ARC 5889C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Rule making related to home- and community-based services eligibility

The Human Services Department hereby amends Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," and Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code chapter 249A.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapter 249A.

Purpose and Summary

The purpose of these amendments to the Home- and Community-Based Services (HCBS) Habilitation program is to adopt the Level of Care Utilization System (LOCUS) for adults ages 19 and older and Child and Adolescent Level of Care Utilization System (CALOCUS) for youth ages 16 to 18 for the purposes of the needs-based eligibility determination, person-centered service planning, and HCBS tier authorization.

These amendments also add provisions related to intensive residential habilitation services as defined in rule 441—25.1(331), adopt training criteria for direct service staff providing HCBS services, and clarify the scope of services included in Home-Based Habilitation (HBH).

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on June 16, 2021, as **ARC 5706C**.

The Department received 26 comments and questions from five respondents on the proposed amendments. The comments and questions and the corresponding responses from the Department are divided into three topic areas: (1) provider standards, (2) needs-based eligibility and LOCUS/CALOCUS implementation, and (3) general comments.

HCBS habilitation and HBH provider standards

Comment 1: Does the training proposed in the rule packet need to be competency-based?

Response 1: The training required in paragraph 77.25(8)"b" does not have to be competency-based; however, that is best practice.

Comment 2: What is the proposed effective date for the rule changes?

Response 2: The effective date of these adopted amendments is November 1, 2021.

Comment 3: How do we approach staff training if a person served moves from a "home-based habilitation" service to an "intensive residential habilitation" service? Do the staff need an additional 48 hours of training? Twenty-four hours of training since they already had their initial 24 hours, or just an additional 12 hours of training on top of the 12 hours they need to have annually?

Response 3: Staff training is not affected if a member moves from HBH services to intensive residential habilitation services. Staff that will be delivering intensive residential habilitation services must meet the criteria of subparagraph 77.25(8)"b"(3), which states that a person providing direct support to members receiving intensive residential habilitation services shall complete 48 hours of training within the first year of employment in mental health and multi-occurring conditions pursuant to subrule 25.6(8).

Comment 4: How will these training rules apply to existing staff? Will the staff be grandfathered in, or will they need to take 24 or 48 hours of training within a year of implementation of the rule? How do the new training expectations impact current staff? Will they need the initial 24 or 48 hours of training in the first year following rule implementation or default to the 12-hour annual training immediately?

Response 4: Existing staff will be expected to have completed the initial 24 or 48 hours of training, as applicable, within 12 months of November 1, 2021. When completing the 2022 HCBS provider self-assessment, the provider will attest to compliance with the HBH training requirements and the intensive residential habilitation training requirements, if applicable. In addition, during future HCBS quality oversight desk reviews and targeted reviews, HBH providers will be expected to show evidence of completion of the required training based on the services being delivered by the employee as documented in each employee's training file.

Comment 5: Do training expectations apply solely to the HBH tier services, or will they additionally apply to staff in employment and day habilitation services as well?

Response 5: The training requirements in paragraph 77.25(8)"b" are applicable to HBH services only. Day habilitation service provider training requirements are included in paragraph 77.25(7)"b," and the supported employment service provider training requirements are listed in paragraph 77.25(10)"c."

Comment 6: Will training types including webinars, seminars and video tutorials that apply to the approved topics be an appropriate training method for staff, or is the expectation that trainings be such that staff must show competency for the topic?

Response 6: Providers may choose from a wide variety of training modalities to deliver the required training.

Comment 7: Do staff providing services to persons served who are receiving services in Intensive I, II, III, and IV need to have 48 hours of training within the first year of employment? Or is this just needed for staff working with persons served who are approved for the new level of service Intensive IV?

Response 7: When a staff person is delivering HBH services, that employee must be provided training in accordance with subparagraphs 77.25(8)"b"(4) and 77.25(8)"b"(5). When a direct support professional is providing intensive residential habilitation – Intensive IV services, that employee must be provided training in accordance with subparagraph 77.25(8)"b"(3).

Since publication of the Notice of Intended Action, the Department has revised subparagraph 77.25(8)"b"(3) in Item 2 by adding a requirement that 24 hours of training be completed each year after the employee's first year of employment.

Comment 8: Paragraphs 77.25(8)"c" and "d." Do these line items pertain to only the "intensive residential service homes" as being "designed to serve up to four persons," or do these pertain to any home providing HBH services?

Response 8: Paragraphs 77.25(8)"c" and "d" apply to any home where HCBS habilitation or HCBS waiver services are provided. These paragraphs implement Iowa Code section 135C.6.

