

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency After Notice

Pursuant to the authority of Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, section 12(24), the Department of Human Services amends Chapter 36, “Facility Assessments,” Chapter 74, “Iowa Health and Wellness Plan,” Chapter 75, “Conditions of Eligibility,” 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 81, “Nursing Facilities,” Chapter 82, “Intermediate Care Facilities for Persons with an Intellectual Disability,” Chapter 83, “Medicaid Waiver Services,” Chapter 85, “Services in Psychiatric Institutions,” and Chapter 90, “Targeted Case Management,” and rescinds Chapter 92, “IowaCare,” Iowa Administrative Code.

Iowa’s Medicaid program is evolving to create a single system of care to address the health care needs of the whole person, including physical health, behavioral health, and long-term care services and supports. This initiative will deliver quality, patient-centered care to improve the overall health of the Medicaid population and will lead to a more predictable and sustainable budget.

Beginning January 1, 2016, HAWK-I members, Iowa Health and Wellness members, as well as the majority of Medicaid members will have their services coordinated through a managed care organization. Medicaid members who will not be served by a managed care organization include members of the Health Insurance Premium Payment (HIPP) Program, Medically Needy Program, or Programs for All-Inclusive Care for the Elderly (PACE); persons who are determined to be presumptively eligible for Medicaid services; members who participate in the Medicare Savings Program; and members who are American Indian or Alaska Natives who do not volunteer to be served through a managed care organization in this program.

This rule making is one of two rule makings that the Department is adopting to implement the Governor’s Medicaid Modernization Initiative as referenced in 2015 Iowa Acts, Senate File 505, section 12(24). The other Adopted and Filed Emergency After Notice rule making is published herein as **ARC 2358C**.

The amendments in this rule making:

- Clarify coverage under the Marketplace Choice Plan, as this coverage will be absorbed under the Iowa Health and Wellness Plan (IHAWP) and will be referred to as “Wellness Plan” moving forward.
- Clarify the process by which an IHAWP member claims a “hardship exemption,” indicating that payment of the monthly contribution for the Wellness Plan will be a financial hardship.
- Remove references to the Iowa Plan for Behavioral Health.
- Rescind outdated subrules regarding provider qualifications, prior to December 31, 2006, for home- and community-based services (HCBS) provided in residential care facilities.
- Remove outdated references to “mental retardation” and replace them with “intellectual disability.”
- Replace outdated references to “comprehensive functional assessment tool” for the intellectual disability waiver with “Supports Intensity Scale (SIS) assessment.”
- Remove outdated references to the Iowa Foundation for Medical Care (IFMC) and replace them with references to the IME medical services unit.
- Add the managed care organizations’ role or responsibility in delivery and payment of Medicaid-covered services.
- Clarify the process for provider notification of incident reports for members enrolled with a managed care organization (MCO).
- Add a new service definition of and reimbursement methodology and record requirements for child care medical services.
- Remove references to accountable care organizations.
- Remove outdated references to average wholesale price (AWP) for drug reimbursement and state maximum allowable cost (SMAC) reimbursement for generic drugs.

- Clarify that requests for prior authorization go through the managed care organization.
- Clarify the process for drug authorization and remove outdated language related to the process.
- Remove references to the MediPASS Program.
- Add definitions of level of care criteria for facilities and the HCBS waivers.
- Remove the service plan as a requirement for the HCBS waiver and state plan HCBS eligibility determinations.
- Rescind rules relating to IowaCare.

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 2242C** on November 11, 2015.

The Department received multiple comments from 28 respondents during the public comment period and at the five public hearings held across the state from December 2, 2015, to December 4, 2015. The comments were lengthy and in many instances duplicative. The public comments shown below are the nine comments that resulted in changes to the proposed amendments, and the Department's response follows each comment. A full electronic copy of the public comments and the Department's responses may be found on the Department's Web site, www.dhs.iowa.gov, under the rules section.

These rules are not intended to reiterate all provisions of the managed care contracts or all applicable federal requirements. The Department's contracts with the MCOs require compliance with all applicable legal requirements.

Comment 1: A respondent suggested the reference to "dental provider" be changed to "dentist" in paragraph 74.11(4)"a."

Department response 1: The Department accepted this recommendation and replaced the words "dental provider" with the word "dentist" in the last sentence of paragraph 74.11(4)"a." The amended paragraph now reads as follows:

"a. Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations 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. Oral examinations must be performed by a dentist consistent with standard oral health guidelines for preventive dental examinations and as defined by the department."

Comment 2: A respondent requested that the Department not change rule 441—77.10(249A), which pertains to medical equipment and appliances, prosthetic devices and medical supplies. The respondent stated that requiring all dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or other states to be certified to participate in Medicare would be a problem in areas where Medicare uses competitive bidding, as limited numbers of providers will be certified. The respondent also stated that it will make specialty items that Medicaid covers but Medicare does not cover even harder to acquire for Medicaid recipients in Iowa.

Department response 2: To ensure the success of this program, the Department accepted this recommendation and did not adopt the proposed amendments to rule 441—77.10(249A) in Item 19 of the Notice. The Department will continue to look at how Medicare is implementing competitive bidding to see if this should be added in the future. Because Item 19 in the Notice has been omitted, subsequent item numbers within the body of this rule-making document have been renumbered accordingly.

Comment 3: A respondent stated that the proposed amendment to rule 441—77.12(249A) requires previously unaccredited behavioral health intervention providers to become accredited to continue to provide services and that requiring accreditation from the named accreditation bodies without a reasonable time frame for transition will decrease access to services for Iowans. The respondent asked that a 12-month transition time line be set to allow providers who are not accredited the time necessary to complete the accreditation process.

Department response 3: The Department changed the amendments to rule 441—77.12(249A) to add a sixth accreditation item to the list being appended to the rule. Specifically, paragraph "6" referencing 441—Chapter 24, Accreditation of providers of services to persons with mental illness, intellectual disabilities or developmental disabilities, has been added as shown below as Chapter 24 is considered an acceptable accreditation body for behavioral health interventions. New paragraph "6" of rule 441—77.12(249A) reads as follows:

“6. Iowa Administrative Code 441—Chapter 24, “Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities.”

Comment 4: A respondent proposed the use of consistent descriptions of services in all rules by using the description “nursing, psychosocial, developmental therapies and personal care” in new rule 441—77.51(249A) to more accurately reflect the program.

Department response 4: The Department accepted this recommendation and made the following change to new rule 441—77.51(249A):

441—77.51(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, ~~and~~ developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

Comment 5: A respondent proposed that new subrule 78.28(8) be changed to use a consistent description of services in all rules, namely, “nursing, psychosocial, developmental therapies and personal care.” The respondent also proposed removal of the words “per discipline” as providers currently indicate expected number of hours per day/days per week based on the plan of care using a combined hourly rate.

Department response 5: The Department accepted this recommendation and made the following changes to new subrule 78.28(8):

78.28(8) Nursing, ~~personal care, or~~ psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service ~~per discipline~~ based on the plan of care using a combined hourly rate.

Comment 6: A respondent recommended that language be added to new subrule 78.57(2), specifically, that “teaching pro-social skills and reinforcing positive interactions” be added to the end of the last sentence after “self-help skills.” The respondent stated that these are current program activities and that the additional language clarifies that these activities could be provided by a trained caregiver without licensed mental health oversight.

Department response 6: The Department accepted this recommendation and made the following change to new subrule 78.57(2):

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member’s physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member’s plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

Comment 7: A respondent recommended changing new subrule 78.57(3) by removing the language “teach pro-social skills and reinforcing positive interactions” and replacing it with “focus at decreasing or eliminating maladaptive behaviors” to clarify the type of care plan interventions that are truly “psychosocial services” and need the review of licensed mental health providers.

Department response 7: The Department accepted this recommendation and made the following change to new subrule 78.57(3):

78.57(3) Psychosocial services are those services that ~~teach pro-social skills and reinforce positive interactions~~ focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in

subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

Comment 8: A respondent proposed that an additional subrule be added to rule 441—78.57(249A). Specifically, the respondent stated that there should be a definitional subrule for developmental therapies and recommended a new subrule to assist in clarifying developmental therapies and that the content of the new subrule might read as follows:

“Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(4). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor and receptive expressive language.”

