IME Policy Clarification # [PC000253]

Date

MCO CEO Name
MCO
Address Line 1
Address Line 2
Des Moines, Iowa XX

Dear Ms/Mr.:

This letter is a formal notification of the state's expectations related to the operations and implementation of Iowa Medicaid under the managed care program. This purpose of this letter is to do following:

X Provide formal guidance
☐Request for information

Content

Medicaid is the payer of last resort. It is the responsibility of the person coordinating care for each member to ensure no duplication is occurring, and that the funding hierarchy is implemented in the following order:

- Private insurance
- Medicare
- Medicaid State Plan
- Medicaid1915(c) Waivers and
- State Only funds

This Policy Clarification is intended is to clarify the relationship between HCBS Waiver services and State Plan benefits and reduce unnecessary exception to policy (ETP) requests to bypass the hierarchy of care when authorizing HCBS Waiver services.

Relationship of Waiver Services to State Plan Services

Waiver services may complement the services that a state furnishes to Medicaid beneficiaries under the state plan by including services that are not covered under the state plan or supplement state plan services by providing for the coverage of services offered under the state plan in an amount, frequency or duration greater than allowed under the state plan.

CMS reviews services requested in the waiver applications to determine if the service is considered sufficiently distant from state plan services to warrant approval. Coverage of a waiver service is considered distinct from state plan benefits when:

(a) The scope of the waiver coverage is materially different from the state plan service.

(b) The providers of the waiver service are different from the providers of the state plan service; and/or,

(c) The method of service delivery is different (this difference may entail the availability of participant direction options under the waiver which are not available under the state plan).

When authorizing waiver services, a state may take into account the services that a waiver participant receives through the state plan. The overarching objectives of this analysis are (1) to ensure that individuals have unfettered access to services to which they are entitled; and, (2) to ensure that there is no duplication (or potential duplication) of payment for services.

Federal HCBS Technical Guide Version 3.6 requires that services that are provided within the medical assistance state plan are accessed before HCBS waiver services are accessed when there is a same or similar service is offered under the state plan. This is applicable when the HCBS waiver covers Extended State Plan services such as Home Health Aide and Nursing services provided by a Home Health Agency, or a statutory service such as Targeted Case Management.

There are three types of services that may be included in a 1915(c) waiver; statutory, extended state plan, and other:

1. Statutory services are services that are specifically authorized or otherwise included in a 1915 (c) waiver. The core definitions of these services describe the commonly understood scope and nature of each of these services. The scope of the service does not have to exactly match the core service definition. So long as the specified scope of the service aligns with the core service definition, the service is considered a statutory service.

2. Extended State Plan service means the coverage parameters (e.g., nature of the service and provider qualifications) contained in the state plan apply. The coverage of a state plan service on an extended basis means providing the service in an amount over and above that permitted under the state plan (e.g., if the plan limits physician visits to three per month, extended coverage may permit additional visits).

3. Other services means services that are not expressly authorized in the statute as long as it can be demonstrated that the service will be necessary to assist a waiver participant to avoid institutionalization and function in the community. Services that a state chooses not to cover under their state plan (optional state plan services) but are included under a waiver, are considered “other” services or

statutory services (e.g., personal care) as the case may be, not extended state plan services. A service is considered an "other" service when:

a) The service is covered under the waiver that is similar to but has a different scope, or
b) The services uses different types of providers than the service covered under the state plan, or
c) The service cannot be reimbursed in whole or in part under the state plan.

Consumer Directed Attendant Care (CDAC) is considered an "other service" under the HCBS Waivers. There is no state plan equivalent service to CDAC. The CDAC service scope is different from that of Home Health Agency scope of services, the CDAC provider qualifications, standards and requirements are different from the Home Health Agency provider qualifications, standards and requirements. CDAC services may not be reimbursed under the state plan. The member determines the rate that they will pay their CDAC provider. The member self-directs their CDAC services, self-direction is not applicable to Home Health Agency services.

Relationship of Waiver Services to Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services

In the case of waivers that serve children, the waiver still may be employed to provide services that supplement the services available under the state plan, beyond those EPSDT benefits, required under §1905(r).