Comment 9: Subparagraph 77.25(8)"b"(1) states that a person providing direct support shall be at least 18 years old and have a high school diploma or its equivalent. This field is drastically short staffed, and this rule may continue to prohibit a provider's ability to hire staff. Is it necessary to have a high school diploma or its equivalent? What exactly does "its equivalent" mean? With the increase in training hours to provide HBH, it appears that providers will be able to train on the skills that are necessary to provide these services regardless if a person has a high school diploma or its equivalent.

Response 9: The age and education requirements for a direct support professional that will be delivering the HBH services set the minimum expectation for the staff. A "high school diploma or equivalent" means having either a high school diploma or a GED certificate. Due to the level of maturity needed to support adults with functional limitations as a result of a diagnosis of serious mental illness, it was determined that the services should be delivered by an adult. If a provider wishes to employ someone who does not meet the minimum requirements under subparagraph 77.25(8)"b"(1), the provider may seek an exception to policy to employ the person in the delivery of HBH services.

Comment 10: Numbered paragraph 78.27(7)"c"(1)"1." What exactly does "medically managed residential services" mean?

Response 10: Once generated, the LOCUS score is used to recommend a person for a level of care. There are seven different levels of care described in the LOCUS that differ according to:

- The types of services and supports available.
- The type and amount of staff support available.
- How often treatment or services are provided.
- The setting in which the treatment or services are provided.
- The ability of the treatment or service setting to manage the safety of people who are at risk of harming themselves or others.

Medically managed residential services is a level of care generally used for those experiencing the greatest severity of behavioral health condition(s), whether acutely or (for a small subset of individuals) for a longer period. This level of care is provided in an environment that allows persons who are at high risk of harm or with severe dysfunction and lack of engagement to be managed safely until their condition improves. The clinical attention and level of intervention provided are generally intense.

Comment 11: Subparagraph 78.27(7)"c"(2). What exactly does "medically monitored residential services" mean?

Response 11: This level of care is for those with higher levels of risk, more difficulties with daily functioning, and less access to or ability to use supports in the home. It commonly involves residential-based services, though it may also be provided through intensive in-home support. There is a great deal of structure and intervention provided under this level of care, with intensive monitoring and some level of 24-hour access to nursing and medical monitoring.

Comment 12: Subparagraph 78.27(7)"c"(7). For High Recovery, it states that the person must have a LOCUS score of level zero. We are concerned with this as our clients all have serious and persistent mental illness and will never have scores of zero on the LOCUS, as they have to meet all of the eligibility criteria which will indicate trouble in areas of functioning to receive habilitation services.

Response 12: The Department recognizes that actual disposition of level one recovery maintenance and health management is the lowest disposition score obtainable through the LOCUS/CALOCUS assessment, and as such, the Department has revised subparagraph 78.27(7)"c"(7) by changing the eligible LOCUS score from level zero to level one.

Comment 13: Subparagraph 78.27(7)"c"(3). What exactly does "medically monitored non-residential services" mean? There should be clarification within the rule as to what this means.

Response 13: This level of care is for those who need a great deal of structure, support and monitoring in order to live safely and successfully in the community. With appropriately matched supports and services, individuals at this level of care do not require an on-site living situation for their treatment. The Department recognizes that members receiving this level of HBH services may be residing in residential settings with daily staffing support.

Comment 14: Paragraphs 78.27(7)"d" and "e." With the additional requirements for support and safety in service provision for serving youth, ensuring children ages 16 to 18 or those living in a 24-hour home for children up to the age of 21 are provided 24-hour supervision, they should get the highest level tier if residing in an agency-operated home. Recently our organization had this situation and did not get the highest level tier of Intensive III. Also, not sure how the LOCUS for children scores are calculated, but they would almost always need that higher tier because of their age. It does state in the rules that children ages 17.5 to 18 shall receive 24-hour supervision and support, but what about the 16 year olds and 17 year olds? We understand that if services are provided in their parental/guardian home, then we wouldn't need that high level tier, but this should be clarified better.

Response 14: In accordance with Department policy regarding serving minors in residential settings outside the family home, minors 16 to 17 years old are to be served in a setting licensed by the Department of Inspections and Appeals. Minors receiving services outside the family home are to receive 24-hour supervision from the service provider. The Department has revised paragraph 78.27(7)"d" by adding new subparagraph 78.27(7)"d"(4) as follows:

"(4) Individuals 16 to 18 years of age shall receive 24-hour site supervision and support."