Department response 8: The Department accepted this recommendation and added a new subrule 78.57(4) to rule 441—78.57(249A) and renumbered proposed subrules 78.57(4) to 78.57(6) as 78.57(5) to 78.57(7). New subrule 78.57(4) reads as follows:

“**78.57(4)** Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.”

Comment 9: A respondent proposed adding the term “developmental therapies” throughout new rule 441—78.57(249A) and proposed that treatment plan language be deleted and “plan of care” be inserted in lieu thereof for consistency. The respondent also proposed changes to proposed subparagraph 78.57(5)“c”(8) to clarify information requirements.

Department response 9: The Department accepted this recommendation and made the following changes to new subrule 78.57(6) (proposed subrule 78.57(5)):

78.57(6) Requirements.

a. Nursing, ~~personal care, or psychosocial,~~ developmental therapies and personal care services shall be ordered in writing.

b. Nursing, ~~personal care, or psychosocial,~~ developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The ~~treatment~~ plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

(1) to (7) No change.

(8) Member's medical condition as reflected by the following information, if applicable:

1. Dates of prior hospitalization.
2. Dates of prior surgery.
3. Date last seen by a primary care provider.
4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
5. Prognosis.
6. Functional limitations.
7. Vital signs reading.

- 8. ~~Date of last episode of instability.~~
 - 9. 8. Date of last episode of acute recurrence of illness or symptoms.
 - 10. 9. Medications.
- (9) to (12) No change.

Pursuant to Iowa Code section 17A.5(2)“b”(1) as amended by 2015 Iowa Acts, House File 536, section 27, the Department finds that the normal effective date of these amendments, 35 days after publication, can be waived and the amendments made effective January 1, 2016, in accordance with legislative authority as found in 2015 Iowa Acts, Senate File 505, section 12(24).

The Council on Human Services adopted these amendments on December 16, 2015.

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, there will be a reduction in the staff of the current vendors providing administrative support to the current Medicaid program; however, the managed care organizations will be hiring new staff to accommodate their new line of business in Iowa.

These amendments are intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, section 12(24).

These amendments became effective January 1, 2016.

The following amendments are adopted.

ITEM 1. Amend **441—Chapter 36**, division I title, as follows:

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR ~~THE MENTALLY RETARDED~~
PERSONS WITH AN INTELLECTUAL DISABILITY

ITEM 2. Amend rule 441—36.1(249A) as follows:

441—36.1(249A) Assessment of fee. Intermediate care facilities for ~~the mentally retarded~~ persons with an intellectual disability (ICFs/~~MR~~ ID) licensed in Iowa under 481—Chapter 64 shall pay a monthly fee to the department. Effective January 1, 2008, the fee shall equal 5.5 percent of the total revenue of the facility for the facility’s preceding fiscal year divided by the number of months of facility operation during the preceding fiscal year.

ITEM 3. Amend subrule 36.2(3) as follows:

36.2(3) ~~The department shall deduct the monthly amount due from medical assistance payments to the facility. The department shall also deduct from medical assistance payments any additional amount due for past months as a result of an adjustment to the assessment. ICFs/ID shall pay the monthly amount due to the department.~~

ITEM 4. Amend subrule 36.3(1) as follows:

36.3(1) Any licensed ICF/~~MR~~ ID in Iowa that is not certified to participate in the Medicaid program shall submit Form 470-0030, Financial and Statistical Report, as required for participating facilities by rule 441—82.5(249A), for purposes of determining the amount of the assessment. The department may audit and adjust the reports submitted, as provided for participating facilities in 441—subrules 82.5(10) and 82.17(1).

ITEM 5. Rescind the definition of “Accountable care organization” in rule **441—74.1(249A,85GA,SF446)**.

ITEM 6. Adopt the following **new** definition of “Managed care organization” in rule **441—74.1(249A,85GA,SF446)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 7. Amend subparagraph **74.11(2)“c”(5)** as follows:

(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, by checking the hardship box on the billing statement (for the month of the billing statement), 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.

ITEM 8. Amend paragraph **74.11(4)“a”** as follows:

a. A Under healthy behaviors, a wellness examination may be related to either physical health or oral health. Physical examinations 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. Oral examinations must be performed by a dentist consistent with standard oral health guidelines for preventive dental examinations and as defined by the department.

ITEM 9. Amend subrule 74.12(1) as follows:

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 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. No change.

~~b. The Iowa wellness plan provider network shall include all providers enrolled in the medical assistance program, including all participating accountable care organizations.~~

~~e. b. 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 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. c. 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.~~

ITEM 10. Amend subrule 74.12(2) as follows:

74.12(2) Marketplace choice plan services. At the department’s discretion, Iowa Health and Wellness Plan members with countable income between 101 percent and 133 percent of the federal poverty level shall may be enrolled in a marketplace choice plan unless the member is determined by the department to be a medically exempt individual. Marketplace At the department’s discretion, marketplace choice coverage shall may 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. to e. No change.

ITEM 11. Amend subrule 74.13(1) as follows:

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 or to the member's Medicaid managed care organization.

ITEM 12. Amend subrule 74.13(2) as follows:

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 or the member's Medicaid managed care organization and the provider.

ITEM 13. Rescind and reserve rule **441—74.15(249A,85GA,ch138)**.

ITEM 14. Amend paragraph **75.21(10)“b”** as follows:

b. For individual health plans, the client shall complete HIPP ~~Individual~~ Private Policy Review, Form 470-3017, for the review.

ITEM 15. Amend subparagraph **75.21(12)“a”(3)** as follows:

(3) The health plan is no longer available to the family (e.g., the employer ~~drops~~ no longer provides health insurance coverage or the policy is terminated by the insurance company).

ITEM 16. Amend rule **441—75.25(249A)**, definition of “Noncovered Medicaid services,” as follows:

“Noncovered Medicaid services” for medically needy shall mean medical services that are not covered under Medicaid because the provider was not enrolled in Medicaid, the services are ones which are otherwise not covered under Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

ITEM 17. Amend subrule 75.28(7) as follows:

75.28(7) *Estate recovery.* Medical assistance, including the amount the state paid to a managed care organization (MCO) for provision of medical services, also called capitation fees, is subject to recovery from the estate of a Medicaid member, the estate of the member's surviving spouse, or the estate of the member's surviving child as provided in this subrule. Effective January 1, 2010, medical assistance that has been paid for Medicare cost sharing or for benefits described in Section 1902(a)(10)(E) of the Social Security Act is not subject to recovery. All assets included in the estate of the member, the surviving spouse, or the surviving child are subject to probate for the purposes of medical assistance estate recovery pursuant to Iowa Code section ~~249A.5(2)“d.”~~ 249A.53(2)“d.” The classification of the debt is defined at Iowa Code section 633.425(7).

a. Definition of estate Definitions.

“Capitated payment/rate” means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract. Payment is made regardless of whether the member receives services during the month.

“Estate.” For the purpose of this subrule, the “estate” of a Medicaid member, a surviving spouse, or a surviving child shall include all real property, personal property, or any other asset in which the member, spouse, or surviving child had any legal title or interest at the time of death, or at the time a child reaches the age of 21, to the extent of that interest. An estate includes, but is not limited to, interest in jointly held property, retained life estates, and interests in trusts.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

b. to f. No change.

g. Waiving the collection of the debt.

(1) The department shall waive the collection of the debt created under this subrule from the estate of the member to the extent that collection of the debt would result in either of the following:

1. No change.
2. Creation of an undue hardship for the person seeking a waiver of estate recovery. Undue hardship exists when total household income is less than 200 percent of the poverty level for a household of the same size, total household resources do not exceed \$10,000, and application of estate recovery would result in deprivation of food, clothing, shelter, or medical care such that life or health would be endangered. For this purpose, “income” and “resources” shall be defined as being under the family ~~medical assistance~~ investment program.

(2) To apply for a waiver of estate recovery due to undue hardship, the person shall provide a written statement and supporting verification to the department within 30 days of the notice of estate recovery pursuant to Iowa Code section ~~633.425~~ 249A.53(2).

(3) No change.

h. to k. No change.

ITEM 18. Rescind and reserve rule **441—75.30(249A)**.

ITEM 19. Amend rule 441—77.12(249A) as follows:

441—77.12(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is ~~enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV. Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.~~ accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. Iowa Administrative Code 441—Chapter 24, “Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities.”

This rule is intended to implement Iowa Code section 249A.4 and 2010 Iowa Acts, chapter 1192, section 31.

