ARC 8344B

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed Emergency

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 81, "Nursing Facilities," Iowa Administrative Code.

These amendments reduce the reimbursement for most Medicaid services to achieve the savings required by Executive Order 19, which mandated a 10 percent across-the-board cut in expenditures. Specifically, these amendments:

- Reduce the rental allowance for durable medical equipment from 150 percent of the purchase price to 100 percent of the purchase price.
- Reduce the reimbursement for nonemergency medical transportation by private automobile from 34 cents per mile to 30 cents per mile.
- Limit the reimbursement for nonemergency medical transportation by public transportation to $1.40 per mile.
- Reduce the reimbursement for generic and brand-name specialty drugs from the average wholesale price less 12 percent to the average wholesale price less 17 percent.
- Reduce the multiplier used to calculate the state maximum allowable cost for generic drugs (SMAC) from 1.4 to 1.2 and clarify that the average acquisition cost is based on generic products only.
- Reduce the pharmacy dispensing fee from $4.57 to $4.34 for the remainder of the state fiscal year.
- Reduce payments to the following providers by 5 percent for services rendered during the remainder of state fiscal year 2010: hospitals (not including critical access hospitals), nursing facilities, and psychiatric medical institutions for children; physicians, podiatrists, advanced registered nurse practitioners, audiologists, occupational and physical therapists, psychologists, optometrists, opticians, and chiropractors; dealers of medical equipment and supplies, hearing aids, orthopedic shoes, and prosthetic devices; remedial and behavioral health services, laboratory, X-ray, and ambulance providers; ambulatory surgical centers, clinics, home health agencies, rehabilitation agencies, lead inspection agencies, family planning providers, and screening centers.
- Reduce payments to the following providers by 2.5 percent for services rendered during the remainder of state fiscal year 2010: dentists, community mental health centers, targeted case management providers, and home- and community-based waiver service providers.
- Provide that computation of administrative, environmental, and property expenses for nursing facilities shall be based on 90 percent of facility capacity, instead of 85 percent, unless the number of inpatient days is higher.
- Provide that nursing facilities shall be reimbursed for holding a bed for a hospitalized resident only if the facility's occupancy rate is at 95 percent or more. For those facilities whose occupancy rate meets that level, the payment will be made at 25 percent of the facility's daily rate, instead of 42 percent of the daily rate.

These amendments do not provide for waivers in specified situations. Needed savings will not be realized if waivers are granted. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

The Council on Human Services adopted these amendments on November 10, 2009.

The Department finds that notice and public participation are impracticable and contrary to the public interest. The Department is statutorily and constitutionally required to reduce spending obligations to the level of constitutionally authorized appropriations. Deeper cuts would be required if the Department were to delay taking action to allow for notice and public participation. Therefore, these amendments are filed pursuant to Iowa Code section 17A.4(3).

The Department also finds, pursuant to Iowa Code section 17A.5(2)"b," that avoidance of deficit spending confers a public benefit and that the immediate efficacy of this amendment is necessary because

of the presently existing constitutional peril to the public welfare caused by spending obligations which exceed available revenues. Therefore, the normal effective date of these amendments is waived.

These amendments are also published herein under Notice of Intended Action as **ARC 8345B** to allow for public comment.

These amendments are intended to implement Executive Order 19 and Iowa Code chapter 249A.

These amendments became effective on December 1, 2009.

The following amendments are adopted.

ITEM 1. Amend subparagraph **78.10(1)"f"(1)** as follows:

(1) The provider shall monitor rental payments up to ~~150~~ 100 percent of the purchase price. At the point that total rent paid equals ~~150~~ 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

ITEM 2. Amend paragraphs **78.13(5)"a"** and **"b"** as follows:

a. ~~Effective September 1, 2008, when~~ When transportation is by car, the maximum payment that may be made will be the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of ~~34~~ 30 cents per mile.

b. When public transportation is utilized, the basis of payment will be the actual charge made by the provider of transportation, not to exceed ~~the charge that would be made by the most economical available source of public transportation~~ $1.40 per mile.

ITEM 3. 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 October 7, 2008. 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. ~~Effective June 25, 2005, reimbursement~~ 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: ~~as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g."*~~

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 *"g"*; 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 *"g."*

(2) No change.