Needs-based eligibility and LOCUS/CALOCUS implementation

Comment 1: Subparagraphs 78.27(2)"f"(1) and (2). Needs Assessment Habilitation Services are utilized to serve Medicaid members who have experienced psychiatric treatment and have a history of severe and persistent mental illness. Our agency strongly recommends that assessments not be completed based solely on a review of records, but that language be included in this section requiring a face-to-face assessment completed by the designated case manager and the interdisciplinary team (including member and guardian). This is consistent with current Iowa Administrative Code rule 441—90.4(249A) guidelines and will ensure the LOCUS score is a true representation of each member's assessed needs.

Response 1: The Department agrees that the comprehensive assessment and social history completed by the integrated health home (IHH) or the community-based case manager (CBCM) must be completed based on a face-to-face interview with the member and the member's representatives as applicable. Consequently, the Department has revised the first sentence of paragraph 78.27(2)"f" so that it now reads as follows:

"The LOCUS or CALOCUS tool has been completed in the LOCUS online system and using the algorithm developed by Deerfield Solutions to derive the actual disposition score based on the comprehensive assessment and social history (CASH) completed by the integrated health home (IHH) or community-based case manager (CBCM) during a face-to-face interview with the member and the member's representative as applicable, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based services."

Comment 2: The assessor should be identified prior to the implementation of these rules (CBCM, IHH or other?). Add into rule the requirement for assessor to have completed LOCUS/CALOCUS training by Deerfield Solutions' authorized training program or certification prior to implementation.

Response 2: The operationalization of the LOCUS/CALOCUS is within the purview of the managed care organizations (MCOs). The MCOs are expected to have trained assessors who meet the criteria in the 1915(i) state plan amendment (SPA) and the managed care contracts. The scoring of the LOCUS/CALOCUS will be operationalized through the contractual obligations of the MCOs.

Comment 3: Add language requiring that any scoring of the LOCUS/CALOCUS use the algorithm developed by Deerfield Solutions.

Response 3: Paragraph 78.27(2)"f" has been revised as noted in Response 1 of this section.

Comment 4: Regarding completion of a member's initial assessment within 7 days of referral for habilitation services, an annual LOCUS/CALOCUS assessment should be completed 30 days prior to the implementation of the new individual service plan.

Response 4: The timelines for completion of the initial assessment and annual reassessment will be completed within the timelines agreed upon in the core standardized assessment (CSA) vendor contract and the managed care contracts. The contractual obligations of the MCOs and CSA vendors will not be placed in administrative rule.

Comment 5: Our agency recommends that a process for appeal of the assessment be developed and clearly outlined, utilizing the Supports Intensity Scale (SIS) assessment process for appeal.

Response 5: Habilitation member appeal rights are included in paragraph 78.27(11)"d." The Department has amended paragraph 78.27(11)"d" in new Item 6 to add the words "or of the LOCUS/CALOCUS actual disposition score" to the paragraph's second sentence so that it now reads as follows:

"The member is entitled to have a review of the determination of needs-based eligibility or of the LOCUS/CALOCUS actual disposition score by the Iowa Medicaid enterprise medical services unit by sending a letter requesting a review to the medical services unit."

Comment 6: Development of evaluation process to ensure interrater reliability of assessment should be included in rules.

Response 6: The oversight of the MCO assessment processes will be included in the scope of work of the MCO oversight vendor contract. Similar processes that are in place today to ensure interrater reliability for the interRAI and SIS assessment tools will be utilized for the scoring of the LOCUS/CALOCUS tool.

Comment 7: The process for reassessment should include a seven-day time frame for completion of LOCUS/CALOCUS in the event of a significant observable change in the member's situation, condition, or circumstances. Include language directing that a copy of the LOCUS/CALOCUS full assessment and scores derived from the assessment be shared with all members of the interdisciplinary team at the conclusion of the assessment with a written report distributed within seven days.

Response 7: The MCO and medical services vendors are contractually obligated to observe the timelines contained in their respective contracts regarding completion of initial and annual assessments. No changes are being made to the rules at this time in response to the comment.

Comment 8: Subparagraphs 78.27(7)"c"(3) and (4). Currently Intensive I and Intensive II tiers (UD and U8) are residential-based services, but they are indicated on here to be "non-residential services" in the proposed rule. The only indicated residential service in the proposed tiers is for Intensive III and IV. This would be a change from the current tier system. This is a concern to us, as we feel they should remain residential services.

Response 8: The definitions related to the LOCUS/CALOCUS actual disposition scores are the definitions for the level of care identified by the LOCUS/CALOCUS online system. For the purposes of the HCBS habilitation program, the Department recognizes that both Intensive I and Intensive II are provided in residential and community-based settings.