ITEM 20. Amend rule 441—77.25(249A), introductory paragraph, as follows:

441—77.25(249A) Home- and community-based habilitation services. To be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall ~~be an enrolled provider of habilitation with the Iowa Plan for Behavioral Health and~~ meet the general requirements in subrules 77.25(2), 77.25(3), and 77.25(4) and shall meet the requirements in the subrules applicable to the individual services being provided.

ITEM 21. Adopt the following **new** definition of “Managed care organization” in subrule **77.25(1)**:
“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 22. Amend subparagraph **77.25(3)“b”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 23. Rescind paragraph **77.25(6)“j.”**

ITEM 24. Rescind paragraph **77.25(7)“g.”**

ITEM 25. Rescind and reserve subrule **77.25(10)**.

ITEM 26. Amend subparagraph **77.30(18)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 27. Amend subparagraph **77.33(22)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 28. Amend subparagraph **77.34(14)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 29. Amend subparagraph **77.37(8)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 30. Amend subparagraph **77.37(23)“d”(4)** as follows:

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on ~~Form 470-3273, Mental Retardation Functional Assessment Tool~~ the Supports Intensity Scale® (SIS) assessment.

ITEM 31. Amend subparagraph **77.37(23)“d”(6)** as follows:

- (6) The individual service plan shall be revised when any of the following occur:
1. and 2. No change.
 3. Changes have occurred in the identified service needs of the child, as listed on ~~Form 470-3273, Mental Retardation Functional Assessment Tool~~ the Supports Intensity Scale® (SIS) assessment.

4. No change.

ITEM 32. Amend subparagraph **77.39(6)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 33. Amend subparagraph **77.41(12)“c”(2)** as follows:

(2) By the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 34. Amend subparagraph **77.46(1)“d”(4)** as follows:

(4) Reporting procedure for major incidents. By the end of the next calendar day after a major incident, the staff member who observed or first became aware of the incident shall also report as much information as is known about the incident to the member’s managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department’s bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 35. Amend subparagraph **77.47(1)“d”(2)** as follows:

(2) Have a direct agreement with ~~the~~ an Iowa Medicaid managed ~~behavioral health care~~ behavioral health care organization to provide health home services for members with SMI or SED;

ITEM 36. Rescind rule 441—77.51(249A) and adopt the following **new** rule in lieu thereof:

441—77.51(249A) Child care medical services. Child care centers are eligible to participate in the medical assistance program when they comply with the standards of 441—Chapter 109. A child care center in another state is eligible to participate when duly licensed in that state. The provider of child care medical services implements a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, psychosocial, developmental therapies and personal care required by the medically dependent or technologically dependent child served. Nursing services must be provided.

ITEM 37. Amend paragraph **78.1(1)“g”** as follows:

g. Charges for surgical procedures on the “Outpatient/Same Day Surgery List” produced by ~~the Iowa Foundation for Medical Care~~ IME medical services unit or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital’s utilization review department prior to the patient’s admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall

be developed by the ~~Iowa Foundation for Medical Care~~, IME medical services unit and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The ~~Iowa Foundation for Medical Care~~ IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

ITEM 38. Amend subrule 78.1(19) as follows:

78.1(19) Preprocedure review by the ~~Iowa Foundation for Medical Care (IFMC)~~ IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the ~~IFMC~~ IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the ~~published~~ criteria established by the ~~IFMC~~ IME medical services unit and the department. If not so approved by the ~~IFMC~~ IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from ~~IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices~~ the IME medical services unit.

The "~~Preprocedure Surgical Review List~~" shall be ~~published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. The "Preprocedure Surgical Review List" shall be developed by the department with advice and consultation from the IFMC and appropriate professional organizations and will list the procedures for which prior review is required and the steps that must be followed in requesting such review. The department shall update the "Preprocedure Surgical Review List" annually. (Cross-reference 78.28(1) "e.")~~

ITEM 39. Amend paragraph **78.1(20)"a"** as follows:

a. Payment will be made only for the following organ and tissue transplant services:

(1) to (3) No change.

(4) Liver transplants for persons with extrahepatic biliary artesia atresia or any other form of end-stage liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver.

Liver transplants require preprocedure review by the ~~Iowa Foundation for Medical Care~~ IME medical services unit. (Cross-reference 78.1(19) and 78.28(1) "f.")

Covered liver transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(5) Heart transplants for persons with inoperable congenital heart defects, heart failure, or related conditions. Artificial hearts and ventricular assist devices as a temporary life-support system until a human heart becomes available for transplants are covered. Artificial hearts and ventricular assist devices as a permanent replacement for a human heart are not covered. Heart-lung transplants are covered where bilateral or unilateral lung transplantation with repair of a congenital cardiac defect is contraindicated.

Heart transplants, heart-lung transplants, artificial hearts, and ventricular assist devices described above require preprocedure review by the ~~Iowa Medicaid enterprise~~ IME medical services ~~prior authorization~~ unit. (Cross-reference 78.1(19) and 78.28(1) "f.") Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

(6) Lung transplants. Lung transplants for persons having end-stage pulmonary disease. Lung transplants require preprocedure review by the ~~Iowa Foundation for Medical Care~~ IME medical services unit. (Cross-reference 78.1(19) and 78.28(1) "f.") Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10). Heart-lung transplants are covered consistent with criteria in subparagraph (5) above.

(7) Pancreas transplants for persons with type I diabetes mellitus, as follows:

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.

2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the ~~Iowa Foundation for Medical Care~~ IME medical services unit. (Cross-reference 78.1(19) and 78.28(1)“f.”)

Covered transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

Transplantation of islet cells or partial pancreatic tissue is not covered.

ITEM 40. Amend subrule 78.2(5) as follows:

78.2(5) Nonprescription drugs.

a. The following drugs that may otherwise be dispensed without a prescription are covered subject to the prior authorization requirements stated below and as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

Acetaminophen tablets 325 mg, 500 mg
 Acetaminophen elixir 160 mg/5 ml
 Acetaminophen solution 100 mg/ml
 Acetaminophen suppositories 120 mg
 Artificial tears ophthalmic solution
 Artificial tears ophthalmic ointment
 Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
 Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
 Aspirin tablets, buffered 325 mg
 Bacitracin ointment 500 units/gm
 Benzoyl peroxide 5%, gel, lotion
 Benzoyl peroxide 10%, gel, lotion
 Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
 Calcium carbonate suspension 1250 mg/5 ml
 Calcium carbonate tablets 600 mg
 Calcium carbonate-vitamin D tablets 500 mg-200 units
 Calcium carbonate-vitamin D tablets 600 mg-200 units
 Calcium citrate tablets 950 mg (200 mg elemental calcium)
 Calcium gluconate tablets 650 mg
 Calcium lactate tablets 650 mg
 Cetirizine hydrochloride liquid 1 mg/ml
 Cetirizine hydrochloride tablets 5 mg
 Cetirizine hydrochloride tablets 10 mg
 Chlorpheniramine maleate tablets 4 mg
 Clotrimazole vaginal cream 1%
 Diphenhydramine hydrochloride capsules 25 mg
 Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
 Epinephrine racemic solution 2.25%
 Ferrous sulfate tablets 325 mg
 Ferrous sulfate elixir 220 mg/5 ml
 Ferrous sulfate drops 75 mg/0.6 ml
 Ferrous gluconate tablets 325 mg
 Ferrous fumarate tablets 325 mg
 Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
 Ibuprofen suspension 100 mg/5 ml
 Ibuprofen tablets 200 mg
 Insulin
 Lactic acid (ammonium lactate) lotion 12%
 Loperamide hydrochloride liquid 1 mg/5 ml