(3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug ~~and all equivalent products~~ (the average price pharmacies pay to obtain ~~drugs~~ the generic drug as evidenced by purchase records) adjusted by a multiplier of ~~1.4~~ 1.2, plus the professional dispensing fee specified in paragraph *"g."*

(4) No change.

b. ~~Effective June 25, 2005, reimbursement~~ Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined: ~~as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph *"g."*~~

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 *"g"*; 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 *"g."*

(2) No change.

c. to *f.* No change.

g. ~~For services rendered after June 30, 2008, the~~ The professional dispensing fee is $4.57 or the pharmacy's usual and customary fee, whichever is lower, except for the period from December 1, 2009, to June 30, 2010, during which the professional dispensing fee shall be $4.34.

h. to *j.* No change.

ITEM 4. Adopt the following **new** rule 441—79.16(249A):

441—79.16(249A) Payment reductions pursuant to executive order. The following payment provisions shall apply to services rendered during the period from December 1, 2009, to June 30, 2010, notwithstanding any contrary provision in this chapter.

79.16(1) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by the following providers shall be reduced by 5 percent from the rates in effect November 30, 2009:

a. Ambulance services.

b. Ambulatory surgical centers.

c. Advanced registered nurse practitioners, including certified nurse-midwives.

d. Audiologists and hearing aid dealers.

e. Behavioral health providers.

f. Birth centers.

g. Chiropractors.

h. Clinics.

i. Durable medical equipment, medical supply, orthopedic shoe, and prosthetic device dealers.

j. Family planning clinics.

k. Hospitals, not including services rendered by critical access hospitals or services billed under the IowaCare program, but including:

(1) Inpatient hospital care, including Medicaid-certified psychiatric and rehabilitation units.

(2) Outpatient hospital care.

(3) Indirect medical education payments.

(4) Direct medical education payments.

(5) Disproportionate-share payments (except for payments to the Iowa state-owned teaching hospital).

l. Independent laboratories and X-ray providers.

m. Independently practicing occupational therapists, physical therapists, and psychologists.

n. Lead inspection agencies.

o. Maternal health centers.

p. Optometrists and opticians.

q. Physicians, excluding services billed to the IowaCare program except for preventative examinations.

r. Podiatrists.

s. Rehabilitation agencies.

t. Screening centers.

79.16(2) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services, and home health care for maternity patients and children provided by home health agencies shall be retrospective cost-related with cost settlement based on the lesser of the following:

a. The maximum Medicare rate in effect November 30, 2009, less 5 percent,

b. The maximum Medicaid rate in effect November 30, 2009, less 5 percent, or

c. 95 percent of the reasonable and allowable Medicaid cost.

79.16(3) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for private duty nursing and personal care for persons aged 20 or under provided by home health agencies shall be retrospective cost-related with cost settlement based on the lesser of the following:

a. The maximum Medicaid rate in effect November 30, 2009, less 5 percent, or

b. 95 percent of the reasonable and allowable Medicaid cost.

79.16(4) Notwithstanding any provision of subrule 79.1(2) or 79.1(23), the basis of reimbursement for remedial services providers shall be consistent with the methodology described in subrule 79.1(23) except that the reasonable and proper cost of operation is equal to the actual and allowable cost less 5 percent subject to the established rate maximum less 5 percent.

79.16(5) Notwithstanding any provision of subrule 79.1(2) or rule 441—81.6(249A), the patient-day-weighted medians used in rate setting for nursing facilities shall be calculated and the rates adjusted to provide a 5 percent decrease in nursing facility rates (except for state-owned facilities).

79.16(6) Notwithstanding any provision of subrule 79.1(2) or rule 441—85.25(249A), the basis of reimbursement for non-state-owned psychiatric medical institutions for children shall be consistent with the methodology described in 441—subrule 85.25(1) except that the per diem rate shall be based on the facility's cost for the service less 5 percent, not to exceed the upper limit as provided in subrule 79.1(2) less 5 percent.

79.16(7) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by dentists shall be reduced by 2.5 percent from the rates in effect November 30, 2009.