The Department has revised subparagraphs 78.27(7)"c"(2) to (7) to remove references to the level of care identified by the LOCUS/CALOCUS online system. The subparagraphs now read as follows:

"(1) Intensive IV residential habilitation services. Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

"1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and

"2. The member meets the criteria in 441—subparagraph 25.6(8)*"c"*(3).

"(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five.

"(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four.

"(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I services, the member must have a LOCUS/CALOCUS actual disposition of level three.

"(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two.

"(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one.

"(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level one."

Comment 9: We have heard that the LOCUS tool would be completed by the MCO as a desk review and not as an interactive assessment completed with the individuals receiving service. We are concerned about individuals not receiving appropriate scoring by only utilizing this method. We strongly encourage that the rules be amended to indicate that the LOCUS would include an interview with the individual requesting services, as that is also indicated in the LOCUS training manual to be done.

Response 9: The member will participate in a face-to-face comprehensive assessment and social history (CASH) to be completed by the IHH or by the CBCM at the time the member is enrolled in habilitation. The CASH will be used to complete the LOCUS/CALOCUS in the LOCUS online system by assessors trained by Deerfield Solutions, the LOCUS/CALOCUS vendor. The Department requested clarification from Deerfield Solutions and the American Association for Community Psychiatry (AACP) regarding the validity of the LOCUS and CALOCUS when completed as a desk review. According to Deerfield Solutions and AACP, it is appropriate to complete the LOCUS/CALOCUS as a desk review as long as the supporting information reflects the member's current status.

Comment 10: The current process allows for a client to change tiers by just having a comprehensive team meeting, but it appears that a new LOCUS would have to be completed by the MCO to get this

done. How timely can this get completed utilizing this proposed process, as often situations can change very rapidly and need a change in tier with very quick turnover?

Response 10: The operationalization of the LOCUS/CALOCUS including timelines for completion and distribution back to the member and the member's IHH or CBCM will be consistent with the terms of the managed care contracts.

Comment 11: There are concerns also about the MCO payer completing the LOCUS and deciding the level of care for a client, overall, as it is a possible conflict of interest. We feel it should be completed by IHH Care Coordinators (IHHCC), as the interRAI is now, as they have the relationship with the client and thus, better understand the needs of the clients.

Response 11: The payer is not determining the service; it is the decision support tool, the LOCUS/CALOCUS, in addition to other supporting documentation that will determine the member's eligibility for habilitation and the LOCUS/CALOCUS tool that will determine the member's level of service for HBH. A dedicated team of trained LOCUS/CALOCUS assessors will enhance the interrater reliability. LOCUS/CALOCUS will be incorporated to the core standardized assessment oversight process that is completed today by Telligen. This process will be similar to the process that is used today to score the SIS assessment used for level of care and service authorization for the intellectual disability waiver.

Comment 12: For HBH services, if someone needs or wants less hours than what they are tested at, do staff have to be provided at that amount?

Response 12: The member and the member's interdisciplinary team will review the LOCUS/CALOCUS Domain scores and Actual Disposition Score to determine if the member's needs can be safely met at a lower tier than that recommended by the LOCUS online tool. If the member can be safely served at a lower level of care, the IHHCC or CBCM will document the discussion and determination made by the team in the member's comprehensive person-centered service plan. That information will be communicated to the MCO or through IoWANS when seeking service authorization.

Comment 13: How will they ensure comp assessments are done thoroughly?

Response 13: The IHHs and CBCMs will be provided training on the interaction between the CASH and the LOCUS/CALOCUS. The IHHs and CBCMs will use the CASH/LOCUS crosswalk tool developed to ensure that the CASH is capturing the member's information and condition accurately and thoroughly to enable accurate scoring of the LOCUS/CALOCUS in the LOCUS online system.

Comment 14: Would providers still do tier reviews with the MCO/IHH?

Response 14: The process for reviewing a member's service authorization will be modified to include updates to the CASH, which would then be submitted to the MCO to complete a new LOCUS/CALOCUS when a change in the member's needs indicates that a change in service level is necessary.

Comment 15: Paragraph 78.27(2)"g," plan for service, states "Home- and community-based habilitation services provided before approval of a member's eligibility for the program cannot be reimbursed." IACP requests the plan for service be developed within 7 days of the initial assessment completion and 30 days prior to the annual Individual Service Plan implementation date. This request is due to the nature of the supports and services offered through the Habilitation Program. Without a completed service plan, providers cannot provide necessary supports and services to individuals, which puts the member at risk.

Response 15: The timelines for completion of the service plan are detailed in subparagraph 78.27(4)"a"(9). In addition, the MCO and medical services vendors are contractually obligated to observe the timelines contained in their respective contracts. No changes are being made to the rules at this time based on this comment.