Loperamide hydrochloride tablets 2 mg
 Loratadine syrup 5 mg/5 ml
 Loratadine tablets 10 mg
 Magnesium hydroxide suspension 400 mg/5 ml
 Magnesium oxide capsule 140 mg (85 mg elemental magnesium)
 Magnesium oxide tablets 400 mg
 Meclizine hydrochloride tablets 12.5 mg, 25 mg oral and chewable
 Miconazole nitrate cream 2% topical and vaginal
 Miconazole nitrate vaginal suppositories, 100 mg
 Multiple vitamin and mineral products with prior authorization
 Neomycin-bacitracin-polymyxin ointment
 Niacin (nicotinic acid) tablets 50 mg, 100 mg, 250 mg, 500 mg
 Nicotine gum 2 mg, 4 mg
 Nicotine lozenge 2 mg, 4 mg
 Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
 Pediatric oral electrolyte solutions
 Permethrin lotion 1%
 Polyethylene glycol 3350 powder
 Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
 Pseudoephedrine hydrochloride liquid 30 mg/5 ml
 Pyrethrins-piperonyl butoxide liquid 0.33-4%
 Pyrethrins-piperonyl butoxide shampoo 0.3-3%
 Pyrethrins-piperonyl butoxide shampoo 0.33-4%
 Salicylic acid liquid 17%
 Senna tablets 187 mg
 Sennosides-docusate sodium tablets 8.6 mg-50 mg
 Sennosides syrup 8.8 mg/5 ml
 Sennosides tablets 8.6 mg
 Sodium bicarbonate tablets 325 mg
 Sodium bicarbonate tablets 650 mg
 Sodium chloride hypertonic ophthalmic ointment 5%
 Sodium chloride hypertonic ophthalmic solution 5%
 Tolnaftate 1% cream, solution, powder

Other nonprescription drugs listed as preferred in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A.

b. Nonprescription drugs for use in a nursing facility, PMIC, or ICF/ID shall be included in the per diem rate paid to the nursing facility, PMIC, or ICF/ID.

ITEM 41. Amend subrule 78.3(13) as follows:

78.3(13) Payment for patients in acute hospital beds who are determined by ~~IFMC~~ the IME medical services unit to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by ~~IFMC~~ the IME medical services unit that the lower level of care is required or (b) for the days ~~IFMC~~ the IME medical services unit determines in an outlier review that the lower level of care was required.

ITEM 42. Amend subrule 78.3(14) as follows:

78.3(14) Payment for patients in acute hospital beds who are determined by ~~IFMC~~ the IME medical services unit to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph

81.6(16) “f”(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by ~~IFMC~~ the IME medical services unit that the lower level of care is required or (b) for the days ~~IFMC~~ the IME medical services unit determines in an outlier review that the lower level of care was required.

ITEM 43. Amend subrule 78.3(15) as follows:

~~78.3(15) Payment for inpatient hospital charges associated with surgical procedures on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital’s utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor’s office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.” normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.~~

ITEM 44. Amend subrule 78.3(18) as follows:

~~78.3(18) Preprocedure review by the IFMC~~ IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices the IME medical services unit. (Cross-reference 78.28(5))

ITEM 45. Amend subrule **78.12(1)**, definition of “Licensed practitioner of the healing arts,” as follows:

“Licensed practitioner of the healing arts” or “LPHA,” as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

- 1. Is licensed by the applicable state authority for that profession;*
- 2. Is enrolled in the Iowa Plan for Behavioral Health (Iowa Plan) pursuant to 441—Chapter 88, Division IV; and*
- 3. Is qualified to provide clinical assessment services (Current Procedural Terminology code 90801) under the Iowa Plan pursuant to 441—Chapter 88, Division IV.*

ITEM 46. Adopt the following **new** definition of “Managed care organization” in subrule **78.12(1)**:

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 47. Amend subparagraph **78.12(4)“b”(2)** as follows:

(2) ~~Diagnosis and treatment plan development provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.~~

ITEM 48. Amend paragraph **78.26(4)“c”** as follows:

c. ~~Preprocedure review by the Iowa Foundation for Medical Care (IFMC) IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices the IME medical services unit. (Cross-reference 78.28(6))~~

ITEM 49. Amend rule 441—78.27(249A), introductory paragraph, as follows:

441—78.27(249A) Home- and community-based habilitation services. Payment for habilitation services will only be made to providers enrolled to provide habilitation through the Iowa Plan ~~for Behavioral Health Medicaid enterprise.~~

ITEM 50. Adopt the following **new** definition of “Managed care organization” in subrule **78.27(1)**:
“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 51. Amend paragraph **78.27(2)“d”** as follows:

d. *Needs assessment.* The member’s case manager or integrated health home care coordinator has completed an assessment of the member’s need for service, and, based on that assessment, the Iowa Medicaid enterprise IME medical services unit ~~or the Iowa Plan for Behavioral Health contractor~~ has determined that the member is in need of home- and community-based habilitation services. ~~A member who is not eligible for integrated health home services shall receive Medicaid case management under 441—Chapter 90 as a home- and community-based habilitation service.~~ The designated case manager or integrated health home care coordinator shall:

(1) and (2) No change.

ITEM 52. Amend paragraph **78.27(2)“e”** as follows:

e. *Plan for service.* The department ~~or the Iowa Plan for Behavioral Health contractor~~ has approved the member’s comprehensive service plan for home- and community-based habilitation services. Home- and community-based habilitation services included in a comprehensive service plan or treatment plan that has been validated through ISIS ~~or in a treatment plan that has been authorized by the Iowa Plan for Behavioral Health contractor~~ shall be considered approved by the department. Home- and community-based habilitation services provided before approval of a member’s eligibility for the program cannot be reimbursed.

(1) to (3) No change.

ITEM 53. Rescind paragraph **78.27(2)“f.”**

ITEM 54. Amend subrule 78.27(3) as follows:

78.27(3) Application for services. The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the Iowa Plan ~~for Behavioral Health contractor or by entering a program request for habilitation services in ISIS for members who are not eligible to enroll in the Iowa Plan for Behavioral Health for any reason~~ IME medical services unit. The department ~~or the Iowa Plan for Behavioral Health contractor~~ shall issue a notice of decision to the applicant when financial eligibility, ~~determination of and~~ needs-based eligibility, ~~and approval of the comprehensive service plan or treatment plan~~ determinations have been completed.

ITEM 55. Amend subparagraph **78.27(4)“a”(9)** as follows:

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the ~~Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise for members who are not eligible to enroll in the Iowa Plan for Behavioral Health,~~ IME medical services unit in the individualized services information system ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

ITEM 56. Amend subparagraph **78.27(4)“a”(10)** as follows:

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the ~~Iowa Plan for Behavioral Health contractor, or by the Iowa Medicaid enterprise~~ IME medical services unit for members not eligible to enroll in the ~~Iowa Plan for Behavioral Health,~~ a managed care organization in the ~~individualized services information system ISIS~~ before the implementation of services. Services provided before the approval date are not payable.

ITEM 57. Amend paragraph **78.27(4)“e”** as follows:

e. Plan approval.

~~(1) A treatment plan that has been validated and authorized by the Iowa Plan for Behavioral Health contractor shall be considered approved.~~

(2) ~~For members who are not Iowa Plan eligible, services~~ Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2) “e.”

ITEM 58. Amend subrule 78.27(11) as follows:

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department ~~or the Iowa Plan for Behavioral Health contractor~~ determines that:

(1) to (5) No change.

b. Reduction. A particular home- and community-based habilitation service may be reduced when the department ~~or the Iowa Plan for Behavioral Health contractor~~ determines that continued provision of service at its current level is not necessary.

c. Termination. A particular home- and community-based habilitation service may be terminated when the department ~~or the Iowa Plan for Behavioral Health contractor~~ determines that:

(1) to (4) No change.

(5) The member has received care in a medical institution for 30 consecutive days in any one stay. When a member has been an inpatient in a medical institution for 30 consecutive days, the department ~~or the Iowa Plan for Behavioral Health contractor~~ will issue a notice of decision to inform the member of the service termination. If the member returns home before the effective date of the notice of decision and the member’s condition has not substantially changed, the decision shall be rescinded, and eligibility for home- and community-based habilitation services shall continue.

(6) to (9) No change.

d. Appeal rights.

~~(1) The Iowa Plan for Behavioral Health contractor shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7.~~

(2) The department shall give notice of any adverse action and the right to appeal in accordance with 441—Chapter 7. The member is entitled to have a review of the determination of needs-based eligibility by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit. If dissatisfied with that decision, the member may file an appeal with the department.

ITEM 59. Amend paragraph **78.28(1)“f”** as follows:

f. Preprocedure review by the ~~Iowa Foundation for Medical Care (IFMC)~~ IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by ~~IFMC~~ the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the ~~published~~ criteria established by the department and the ~~IFMC~~ IME medical services unit. If not so approved by the ~~IFMC~~ IME medical services unit, payment will not be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from ~~IFMC, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices~~ the IME medical services unit.

