benefit plan pursuant to 42 CFR § 440.315 as amended on July 15, 2013.

ITEM 4. Amend subrule 74.2(2) as follows:

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 who will be claimed as a dependent by the parent or caretaker relative for state or federal income tax purposes 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.

ITEM 5. Amend rule 441—74.5(249A,85GA,SF446) as follows:

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

74.5(1) *Effective dates of eligibility.* 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) *Retroactive enrollment.* ~~Care provided before enrollment. No payment shall be made for medical care received before the effective date of enrollment.~~ Medical assistance shall be available for all or any of the three months preceding the month in which an application is filed in accordance with 441—subrule 76.13(2).

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).

74.5(4) *Presumptive eligibility.* The enrollment period of 12 consecutive months shall not apply to individuals temporarily enrolled in Medicaid based on a presumptive eligibility determination by a qualified entity in accordance with rules 441—76.7(249A) and 441—76.13(249A).

ITEM 6. Amend rule 441—74.6(249A,85GA,SF446) as follows:

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.~~ A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.

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) and 441—Chapter 11. Program expenditures may include, but are not limited to, premiums and capitation payments.

74.6(3) No change.

ITEM 7. Amend rule 441—74.8(249A,85GA,SF446) as follows:

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

1. to 7. No change.

8. ~~The member's dependent child loses minimum essential coverage.~~ A child under the age of 21 living with the member loses minimum essential coverage, if the member is the child's parent or other caretaker relative and will claim the child as a dependent for state or federal income tax purposes.

9. No change.

10. The member ~~becomes~~ reports that she is pregnant.

11. No change.

12. The member does not pay monthly contributions as required by subrule 74.11(2).

ITEM 8. Amend rule 441—74.10(249A,85GA,SF446) as follows:

441—74.10(249A,85GA,SF446) Right to appeal.

74.10(1) 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.~~ A provider requesting a hearing on behalf of a member must have the prior express written consent of the member or the member's lawfully appointed guardian. Notwithstanding any contrary provision in 441—Chapter 7, no hearing will be granted unless the provider submits a document providing the member's consent to the request for a state fair hearing. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the member's knowledge of the potential for PHI to become public and that the member knowingly, voluntarily, and intelligently consents to the provider's bringing the state fair hearing on the member's behalf.

74.10(2) 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).

74.10(3) Coverage decisions and actions by participating marketplace choice plans must first be appealed through the plan's internal appeal process and through the external review process pursuant to Iowa Administrative Code 191—Chapter 76. After a member has exhausted the member's rights under the external review process, the member may appeal a decision or action pursuant to 441—Chapter 7. Appeal requests made pursuant to 441—Chapter 7 shall result in a change from benefits and service delivery under subrule 74.12(2) to benefits and service delivery under subrule 74.12(1). Benefits and service delivery under subrule 74.12(1) shall remain in effect for the remainder of the member's eligibility period.

ITEM 9. Amend rule 441—74.11(249A,85GA,SF446) as follows:

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~~ an $8 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~~ calendar year 2014.

74.11(2) *Monthly contributions.* ~~Reserved.~~ Members enrolled in the Iowa Health and Wellness Plan with household income at or above 50 percent of the federal poverty level are required to pay monthly contributions pursuant to this rule.

a. Monthly contribution amount. The monthly contribution amount for each member is based on the countable income of the member's household, determined pursuant to rule 441—75.70(249A), as a percentage of the federal poverty level (FPL) for the household. Monthly contribution amounts are as follows:

(1) For a member with household income between 50 and 100 percent of the FPL, $5;

(2) For a member with household income above 100 percent of the FPL, $10.

b. Waiver during the first year of enrollment. The monthly contribution will be waived during the member's first 12 months of continuous enrollment.

c. Monthly contribution exemptions. A member shall be exempt from monthly contribution payments when any of the following circumstances apply:

(1) The member completed healthy behaviors pursuant to subrule 74.11(4) in the previous enrollment period.

(2) The member is determined to be a medically exempt individual pursuant to subrule 74.12(3).

(3) The member has access to cost-effective, employer-sponsored coverage and is enrolled in the health insurance premium payment program pursuant to 441—Chapter 75.

(4) The member is exempt from premiums pursuant to 42 CFR 447.56(a)(1)(x) as an Indian who is eligible to receive or has received an item or service furnished by an Indian health care provider or through referral under contract health services.

(5) The member claims a hardship exemption indicating that payment of the monthly contribution will be a financial hardship. The member may claim a hardship exemption by telephoning the call center designated by the department or by submitting a written statement to the address designated by the department. The member's hardship exemption must be received or postmarked within five working days after the monthly contribution due date. If the hardship exemption request is not made in a timely manner, the exemption shall not be granted.

d. Billing and payment. Form XXX-XXX, Iowa Health and Wellness Plan Billing Statement, shall be used for billing and collection.

(1) Method of payment. Members shall submit contribution payments to the following address: Iowa Medicaid Enterprise, Iowa Health and Wellness Plan Monthly Contributions, P.O. Box XXXXX, Des Moines, Iowa XXXXX.

(2) Due date. When the department notifies a member of the amount of the monthly contribution, the member shall pay any monthly contributions due in accordance with the following:

1. The monthly contribution for each month is due on the last calendar day of the month that the monthly contribution is to cover.