Comment 16: At the June 1, 2021, workgroup meeting, it was announced that the LOCUS/CALOCUS tool that is to replace the interRAI would no longer be completed by the IHH during a meeting with the client (aka member), but instead the MCOs would complete the tool by doing a desk review of the 30+ page CASH document compiled by the IHH via meetings with the client. It was suggested by the MCOs that maybe the IHHs could highlight areas of the CASH when changes were made and add more in-depth verbiage throughout the CASH so that it would be easier for

the MCO to more readily recognize these areas when completing the LOCUS/CALOCUS as a desk review. We are opposed to the change in how the LOCUS tool would be utilized.

1. The LOCUS is designed for interaction with a client to understand their needs, not as a desk review tool of other documents. The LOCUS Training Manual clearly states that "Although the instrument does supply some guidelines, you will be required to make a determination based upon the interview with the client and your intuition about where the most appropriate assignment or rating level falls within a dimension." The LOCUS has a guided interview to gather the information with the client. There is also a need to understand the client, to know the client, and to be able to determine how the client's ability to engage may affect his or her capacity for making changes that will enhance well-being.

2. A crosswalk between the CASH and the LOCUS/CALOCUS tool needs to be completed with provider input and advanced training provided. The CASH takes over an hour with the client just to read the questions on the 30+ pages; it is more focused on the history and strengths of how a client is doing, whereas the LOCUS is a tool to determine the resource intensity needs of the client via a disposition score.

3. There are again concerns with interrater reliability as the MCO payer also becomes the decider of the level of care for a client without even meeting with that client. Past experience shows that MCO staff are not consistent in the review of client files and charts even when all are reporting on the same documents.

Response 16: The CASH is a person-centered tool and identifies the member's needs. If all necessary information is present, a desktop review is acceptable to complete the LOCUS/CALOCUS. According to Deerfield and AACP, it is appropriate to complete the LOCUS/CALOCUS as a desk review as long as the supporting information reflects the member's current status. The LOCUS/CALOCUS will be completed by a trained assessor using the information submitted by the IHH or CBCM on the CASH. The assessment functions within the MCO are separate from utilization management functions, which ensures an appropriate firewall in the administration of the assessment.

A crosswalk between the CASH and LOCUS is in process at this time. IHHs will receive comprehensive training on the completion of the CASH and interaction between the CASH and the LOCUS tools in advance of implementation.

The payer is not determining the level of care or the service; the LOCUS/CALOCUS is a decision support tool. All needs-based eligibility determinations are made by the IME. A dedicated team of trained LOCUS/CALOCUS assessors will enhance the interrater reliability. LOCUS/CALOCUS interrater reliability processes will be incorporated to the core standardized assessment oversight process that is completed today by Telligen.

Comment 17: If the MCOs are to complete the LOCUS/CALOCUS, then they should also be actively involved in completing the CASH so that they will have direct contact with the client to best understand the overall needs of each respective client. Additionally, a process and timeline for completion of the tool scoring as well as the appeal process needs to be developed to ensure there is a not a gap in services or provider payments due to the changes proposed by these rules.

Response 17: In accordance with rule 441—90.4(249A), the IHHs and CBCMs are responsible to complete the CASH for the members that they are assigned. Habilitation member appeal rights are included in paragraph 78.27(11)"d." The Department has amended paragraph 78.27(11)"d" as described in Response 5 of this section.

The timelines for completion of the initial assessment and annual reassessment will be completed within the timelines agreed upon in the Core Standardized Assessment vendor contract and the managed care contracts. The contractual obligations for the MCOs and CSA vendors will not be placed in administrative rule.

Comment 18: We strongly encourage you to amend the rules to state the LOCUS/CALOCUS tool cannot be utilized as a desk review and must be completed as designed as an interactive interview with the client by care coordinators and staff who already have a relationship and understanding of the needs of the client and focused on the client's overall well-being.

Response 18: The CASH will be used to complete the LOCUS/CALOCUS in the LOCUS online system by assessors trained by Deerfield Solutions, the LOCUS/CALOCUS vendor. The Department

requested clarification from Deerfield Solutions and AACP regarding the validity of the LOCUS and CALOCUS when completed as a desk review. According to Deerfield and AACP, it is appropriate to complete the LOCUS/CALOCUS as a desk review as long as the supporting information reflects the member's current status.

Comment 19: Considering the time commitment necessary for assessments for other HCBS Waivers (ID Waiver and the SIS), what is the expectation for provider staff involvement in the LOCUS or CALOCUS assessment process? Will providers need to plan for additional staff time to be involved in these assessments?