~~The “Preprocedure Surgical Review List” shall be published by the department in the provider manuals for physicians, hospitals, and ambulatory surgical centers. (Cross-reference 78.1(19))~~

ITEM 60. Amend paragraph **78.28(5)“b”** as follows:

b. All inpatient hospital admissions are subject to ~~preadmission~~ retrospective review. Payment for inpatient hospital admissions ~~which are retrospectively reviewed~~ is approved when ~~it the claim~~ meets the criteria for inpatient hospital care as determined by the ~~IFMC or its delegated hospitals~~ IME medical services unit. Criteria are available from ~~IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices~~ the IME medical services unit. (Cross-reference 441—78.3(249A))

ITEM 61. Amend paragraph **78.28(5)“c”** as follows:

c. Preprocedure review by the ~~IFMC~~ IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the ~~IFMC~~ IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department and ~~IFMC~~. The criteria are available from ~~IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices~~ the IME medical services unit.

ITEM 62. Adopt the following **new** subrule 78.28(8):

78.28(8) Nursing, psychosocial, developmental therapies and personal care services provided by a licensed child care center for members aged 20 or under require prior approval and shall be approved if the services are determined to be medically necessary. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation and shall identify the types and service delivery levels of all other services provided to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of nursing, home health aide or behavior intervention hours per day, the number of days per week, and the number of weeks or months of service based on the plan of care using a combined hourly rate.

ITEM 63. Amend subrule 78.31(1) as follows:

78.31(1) *Covered hospital outpatient services.* Payment will be approved only for the following outpatient hospital services and medical services when provided on the licensed premises of the hospital or pursuant to subrule 78.31(5). Hospitals with alternate sites approved by the department of inspections and appeals are acceptable sites. All outpatient services listed in paragraphs “g” to “m” are subject to a random sample retrospective review for medical necessity by the ~~Iowa Foundation for Medical Care~~ IME medical services unit. All services may also be subject to a more intensive retrospective review if abuse is suspected. Services in paragraphs “a” to “j” shall be provided in hospitals on an outpatient basis and are subject to no further limitations except medical necessity of the service.

Services listed in paragraphs “g” to “m” shall be provided by hospitals on an outpatient basis and must be certified by the department before payment may be made. Other limitations apply to these services.

a. to n. No change.

ITEM 64. Amend rule 441—78.33(249A) as follows:

441—78.33(249A) Case management services.

~~78.33(1)~~ Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

a. 1. Members who are 18 years of age or over and have a primary diagnosis of ~~mental retardation~~ intellectual disability, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. 2. Members who are under 18 years of age and are receiving services under the HCBS intellectual disability waiver or children’s mental health waiver.

~~78.33(2)~~ Notwithstanding ~~subrule 78.33(1)~~, payment shall not be made for targeted case management services for members who are enrolled in the Iowa Plan for Behavioral Health to receive habilitation pursuant to rule 441—78.27(249A) and are enrolled in an integrated health home as described in rule 441—78.53(249A). Members enrolled in the Iowa Plan for Behavioral Health for habilitation and an integrated health home shall receive care coordination in lieu of case management.

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

ITEM 65. Adopt the following new rule 441—78.57(249A):

441—78.57(249A) Child care medical services. Payments will be made to licensed child care centers that provide medical services in addition to child care. Medically necessary services are provided under a plan of care that is developed by licensed professionals within their scope of practice and authorized by the member’s physician. The services include and implement a comprehensive protocol of care that is developed in conjunction with the parent or guardian and specifies the medical, nursing, personal care, psychosocial and developmental therapies required by the medically dependent or technologically dependent child served.

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member’s physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member’s physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member’s plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching pro-social skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member’s plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member’s physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member’s plan of care and authorized by a physician. Developmental therapies include activities based on the individual’s needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) “Medically necessary” means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in

illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

b. Nursing, psychosocial, developmental therapies and personal care services shall be authorized by the department or the department's designated review agent prior to payment.

c. Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization. The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. A treatment plan shall be completed prior to the start of care and at a minimum reviewed every 180 days thereafter. The plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

- (1) Place of service.
- (2) Type of service to be rendered and the treatment modalities being used.
- (3) Frequency of the services.
- (4) Assistance devices to be used.
- (5) Date on which services were initiated.
- (6) Progress of member in response to treatment.
- (7) Medical supplies to be furnished.
- (8) Member's medical condition as reflected by the following information, if applicable:
 1. Dates of prior hospitalization.
 2. Dates of prior surgery.
 3. Date last seen by a primary care provider.
 4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
 5. Prognosis.
 6. Functional limitations.
 7. Vital signs reading.
 8. Date of last episode of acute recurrence of illness or symptoms.
 9. Medications.
- (9) Discipline of the person providing the service.
- (10) Certification period.
- (11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.

(12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.

78.57(7) Nursing, personal care, and psychosocial services do not include:

a. Services provided to members aged 21 and older.

b. Services that require prior authorizations that are provided without regard to the prior authorization process.

c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).

d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).

e. Transportation services.

f. Services provided to a member while the member is in institutional care.

This rule is intended to implement Iowa Code chapter 249A.

ITEM 66. Amend rule 441—79.1(249A), introductory paragraph, as follows:

441—79.1(249A) Principles governing reimbursement of providers of medical and health services. The basis of payment for services rendered by providers of services participating in the medical assistance program is either a system based on the provider’s allowable costs of operation or a fee schedule. Generally, institutional types of providers such as hospitals and nursing facilities are reimbursed on a cost-related basis, and practitioners such as physicians, dentists, optometrists, and similar providers are reimbursed on the basis of a fee schedule. Providers of service must accept reimbursement based upon the department’s methodology without making any additional charge to the member.

For purposes of this chapter, “managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 67. Amend subrule **79.1(2)**, provider categories of “Behavioral health intervention,” “Federally qualified health centers,” “Psychiatric medical institutions for children” and “Rural health clinics,” as follows:

Provider category	Basis of reimbursement	Upper limit
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/13.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A) <u>Chapter 73</u>	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve “1” or “2” above.
Psychiatric medical institutions for children:		
1. Inpatient in non-state-owned facilities	Provider-specific fee Fee schedule as determined by the Iowa Plan for Behavioral Health contractor	Effective 7/1/14: non-state-owned facilities provider-specific fee schedule in effect.
2. Inpatient in state-owned facilities	Retrospective cost-related	Effective 8/1/11: 100% of actual and allowable cost.
3. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A) <u>Chapter 73</u>	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below.

Provider category	Basis of reimbursement	Upper limit
		2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.
		3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.

ITEM 68. Adopt the following new provider categories in alphabetical order in subrule **79.1(2)**:

Provider category	Basis of reimbursement	Upper limit
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.

ITEM 69. Amend subrule 79.1(8) as follows:

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to May 16, 2012. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. ~~Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.~~

~~a. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) "c," whichever is later, reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:~~

~~(1) The estimated acquisition cost, defined:~~

~~1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i"; or~~

~~2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i."~~

~~(2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph 79.1(8) "i."~~

~~(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph 79.1(8) "i."~~

~~(4) The submitted charge, representing the provider's usual and customary charge for the drug.~~

~~b. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8) "d," whichever is later, reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:~~

~~(1) The estimated acquisition cost, defined:~~

~~1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph 79.1(8) "i"; or~~

~~2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph 79.1(8)“i.”~~

~~(2) The submitted charge, representing the provider’s usual and customary charge for the drug.~~

~~e. a. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement Reimbursement for covered generic prescription drugs and for covered nonprescription drugs shall be the lowest of the following, as of the date of dispensing:~~

~~(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“k g,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“j f.”~~

~~(2) The maximum allowable cost (MAC), defined as the specific upper limit for multiple source drugs established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“j f.”~~

~~(3) The submitted charge, representing the provider’s usual and customary charge for the drug.~~

~~d. b. Effective February 1, 2013, or upon federal approval, whichever is later, reimbursement Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:~~

~~(1) The average actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)“k g,” plus the professional dispensing fee determined pursuant to paragraph 79.1(8)“j f.”~~

~~(2) The submitted charge, representing the provider’s usual and customary charge for the drug.~~