2. If the last calendar day falls on a weekend or state or federal holiday, payment is due on the first working day following the weekend or holiday.

3. Monthly contribution payments must be received or postmarked by the due date.

(3) Application of payment. The department shall apply monthly contributions payments received to the oldest unpaid month in the current enrollment period. When monthly contributions for all months in the enrollment period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

e. Failure to pay monthly contributions.

(1) An Iowa wellness plan member who fails to pay the assessed monthly contributions and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall owe the monthly contribution to the department as an unpaid premium subject to recovery in accordance with rule 441—75.28(249A). A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before the unpaid amount shall be subject to recovery.

(2) A marketplace choice plan member who fails to pay the assessed monthly contribution and who does not qualify for a monthly contribution exemption pursuant to subrule 74.11(2) shall have the member's eligibility terminated. In addition, the unpaid monthly contribution shall be subject to recovery in accordance with rule 441—75.28(249A) as an unpaid premium.

1. A member shall have no less than 90 days from the due date to pay any unpaid monthly contribution before eligibility will be terminated or the unpaid amount will be subject to recovery.

2. A member whose eligibility is terminated due to nonpayment of monthly contributions must reenroll for Medicaid benefits pursuant to 441—Chapter 76.

f. Refund of monthly contributions.

(1) Monthly contributions paid for any period shall be refunded if the member qualified for a monthly contribution exemption pursuant to paragraph 74.11(2)*"c"* or when a member's Iowa Health and Wellness Plan coverage is terminated for the following reasons:

1. The member is no longer eligible for coverage in the Iowa Health and Wellness Plan; or

2. The member dies.

(2) The amount of any refund shall be offset by any outstanding monthly contributions owed.

(3) The refund shall be paid within two calendar months.

74.11(3) *Aggregate annual limits on copayments and monthly contributions.* The total aggregate annual amount of copayments and monthly contributions for an individual shall not exceed 5 percent of the household's countable annual income determined pursuant to rule 441—75.70(249A).

74.11(4) *Healthy behaviors.* An Iowa Health and Wellness Plan member who completes a wellness examination and health risk assessment during any enrollment year shall have monthly contributions waived in the subsequent enrollment year.

a. A wellness examination must be performed by a medical provider and must assess a member's overall physical health consistent with standard clinical guidelines for preventive physical examinations and as defined by the department.

b. A health risk assessment must be one of the following:

(1) An "Assess My Health" assessment offered through the department;

(2) An assessment offered by a managed care plan through which the member is receiving Iowa Health and Wellness Plan benefits; or

(3) An assessment offered by a qualified health plan through which the member is receiving Iowa Health and Wellness Plan benefits.

ITEM 10. Amend rule 441—74.12(249A,85GA,SF446) as follows:

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~~ a medically 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), including 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~~ 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~~ 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.

e. Dental services shall be provided through a contract with one or more commercial dental plans. The department may restrict member access to those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

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~~ a medically 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~~ marketplace choice 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~~ marketplace choice 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~~ in the qualified health 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~~ for covered medical services not provided by the qualified health 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.

e. Dental services shall be provided through a contract with one or more commercial dental plans with covered services consistent with 441—Chapter 78. The department may restrict member access to those entities with which the department contracts. The dental plan or plans shall provide the member with a dental card identifying the member as eligible for dental services.

74.12(3) ~~*Exempt*~~ *Medically exempt individuals.* An Iowa Health and Wellness Plan member who has been determined by the department to be ~~an~~ a medically 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.

a. A member may attest to being a medically exempt individual by submitting a completed Form 470-5194.

b. A provider with a current National Provider Identifier number, an employee of the department of human services, a designee of the department of corrections, a qualified health plan, or a mental health and disability services region established pursuant to Iowa Code sections 331.388 to 331.399 may refer a member for a medically exempt individual determination by submitting a completed Form 470-5196, Medically Exempt Attestation and Referral Form.

c. Upon receipt of Form 470-5194 or 470-5196, the Iowa Medicaid enterprise shall determine whether the member qualifies as a medically exempt individual in accordance with 42 CFR § 440.315 as amended on July 15, 2013.

74.12(4) No change.

ITEM 11. Adopt the following **new** rule 441—77.51(249A):

441—77.51(249A) Accountable care organizations. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as an accountable care organization (ACO).

77.51(1) *ACO qualifications.* ACO entities must meet the following requirements for participation as an ACO:

a. An ACO must be a Medicaid-enrolled provider. An ACO must complete enrollment in accordance with rule 441—79.14(249A).

b. The ACO shall execute a provider participation agreement in accordance with rule 441—79.6(249A).

c. An ACO must complete Form 470-5264, Iowa Wellness Plan ACO Readiness Application. The department reserves the right to approve the application.

d. The department and ACO shall enter into an agreement on Form 470-5218, Iowa Medicaid Accountable Care Organization (ACO) Agreement. The ACO shall comply with all requirements as identified in Form 470-5218.

e. The department reserves the right to restrict ACO enrollment so that the mixture of enrolled ACOs best matches the needs of the Medicaid member population.

77.51(2) *Member selection.* Medicaid members eligible for services from providers attributed to an ACO shall be required to choose their providers in accordance with 441—subrules 88.3(2) and 88.3(7).