Response 19: Providers are expected to participate as necessary in the development of the CASH completed by the member's IHHCC or the CBCM of the member's MCO. The MCOs will be completing the LOCUS/CALOCUS in the LOCUS online system as a desk review based on submission of the CASH by the IHHCC or CBCM.

Comment 20: What is the process for requesting a need for service plan change related to member situation, condition or circumstance?

Response 20: The processes to request a service plan change remains unchanged. Members and their service providers are to work through the IHHCC or MCO's CBCM to request service plan changes.

Comment 21: Does the requirement for the service plan to include LOCUS/CALOCUS disposition, composite score and domain scores apply to the service provider plan in addition to the authorizing plan?

Response 21: The requirement for the service plan to include LOCUS/CALOCUS disposition, composite score and domain scores applies to the comprehensive person-centered service plan developed by the IHH or CBCM in coordination with the member's interdisciplinary team. The provider delivering HBH services will indicate in the provider-specific service plan the member's LOCUS/CALOCUS actual disposition score and the HBH tier that the provider is authorized to deliver.

General Comments

The Department received a number of positive comments in support of the proposed rule making. The Department thanks the agencies that participated in the Habilitation workgroup and those who are supportive of the changes to the Habilitation program.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on August 12, 2021.

Fiscal Impact

Assumptions are based on the change in the HBH service eligibility criteria of individuals accessing services under each of the tiers for HBH. The SFY22 State share estimate assumes the COVID-19-related increase in the Federal Medical Assistance Percentage (FMAP) will remain in effect through December 2021. The estimate does not include the potential 10 percent FMAP increase for HCBS waiver services authorized through the American Rescue Plan Act since decisions on this FMAP increase are still pending. This rule making will change the assessment tool for this population from the current interRAI to the LOCUS/CALOCUS assessment tool. The contractor costs associated with completing the assessments are comparable between these tools, so no additional administrative impact is anticipated. Use of the new assessment tool is expected to shift utilization across the HBH reimbursement tiers. Estimates were derived from Optumas using historical data from Iowa Total Care and Amerigroup on utilization and costs for different tiers of service. Funding will need to come from the existing Medical Assistance appropriation. Providers will likely see increased Medicaid payments due to the redistribution of members by reimbursement tier.

Jobs Impact

The impact on jobs is unknown at this time but is anticipated to be minimal.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on November 1, 2021.

The following rule-making actions are adopted:

ITEM 1. Adopt the following **new** definition of "Intensive residential service homes" in subrule **77.25(1)**:

"Intensive residential service homes" or *"intensive residential services"* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in 441—subrule 25.6(8).

ITEM 2. Amend subrule 77.25(8) as follows:

77.25(8) *Home-based habilitation.*

a. The following agencies may provide home-based habilitation services:

~~*a.*~~ (1) An agency that is certified by the department to provide supported community living services under:

~~(1)~~ 1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

~~(2)~~ 2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

~~*b.*~~ (2) An agency that is accredited under 441—Chapter 24 to provide supported community living services.

~~*c.*~~ (3) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

~~*d.*~~ (4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

~~*e.*~~ (5) An agency that is accredited by the Council on Accreditation of Services for Families and Children.

~~*f.*~~ (6) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

b. Direct support staff providing home-based habilitation services shall meet the following minimum qualifications in addition to the other requirements outlined in this rule:

(1) A person providing direct support shall be at least 18 years old and have a high school diploma or its equivalent.

(2) A person providing direct support shall not be an immediate family member of the member receiving services.

(3) A person providing direct support to members receiving intensive residential habilitation services shall complete 48 hours of training within the first year of employment and 24 hours of training each year thereafter in mental health and multi-occurring conditions pursuant to 441—subrule 25.6(8).

(4) A person providing direct support to members receiving home-based habilitation services shall complete a minimum of 24 hours of training within the first year of employment in mental health and multi-occurring conditions, including but not limited to the following topics:

1. Mental health diagnoses, symptomology, and treatment;

2. Intervention strategies that may include applied behavioral analysis, motivational interviewing, or other evidence-based practices;

3. Crisis management, intervention, and de-escalation;

4. Psychiatric medications, common medications, and potential side effects;

5. Member-specific medication protocols, supervision of self-administration of medication, and documentation;

6. Substance use disorders and treatment;

7. Other diagnoses or conditions present in the population served; and

8. Individual-person-centered service plan, crisis plan, and behavioral support plan implementation.

(5) A person providing direct support to members receiving home-based habilitation services shall complete a minimum of 12 hours of training annually on the topics listed in subparagraph 77.25(8)*"b"*(4) or other topics related to serving individuals with severe and persistent mental illness.

c. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

d. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area; and

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need; or

2. The quantity of affordable rental housing in the county is insufficient to meet the need; or

3. Approval will result in a reduction in the size or quantity of larger congregate settings.

ITEM 3. Adopt the following **new** definitions of "Child and Adolescent Level of Care Utilization System," "Intensive residential service homes," "Level of Care Utilization System" and "Severe and persistent mental illness" in subrule **78.27(1)**:

"Child and Adolescent Level of Care Utilization System" or *"CALOCUS"* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service for individuals aged 16 to 18.