~~e. c. No payment shall be made for sales tax.~~

~~f. d. All hospitals that wish to administer vaccines which are available through the Vaccines for Children Program to Medicaid members shall enroll in the Vaccines for Children Program. In lieu of payment, vaccines available through the Vaccines for Children Program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.~~

~~g. Until February 1, 2013, or federal approval of the reimbursement methodology provided in paragraph 79.1(8)“e,” whichever is later, the basis of payment for nonprescription drugs shall be the same as specified in paragraph 79.1(8)“a” except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.~~

~~h. e. An additional reimbursement amount of one cent per dose shall be added to the allowable cost of a prescription pursuant to paragraphs 79.1(8)“a” and “b” for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.~~

~~i. Rescinded IAB 6/11/14, effective 8/1/14.~~

~~j. f. The professional dispensing fee shall be a fee schedule amount determined by the department based on a survey of Iowa Medicaid participating pharmacy providers’ costs of dispensing drugs to Medicaid beneficiaries conducted every two years beginning in SFY 2014-2015.~~

~~k. g. For purposes of this rule, average actual acquisition cost (AAC) is defined as retail pharmacies’ average prices paid to acquire drug products. Average AAC shall be determined by the department based on a survey of invoice prices paid by Iowa Medicaid retail pharmacies. Surveys shall be conducted at least once every six months, or more often at the department’s discretion. The average AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average AAC.~~

~~l. For purposes of this subrule, “equivalent products” shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, “Approved Prescription Drug Products With Therapeutic Equivalence Evaluations.”~~

~~*m.* Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.~~

~~*n. h.* Payment to physicians for physician-administered drugs billed with healthcare common procedure coding system (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).~~

ITEM 70. Amend paragraph **79.1(16)“b”** as follows:

b. Outpatient hospital services. Medicaid adopts the Medicare categories of hospitals and services subject to and excluded from the hospital outpatient prospective payment system (OPPS) at 42 CFR 419.20 through 419.22 as amended to October 1, 2007, except as indicated in this subrule.

(1) and (2) No change.

~~(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.~~

~~(4) Emergency psychiatric evaluations for members who are covered by the Iowa Plan shall be the responsibility of the Iowa Plan contractor. For members who are not covered by the Iowa Plan, services shall be payable under the APC for emergency psychiatric evaluation.~~

~~(5) Substance abuse services for persons enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.~~

ITEM 71. Amend subparagraph **79.1(16)“r”(3)** as follows:

(3) If the emergency room visit does not result in an inpatient hospital admission and does not involve emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room ~~and on whether the member is participating in the MediPASS program.~~

1. For members ~~not participating in the MediPASS program~~ who were referred to the emergency room by appropriate medical personnel ~~and for members participating in the MediPASS program who were referred to the emergency room by their MediPASS primary care physician,~~ payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members ~~not participating in the MediPASS program~~ who were not referred to the emergency room by appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

~~3. For members participating in the MediPASS program who were not referred to the emergency room by their MediPASS primary care physician, no payment will be made for treatment provided in the emergency room.~~

ITEM 72. Amend subparagraph **79.1(24)“d”(2)** as follows:

(2) For dates of services ~~on or after~~ from January 1, 2014, through December 31, 2015, providers shall be reimbursed by the Iowa Plan for Behavioral Health contractor at the rate negotiated by the provider and the contractor. However, if a provider fails to submit a cost report for services provided prior to July 1, 2013, that meets the requirements of paragraph 79.1(24)“b,” the Iowa Plan for Behavioral Health contractor shall reduce the provider’s reimbursement rate to 76 percent of the negotiated rate. The reduced rate shall be paid until acceptable cost reports for all services provided prior to July 1, 2013, have been received.

ITEM 73. Adopt the following new subparagraph **79.1(24)“d”(3)**:

(3) For dates of services on or after January 1, 2016, providers shall be reimbursed by fee schedule.

ITEM 74. Amend paragraph **79.1(25)“b”** as follows:

b. Reimbursement methodology for community mental health centers. Effective for services rendered on or after July 1, 2014, community mental health centers may elect to be paid on either a 100

percent of reasonable costs basis, as determined by Medicare reimbursement principles, or in accordance with an alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services and approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology established by the Medicaid program's managed care contractor for mental health services, the community mental health center may not change its elected reimbursement methodology to 100 percent of reasonable costs.

ITEM 75. Adopt the following new subparagraph **79.3(2)“d”(43)**:

(43) Child care medical services:

1. Plan of care.
2. Certification and recertification.
3. Service notes or narratives.
4. Physician orders or medical orders.
5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

ITEM 76. Amend rule 441—79.8(249A), introductory paragraph, as follows:

441—79.8(249A) Requests for prior authorization. ~~When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.~~ This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

ITEM 77. Amend paragraph **79.8(1)“a”** as follows:

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs ~~may also be made by telephone~~ must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

ITEM 78. Amend subrule 79.8(7) as follows:

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78.

a. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

~~*a.*~~ (1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

~~*b.*~~ (2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

~~*c.*~~ (3) The recommendation to the department from the appropriate advisory committee.

~~*d.*~~ (4) Whether there are other less expensive procedures which are covered and which would be as effective.

~~*e.*~~ (5) The advice of an appropriate professional consultant.

b. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

ITEM 79. Amend subrule 79.10(5) as follows:

79.10(5) The requirement to obtain preadmission review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the admission has been obtained from the patient manager as described in 441—Chapter ~~88~~ 73.

ITEM 80. Amend subrule 79.11(6) as follows:

79.11(6) The requirement to obtain preprocedure surgical review is waived when the patient is enrolled in the managed health care option known as patient management and proper authorization for the procedure has been obtained from the patient manager as described in 441—Chapter 88 73.

ITEM 81. Amend subrule 79.14(1), introductory paragraph, as follows:

79.14(1) Application request. Iowa Medicaid providers ~~other than managed care organizations and Medicaid fiscal agents~~, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site. Managed care organizations and fiscal agents are exempt from completing an application.

ITEM 82. Adopt the following **new** definitions of “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—81.1(249A)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 83. Amend rule 441—81.5(249A), introductory paragraph, as follows:

441—81.5(249A) Discharge and transfer. (See subrules ~~81.13(2)“a”~~ and paragraph 81.13(6)“c.”)

ITEM 84. Amend subrule 81.5(1) as follows:

81.5(1) Notice. When a ~~public assistance recipient~~ Medicaid member requests transfer or discharge, or another person requests this for the ~~recipient member~~, the administrator shall promptly notify ~~the local office of~~ the department. This shall be done in sufficient time to permit a social service worker or case manager to assist in the planning for the transfer or discharge.

ITEM 85. Amend subrule 81.7(1) as follows:

81.7(1) Level of care. The IME medical services unit shall review Medicaid members’ need ~~of~~ for continued care in nursing facilities, pursuant to the standards and subject to the appeals process in subrule 81.3(1). For all members enrolled with a managed care organization, the managed care organization shall review a Medicaid member’s need for continued care in a nursing facility at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews

that indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

ITEM 86. Amend rule 441—81.12(249A) as follows:

441—81.12(249A) Closing of facility. When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving medical assistance shall be approved by the local office of the department resident's managed care organization or by the IME medical services unit for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code sections 249A.2(6) and 249A.3(2) "a."

ITEM 87. Amend subparagraph **81.13(6)"a"(4)** as follows:

(4) Notice before transfer. Before a facility transfers or discharges a resident, the facility shall:

1. Notify the resident, the resident's case manager for those residents enrolled with a managed care organization and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.

2. and 3. No change.

ITEM 88. Amend subparagraph **81.13(9)"d"(2)** as follows:

(2) A comprehensive care plan shall be developed within seven days after completion of the comprehensive assessment by an interdisciplinary team and with the participation of the resident, the resident's case manager as appropriate and as allowed by the resident for those residents enrolled with a managed care organization, and the resident's family or legal representative to the extent practicable, and shall be periodically reviewed and revised by a team of qualified persons after each assessment.

The interdisciplinary team shall include the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs.

ITEM 89. Amend subrule 81.14(2) as follows:

81.14(2) Audit of proper billing and handling of patient funds.

a. ~~Field~~ The Iowa Medicaid enterprise, the department's contracted managed care organizations, ~~field~~ auditors of the department of inspections and appeals, ~~or and~~ representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. ~~Field~~ The Iowa Medicaid enterprise, the department's contracted managed care organizations, ~~field~~ auditors of the department of inspections and appeals ~~or and~~ representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 81.4(3).

c. to f. No change.