79.16(8) Notwithstanding any provision of subrule 79.1(2) or 79.1(25), the basis of reimbursement for community mental health centers shall be retrospective and cost-related with cost settlement limited to 97.5 percent of the provider's reasonable and allowable Medicaid cost.

79.16(9) Notwithstanding any provision of subrule 79.1(2), the basis of reimbursement for targeted case management shall be fee for service with cost settlement limited to 97.5 percent of the provider's reasonable and allowable Medicaid cost.

79.16(10) Notwithstanding any provision of subrule 79.1(2), payment for covered services rendered by home- and community-based waiver service providers shall be reduced by 2.5 percent from the rates in effect November 30, 2009.

a. Rates based on a submitted financial and statistical report shall be consistent with the methodology described in subparagraph 79.1(15)*"d"*(1) except that the inflation adjustment applied to actual, historical costs and the prior period base cost shall be reduced by 2.5 percent.

b. The retrospective adjustment of prospective rates shall be made based on revenues exceeding 100 percent of adjusted actual costs. Adjusted actual costs shall not exceed the upper limits as specified in subrule 79.1(2).

This rule is intended to implement Executive Order 19 and Iowa Code chapter 249A.

ITEM 5. Amend subparagraph **81.6(16)"a"(1)** as follows:

(1) Non-state-owned nursing facilities. ~~Beginning July 1, 2001, patient days for purposes of the computation of administrative, environmental, and property expenses shall be inpatient days as specified in subrule 81.6(7) or 80 percent of the licensed capacity of the facility, whichever is greater. Beginning July 1, 2003, and thereafter, patient~~ Patient days for purposes of the computation of administrative, environmental, and property expenses for non-state-owned facilities shall be inpatient days as determined in subrule 81.6(7) or ~~85~~ 90 percent of the licensed capacity of the facility, whichever is greater. Patient days for purposes of the computation of all other expenses shall be inpatient days as determined in subrule 81.6(7).

ITEM 6. Amend subparagraph **81.6(16)"h"(9)** as follows:

(9) Calculation of capital cost per diem instant relief add-on. The capital cost per diem instant relief add-on is calculated by dividing the annual estimated property costs for the complete replacement, new construction, or major renovation project for which the add-on is granted by the facility's estimated annual total patient days.

1. Total patient days shall be determined using the most current submitted financial and statistical report or using the estimated total patient days as reported in the request for the add-on. For purposes of calculating the add-on, total patient days shall be the greater of the estimated annual total patient days or ~~85~~ 90 percent of the facility's estimated licensed capacity.

2. and 3. No change.

ITEM 7. Amend subparagraph **81.6(16)"h"(12)** as follows:

(12) Reconciliation of capital cost per diem instant relief add-on. During the period in which the capital cost per diem instant relief add-on is granted, the Iowa Medicaid enterprise shall recalculate the amount of the add-on based on actual allowable costs and patient days reported on the facility's submitted annual financial and statistical report. A separate reconciliation shall be performed for each cost report period in which the capital cost per diem instant relief add-on was paid. The facility shall submit with the annual financial and statistical report a separate schedule reporting total patient days per calendar quarter and a current depreciation schedule identifying the assets related to the add-on.

1. For purposes of recalculating the capital cost per diem instant relief add-on, total patient days shall be based on the greater of the number of actual patient days during the period in which the add-on was paid or ~~85~~ 90 percent of the facility's actual licensed bed capacity during the period in which the add-on was paid.

2. No change.

ITEM 8. Amend paragraph **81.10(4)"f"** as follows:

f. Payment for periods when residents are absent for a visit ~~or hospitalization~~ shall be made at 42 percent of the nursing facility's rate. ~~Effective May 1, 2003, Medicaid reimbursement savings attributable to the limitation of payments to facilities for periods when residents are absent shall be used to pay costs associated with the design and implementation of that limitation before reversion to Medicaid.~~ Payment for periods when residents are absent for hospitalization shall:

(1) Be made at 25 percent of the nursing facility's rate if the facility occupancy percentage is 95 percent or greater.

(2) Not be made if a facility's occupancy percentage is less than 95 percent.

(3) Be made at 42 percent of the nursing facility's rate for special population facilities.

[Filed Emergency 11/10/09, effective 12/1/09]
[Published 12/2/09]

EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 12/2/09.