"Intensive residential service homes" or *"intensive residential services"* means intensive, community-based services provided 24 hours per day, 7 days per week, 365 days per year to individuals with a severe and persistent mental illness who have functional impairments and may also have multi-occurring conditions. Providers of intensive residential service homes are enrolled with Medicaid as providers of HCBS habilitation or HCBS intellectual disability waiver supported community living and meet additional criteria specified in 441—subrule 25.6(8).

"Level of Care Utilization System" or *"LOCUS"* means the comprehensive functional assessment tool utilized to determine eligibility for the habilitation program and service authorization for the home-based habilitation service for individuals aged 19 and older.

"Severe and persistent mental illness" means the same as defined in rule 441—25.1(331).

ITEM 4. Amend subrule 78.27(2) as follows:

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. *Age.* The member is at least 16 years of age or older.

b. LOCUS/CALOCUS actual disposition. The member has a LOCUS/CALOCUS actual disposition of level one recovery maintenance and health management or higher on the most current LOCUS/CALOCUS assessment completed within the past 30 days.

~~*a.*~~ *c.* *Risk factors.* The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., crisis response services, subacute mental health services, emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member is currently receiving habilitation or integrated health home services; or

~~(2)~~ (3) The member has a history of ~~psychiatric illness~~ severe and persistent mental illness resulting in at least one episode of continuous, professional supportive care other than hospitalization~~.~~ (e.g., counseling, therapy, assertive community treatment, or medication management); or

(4) The member has a history of severe and persistent mental illness resulting in involvement in the criminal justice system (e.g., prior incarceration, parole, probation, criminal charges, jail diversion program or mental health court); or

(5) Traditional mental health services available in the member's community have not been able to meet the member's needs.

~~*b.*~~ *d.* *Need for assistance.* The member has a need for assistance or is likely to need assistance related to functional impairment arising out of a mental health diagnosis typically demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least ~~two years~~ 12 months:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history, and the member is currently receiving employment services or the member has a need for employment services to obtain or maintain employment.

(2) The member requires financial assistance ~~for out-of-hospital maintenance and is~~ to reside independently in the community or may be homeless or at risk of homelessness if unable to procure this assistance without help.

(3) The member shows ~~severe~~ significant inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits ~~inappropriate~~ social behavior that ~~results in a demand for intervention~~ puts the member's safety or others' safety at risk, which results in the need for service intervention which may include crisis management or protective oversight.

~~*c.*~~ *e.* *Income.* The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

~~*d.*~~ *f.* *Needs assessment.* The ~~interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older~~ LOCUS or CALOCUS tool has been completed in the LOCUS online system, and using the algorithm developed by Deerfield Solutions to derive the actual disposition score based on the comprehensive assessment and social history (CASH) completed by the integrated health home (IHH) or community-based case manager (CBCM) during a face-to-face interview with the member and the member's representative as applicable, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The ~~interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH)~~ LOCUS/CALOCUS information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the ~~interRAI~~ LOCUS or CALOCUS, before services begin and annually thereafter, and more frequently if significant observable changes occur in the member's situation, condition or circumstances.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4)~~,~~ and 441—paragraph 90.4(1)*"b"* before services begin and annually thereafter, and when there is a significant observable change in the member's situation, condition, or circumstances.

~~*e.*~~ *g.* *Plan for service.* The department or the member's managed care organization 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~~ by the IME or the member's managed care organization 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) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4)~~.~~ and 441—paragraph 90.4(1)*"b."* A service plan may change ~~at any time due to a significant change in the member's needs~~ when requested by the member or the member's interdisciplinary team when there is a significant observable change in the member's situation, condition, or circumstances.

(2) For members receiving home-based habilitation, the service plan shall include the member's LOCUS/CALOCUS actual disposition, the LOCUS/CALOCUS composite score, and each individual domain score for each of the six LOCUS/CALOCUS domains.