ITEM 90. Amend rule 441—81.20(249A), introductory paragraph, as follows:

441—81.20(249A) Out-of-state facilities. Payment will be made for care in out-of-state nursing facilities. For members enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

ITEM 91. Adopt the following **new** definitions of "Intermediate care facility for persons with an intellectual disability (ICF/ID)," "Intermediate care facility for persons with an intellectual disability level of care" and "Managed care organization" in rule **441—82.1(249A)**:

"Intermediate care facility for persons with an intellectual disability (ICF/ID)" means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons with an intellectual disability or persons with related conditions and that provides, in a protected residential setting, ongoing evaluation,

planning, 24-hour supervision, coordination and integration of health or related services to help each person function at the greatest ability and is an approved Medicaid vendor.

“Intermediate care facility for persons with an intellectual disability level of care” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“Managed care organization” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 92. Amend rule 441—82.2(249A), introductory paragraph, as follows:

441—82.2(249A) Licensing and certification. In order to participate in the program, a facility shall be licensed as a ~~hospital, nursing facility, or an intermediate care facility for persons with an intellectual disability~~ by the department of inspections and appeals under the department of inspections and appeals rules found in 481—Chapter 64. The facility shall meet the following conditions of participation:

ITEM 93. Amend subparagraph **82.2(4)“c”(2)** as follows:

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. For those clients enrolled with a managed care organization, the client’s case manager shall participate as appropriate and as allowed by the client. Participation by the client, the client’s parents (if the client is a minor), or the client’s legal guardian is required unless that participation is unobtainable or inappropriate.

ITEM 94. Amend subrule 82.6(3) as follows:

82.6(3) Certification statement. Eligible individuals may be admitted to an intermediate care facility for persons with an intellectual disability upon the certification of a physician that there is a necessity for care at the facility. For clients enrolled with a managed care organization, authorization for admission must be obtained from the managed care organization prior to admission. Eligibility shall continue as long as a valid need for the care exists.

ITEM 95. Amend paragraph **82.7(2)“b”** as follows:

b. Once ICF/ID placement is approved, including approval of ICF/ID level of care as described in subrule 82.7(3), 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, subject to the provision of ICF/ID services through managed care pursuant to 441—Chapter 73.

ITEM 96. Amend subrule 82.7(3) as follows:

82.7(3) Approval of level of care. Medicaid payment shall be made for 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/ID admissions and transfers only when documentation is provided which verifies a referral from targeted case management that includes an approval by the department.~~

ITEM 97. Amend rule 441—82.8(249A) as follows:

441—82.8(249A) Determination of need for continued stay. ~~Certification~~ For clients not enrolled with a managed care organization, certification of need for continued stay shall be made according to procedures established by the Iowa Medicaid enterprise (IME) medical services unit. For all clients enrolled with a managed care organization, the managed care organization shall review the Medicaid client’s need for continued care in an ICF/ID at least annually. The managed care organization must submit documentation to the IME medical services unit for all reviews that indicate a change in the

client's level of care. The IME medical services unit shall make a final determination for any reviews that indicate a change in the level of care.

This rule is intended to implement Iowa Code section 249A.12.

ITEM 98. Amend subrule 82.9(2) as follows:

82.9(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state Medicaid payment is made. ~~The state Medicaid~~ will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.

ITEM 99. Rescind and reserve rule **441—82.11(249A)**.

ITEM 100. Rescind and reserve rule **441—82.12(249A)**.

ITEM 101. Amend subrule 82.15(1) as follows:

82.15(1) *Claims.* Claims for service ~~for clients not enrolled with a managed care organization~~ must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. ~~Claims may~~ Such claims must be submitted electronically on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039, Iowa Medicaid Long Term Care Claim through IME's electronic clearinghouse.

a. ~~When payment is made, the facility will receive a copy of Form 470-0039. The white copy of the original shall be returned as a claim for the next month. If the claim is submitted electronically, the facility will receive a remittance statement of the claims paid. A remittance advice of the claims paid may be obtained through the Iowa Medicaid portal access (IMPA) system.~~

b. ~~When there has been a new admission, a discharge, a correction, or a claim for a reserved bed, the facility shall submit Form 470-0039 with the changes noted. Adjustments to electronically submitted claims may be made electronically as provided for by the Iowa Medicaid enterprise.~~

ITEM 102. Amend rule 441—82.16(249A) as follows:

441—82.16(249A) *Closing of facility.* When a facility is planning on closing, the department and the department's contracted managed care organizations with which the facility is enrolled shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the county office of the department resident's managed care organization or by the Iowa Medicaid enterprise for residents not enrolled with a managed care organization.

This rule is intended to implement Iowa Code section 249A.12.

ITEM 103. Amend subrule 82.17(2) as follows:

82.17(2) *Auditing of proper billing and handling of patient funds.*

a. ~~Field~~ The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals or and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. ~~Field~~ The Iowa Medicaid enterprise, the department's contracted managed care organizations, field auditors of the department of inspections and appeals or and representatives of the U.S. Department of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.9(3).

c. to f. No change.

ITEM 104. Adopt the following **new** definitions of “Intermediate care facility for persons with an intellectual disability level of care,” “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—83.1(249A)**:

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 105. Amend paragraph **83.2(1)“d”** as follows:

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) No change.

(2) ~~The IME medical services unit shall be responsible for approval of the certification of the level of care.~~ the initial determination of the member’s level of care certification. The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

(3) No change.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 106. Amend paragraph **83.3(3)“b”** as follows:

b. Decisions shall be mailed or given to the applicant on the date when income maintenance eligibility and level of care determinations ~~and the client case plan~~ are completed.

ITEM 107. Amend subrule 83.3(4) as follows:

83.3(4) Effective date of eligibility.

a. Deeming of parental or spousal income and resources ceases and eligibility shall be effective on the date the income and resource eligibility and level of care determinations ~~and the case plan~~ are completed; but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the health and disability waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs 83.3(4) “a” and “c” do not apply is the date on which the income eligibility and level of care determinations ~~and the case plan~~ are completed.

c. Eligibility for persons covered under subparagraph 83.2(1) “c”(3) shall exist on the date the income and resource eligibility and level of care determinations ~~and case plan~~ are completed; but shall not be earlier than the first of the month following the date of application.

d. No change.

ITEM 108. Amend rule 441—83.5(249A) as follows:

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the health and disability waiver shall be completed at least once every 12 months or when there is significant change in the person’s situation or condition.

A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.2(249A). A redetermination shall include verification of the existence of a current service plan meeting the requirements listed in rule 441—83.7(249A).

83.5(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 109. Amend rule 441—83.7(249A), introductory paragraph, as follows:

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with ~~rule 441—130.7(234) except that service 441—paragraph 90.5(1) “b.”~~ Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person’s situation or condition.

ITEM 110. Adopt the following **new** definitions of “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—83.21(249A)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.

2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 111. Amend paragraph **83.22(1)“d”** as follows:

d. Certified as being in need of the intermediate or skilled level of care based on information submitted on Form 470-4392, Level of Care Certification for HCBS Waiver Program.

(1) A physician, doctor of osteopathy, registered nurse practitioner, or physician assistant shall complete Form 470-4392 when the person applies for waiver services, upon request to report a change in the person’s condition, and annually for reassessment of the person’s level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

(2) ~~The IME medical services unit shall be responsible for approval of the certification of the level of care or the member’s managed care organization shall be responsible for annual redetermination of the level of care.~~

(3) No change.

(4) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 112. Amend paragraph **83.23(4)“a”** as follows:

a. ~~The effective date of eligibility cannot precede the date the case manager signs the case plan is the date on which the income eligibility and level of care determinations are completed.~~

ITEM 113. Amend rule 441—83.25(249A) as follows:

441—83.25(249A) Redetermination. A complete redetermination of eligibility for elderly waiver services shall be done at least once every 12 months.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.22(249A). A redetermination shall contain the components listed in rule 441—83.27(249A).

83.25(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.25(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 114. Adopt the following **new** definitions of “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—83.41(249A)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 115. Amend subparagraph **83.42(1)“b”(2)** as follows:

(2) The IME medical services unit shall be responsible for approval of the certification of the level of care, and the IME medical services unit or a managed care organization will be responsible for annual redeterminations.