~~(2)~~ (3) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

~~(3)~~ (4) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

ITEM 5. Amend subrule 78.27(7) as follows:

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living, working, and recreating in the community.

a. *Scope.* Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities ~~of daily living~~ to address daily living needs;

(3) Assistance with symptom management and participation in mental health treatment;

(4) Assistance with accessing physical and mental health care treatment, communication, and implementation of health care recommendations and treatment;

(5) Assistance with accessing and participating in substance use disorder treatment and services;

(6) Assistance with medication administration and medication management;

(7) Assistance with understanding communication whether verbal or written;

~~(3)~~ (8) Community inclusion and active participation in the community;

~~(4)~~ (9) Transportation;

~~(5)~~ (10) Adult educational supports, which may include assistance and support with enrolling in educational opportunities and participation in education and training;

~~(6)~~ (11) Social and leisure skill development;

~~(7)~~ (12) Personal care; and

~~(8)~~ (13) Protective oversight and supervision.

b. Setting requirements. Home-based habilitation services shall occur in the member's home and community.

(1) A member may live in the member's own home, within the home of the member's family or legal representative, or in another community living arrangement that meets the criteria in 441—subrule 77.25(5).

(2) A member living with the member's family or legal representative is not subject to the criteria in 441—paragraphs 77.25(8)*"c"* and *"d."*

(3) A member may not reside in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

c. Home-based habilitation level of service criteria. Home-based habilitation services shall be available to members based on the member's most current LOCUS/CALOCUS actual disposition score, according to the following criteria:

(1) Intensive IV residential habilitation services. Intensive IV services are provided 24 hours per day. To be eligible for intensive IV services, a member must meet the following criteria:

1. The member has a LOCUS/CALOCUS actual disposition of level six medically managed residential services, and

2. The member meets the criteria in 441—subparagraph 25.6(8)*"c"*(3).

(2) Intensive III services are provided 17 to 24 hours per day. To be eligible for intensive III services, the member must have a LOCUS/CALOCUS actual disposition of level five.

(3) Intensive II services are provided 13 to 16.75 hours per day. To be eligible for intensive II services, the member must have a LOCUS/CALOCUS actual disposition of level four.

(4) Intensive I services are provided 9 to 12.75 hours per day. To be eligible for intensive I services, the member must have a LOCUS/CALOCUS actual disposition of level three.

(5) Medium need services are provided 4.25 to 8.75 hours per day as needed. To be eligible for medium need services, the member must have a LOCUS/CALOCUS actual disposition of level two.

(6) Recovery transitional services are provided 2.25 to 4 hours per day as needed. To be eligible for recovery transitional services, the member must have a LOCUS/CALOCUS actual disposition of level one.

(7) High recovery services are provided 0.25 to 2 hours per day as needed. To be eligible for high recovery services, the member must have a LOCUS/CALOCUS actual disposition of level one.

d. Additional criteria for receiving home-based habilitation services for transition-age youth 16 to 17.5 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside the family home may only receive home-based habilitation services in residential settings with 16 or fewer beds licensed by the department of inspections and appeals.

(3) The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.25(5).

(4) Individuals 16 to 18 years of age shall receive 24-hour site supervision and support.

e. Additional criteria for receiving home-based habilitation services for transition-age youth 17.5 to 18 years of age.

(1) Members residing in the family home may receive home-based habilitation services as needed, subject to the criteria set forth in this rule.

(2) Members residing outside of the family home may receive daily home-based habilitation in a provider-owned or controlled setting when the following criteria are met:

1. The proposed living environment must meet HCBS setting requirements in accordance with 441—subrule 77.25(5).

2. All providers of the service setting being requested must meet the following additional safety and service requirements for serving youth under the age of 18:

- Individuals 17.5 to 18 years of age shall receive 24-hour site supervision and support.
- Individuals under the age of 18 may not reside in settings with individuals over the age of 21.

● The comprehensive service plan shall specifically identify educational services and supports for individuals who have not obtained a high school diploma or equivalent.

● For individuals who have obtained a high school diploma or equivalent, the comprehensive service plan shall include supported employment, additional training, or educational supports.

3. The member's parent or guardian has consented to home-based habilitation services.

4. The member is able to pay room and board costs (funding sources may include, but are not limited to, supplemental security income, child support, adoptions subsidy, or private funds).

5. A licensed setting, such as those approved to provide residential-based supported community living, is not available.

~~*b.*~~ *f.* *Exclusions.* Home-based habilitation payment shall not be made for the following:

(1) to (6) No change.

ITEM 6. Amend paragraph **78.27(11)"d"** as follows:

d. *Appeal rights.* 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 or of the LOCUS/CALOCUS actual disposition score 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.

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