ITEM 116. Amend subrule 83.43(4) as follows:

83.43(4) Effective date of eligibility.

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations ~~and the service plan~~ are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations ~~and the service plan~~ are completed.

c. No change.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations ~~and the service plan~~ are completed; but shall not be earlier than the first of the month following the date of application.

ITEM 117. Amend rule 441—83.45(249A) as follows:

441—83.45(249A) Redetermination. A complete redetermination of eligibility for AIDS/HIV waiver services shall be completed at least once every 12 months or when there is significant change in the person's situation or condition. A redetermination of continuing eligibility factors shall be made in accordance with rules 441—76.7(249A) and 441—83.42(249A). A redetermination shall include the components listed in rule 441—83.47(249A).

83.45(1) The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

83.45(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which

indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 118. Adopt the following **new** definitions of “Intermediate care facility for persons with an intellectual disability level of care” and “Managed care organization” in rule **441—83.60(249A)**:

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

ITEM 119. Amend paragraph **83.61(1)“c”** as follows:

c. Be certified as being in need for long-term care that, but for the waiver, would otherwise be provided in an ICF/ID. The IME medical services unit shall be responsible for the initial approval, and the IME medical services unit or a managed care organization will be responsible for the annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

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

ITEM 120. Amend rule 441—83.64(249A) as follows:

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which an SIS assessment is not completed, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member’s functional status since the previous SIS or other full assessment.

A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.61(249A).

83.64(1) The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 121. Adopt the following **new** definitions of “Intermediate care facility for persons with an intellectual disability level of care,” “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—83.81(249A)**:

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member’s daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member’s capacity to live independently.
2. The member’s physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

“*Skilled nursing facility level of care*” means that the following conditions are met:

1. The member’s medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.
2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).
3. Documentation submitted for review indicates that the member has:
 - a. A physician order for all skilled services.
 - b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.
 - c. An individualized care plan that identifies support needs.
 - d. Confirmation that skilled services are provided to the member.
 - e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.
 - f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 122. Amend subrule 83.87(3) as follows:

83.87(3) Annual assessment. The IME medical services unit shall assess the member annually and certify the member’s need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed Form 470-4694, Case Management Comprehensive Assessment, and supporting documentation as needed.

a. The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member’s level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 123. Adopt the following **new** definitions of “Intermediate care facility for persons with an intellectual disability level of care,” “Managed care organization,” “Nursing facility level of care” and “Skilled nursing facility level of care” in rule **441—83.101(249A)**:

“*Intermediate care facility for persons with an intellectual disability level of care*” means that the individual has a diagnosis of intellectual disability made in accordance with the criteria provided in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association; or has a related condition as defined in 42 CFR 435.1009; and needs assistance in at least three of the following major life areas: mobility, musculoskeletal skills, activities of daily living, domestic skills, toileting, eating skills, vision, hearing or speech or both, gross/fine motor skills, sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Nursing facility level of care*” means that the following conditions are met:

1. The presence of a physical or mental impairment which restricts the member's daily ability to perform the essential activities of daily living, bathing, dressing, and personal hygiene, and impedes the member's capacity to live independently.

2. The member's physical or mental impairment is such that self-execution of required nursing care is improbable or impossible.

"Skilled nursing facility level of care" means that the following conditions are met:

1. The member's medical condition requires skilled nursing services or skilled rehabilitation services as defined in 42 CFR 409.31(a), 409.32, and 409.34.

2. Services are provided in accordance with the general provisions for all Medicaid providers and services as described in rule 441—79.9(249A).

3. Documentation submitted for review indicates that the member has:

a. A physician order for all skilled services.

b. Services that require the skills of medical personnel, including registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, or audiologists.

c. An individualized care plan that identifies support needs.

d. Confirmation that skilled services are provided to the member.

e. Skilled services that are provided by, or under the supervision of, medical personnel as described above.

f. Skilled nursing services that are needed and provided seven days a week or skilled rehabilitation services that are needed and provided at least five days a week.

ITEM 124. Amend paragraph **83.103(2)“e”** as follows:

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker or case manager in the development of the service plan, ~~which must be approved by the department service worker~~ prior to the start of services.

ITEM 125. Amend subrule 83.103(3) as follows:

83.103(3) Effective date of eligibility.

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in ~~rule 441—83.102(249A)~~ subrule 83.102(1).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in ~~rule 441—83.102(249A)~~ subrule 83.102(1) and when the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in ~~rule 441—83.102(249A)~~ subrule 83.102(1). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the physical disability waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

ITEM 126. Amend subrule 83.107(2) as follows:

83.107(2) Annual assessment. The IME medical services unit shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1) “h” and the appeal process at rule 441—83.109(249A), based on the completed Form 470-4392, Level of Care Certification for HCBS Waiver Program, and supporting documentation as needed.

a. The IME medical services unit or the member's managed care organization shall be responsible for annual redetermination of the level of care.

b. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 127. Adopt the following new definitions of “Managed care organization” and “Psychiatric medical institution for children level of care” in rule **441—83.121(249A)**:

“*Managed care organization*” means an entity that (1) is under contract with the department to provide services to Medicaid recipients and (2) meets the definition of “health maintenance organization” as defined in Iowa Code section 514B.1.

“*Psychiatric medical institution for children level of care*” means that the member has been diagnosed with a serious emotional disturbance and an independent team as identified in 441—subrule 85.22(3) has certified that ambulatory care resources available in the community do not meet the treatment needs of the recipient, that proper treatment of the recipient’s psychiatric condition requires services on an inpatient basis under the direction of a physician, and that the services can reasonably be expected to improve the recipient’s condition or prevent further regression so that the services will no longer be needed.

ITEM 128. Amend subrule 83.122(3) as follows:

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant’s level of care annually based on Form 470-4694, Case Management Comprehensive Assessment.

ITEM 129. Amend subrule 83.123(2) as follows:

83.123(2) *Approval of waiver eligibility.*

a. Time limit. Applications for the HCBS children’s mental health waiver program shall be processed within 30 days unless one or more of the following conditions exist:

(1) and (2) No change.

(3) The application is pending because the assessment ~~or the service plan~~ has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a ~~service plan~~ completed assessment, the application shall be denied.

b. Notice of decisions. The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations ~~and the consumer’s service plan~~ are completed.

ITEM 130. Amend subrule 83.123(3) as follows:

83.123(3) *Effective date of eligibility.* The effective date of a consumer’s eligibility for children’s mental health waiver services shall be the first date that all of the following conditions exist:

a. All eligibility requirements are met; and

b. Eligibility and level of care determinations have been made; ~~and~~

~~*c.* The service plan has been completed.~~

ITEM 131. Amend subrule 83.125(1) as follows:

83.125(1) *Eligibility review.*

a. Every 12 months, the ~~local office~~ department shall review a consumer’s eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify:

~~*a.* Continuing continuing eligibility factors as specified in rule 441—83.122(249A).~~

b. ~~The existence of a current service plan meeting the requirements listed in rule 441—83.125(249A).~~ The IME medical services unit or a managed care organization shall review the member’s need for continued care annually and recertify the member’s need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed department-approved assessment and supporting documentation as needed.

c. The IME medical services unit or the member’s managed care organization shall be responsible for annual redetermination of the level of care.

d. The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

ITEM 132. Amend subrule 85.25(2) as follows:

85.25(2) *Inpatient reimbursement for non-state-owned facilities effective ~~July 1, 2014~~ January 1, 2016.* Services rendered by non-state-owned facilities on or after July 1, 2014, ~~shall be reimbursed according to the Iowa Plan for Behavioral Health contractor's negotiated, provider-specific per diem rate~~ January 1, 2016, are paid on a fee-for-service basis.

ITEM 133. Rescind and reserve subrule **90.3(3)**.

ITEM 134. Amend subparagraph **90.8(1)“a”(2)** as follows:

(2) By the end of the next calendar day after the incident, the case manager who observed the incident shall also report as much information as is known about the incident to the member's managed care organization in the format defined by the managed care organization. If the member is not enrolled with a managed care organization, the staff member shall report the information to the department's bureau of long-term care either:

1. By direct data entry into the Iowa Medicaid Provider Access System, or
2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

ITEM 135. Rescind and reserve **441—Chapter 92**.

[Filed Emergency After Notice 12/16/15, effective 1/1/16]

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