If a service is available to a child under the state plan or could be furnished as service required under the EPSDT benefit under the provisions of §1905(r), it may not be covered as a waiver service for child waiver participants. Thus, in a waiver that serves children, services such as rehabilitative services (as defined in 42 CFR §440.130), private duty nursing (as defined in 42 CFR §440.80), physical and occupational therapy (as defined in 42 CFR §440.110), and nurse practitioner services (as defined in 42 CFR §440.166) may not be furnished as waiver services to children.

The table below lists the approved HCBS Waiver services contained in the HCBS Waiver Application. The waiver application category of service and the equivalent state plan benefit as applicable. For those services where no state plan alternative exists, the waiver service may be authorized to meet the members need. Where a same or similar state plan service exists such as with extended state plan services and some mandatory services, the state plan must first be accessed prior to accessing those services under the waiver.

HCBS Waiver Service	Waiver Application Service Category	Same or Similar State Plan Service
Adult Day Care	Statutory	None
Assistive Devices	Other	Durable Medical Equipment
Assisted Living	Other	None
Behavioral Programming	Other	

Case Management Services	Statutory	Targeted Case Management
Chore	Other	None
Consumer Choices Option (CCO)	Supports for Participant self-direction	None
Consumer Directed Attendant Care (CDAC)	Other	None
Counseling	Other	None
Day Habilitation	None	None
Emergency Response	None	None
Environmental Modifications and Adaptive Devices	Other	None
Family and Community Support	Statutory	Behavioral Health Intervention Services
Family Counseling & Training	Other	None
Home Delivered Meals	Other	None
Home Health Aide	Statutory	Home Health Agency Services – EPSTD Personal Care
Homemaker	Statutory	None
Home/Vehicle Modifications	Other	None
In-home Family Therapy	Other	None
Interim Medical Monitoring & Treatment (IMMT)	Other	None
Mental Health Outreach	Other	None
Nursing	Statutory	Home Health Agency Services – EPSTD Private Duty Nursing
Nutritional Counseling	Other	None
Prevocational Services *includes Career Exploration	Statutory	None
Respite: Individualized, group, specialized	Statutory	None
Senior Companion	Other	None
Supported Community Living (SCL)	Other	None
Specialized Medical Equipment	Extended State Plan Service	Durable Medical Equipment
Supported Community Living: Residential-Based (RBSCL) for children	Other	None
Supports for Participant Direction • Financial Management Services	Support For Participant Self Direction	None

• Independent Support Broker • Individual Directed Goods and Services • Self-Directed Community Support and Employment • Self-Directed Personal Care		
Supported Employment (SE)	Statutory	None *See IVRS DHS MOA for HCBS SE.
Transportation	Other	None

Iowa Administrative Rules

Iowa administrative rules require:

- HCBS Service plans reflect the use of nonwaiver services.
- Service plans for persons aged 20 or under must reflect the use of all appropriate nonwaiver services so as not to duplicate or replace those services.
- Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid EPSDT services.
- To be eligible for Interim Medical Monitoring and Treatment(IMMT) under the waiver, the member must be:
    - Under the age of 21
    - Currently receiving Home Health Agency Services and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services
    - Residing in the consumer's family home or foster family home; and
    - In need of interim medical monitoring and treatment as ordered by a physician, nurse practitioner, clinical nurse specialist, or physician assistant

HCBS Waivers

441.83 Preamble
Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.

HCBS Waiver Program	**Administrative Rules addressing use of nonwaiver services**

AIDS/HIV Waiver	441.78.38(10)a., 441.83.47(3)
Brain Injury Waiver	441.78.43(16)a., 441.83.82(2), 441.83.87(2)
Children's Mental Health Waiver	441.78.52(1)a.
Elderly Waiver	441.78.37(19), 441.83.22(2)d.(8)
Health & Disability Waiver	441.78.34(14), 441.83.2(2)a(2) and 441 83.2(2)a.(3) , 441.83.7(3)
Intellectual Disability Waiver	441.78.43(16)a., 441.83.61(2)g(2) and 441.83.61(2)g.(3)
Physical Disability Waiver	441.78.46(7)a., 441.83.107(1)a.

Iowa Code: None

Contract Language
4.4.3 Service Plan Content
4.4.3.1.6 Reflects the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports;

Conclusion:
An ETP is not needed when a member chooses to receive CDAC services to provide for the member's personal care needs.

This formal guidance impacts capitation rates in the following manner:
X This is an Iowa Medicaid practice prior to April 1, 2016 and was included in the experience used to develop the capitation rates.
☐This is a new process or policy that does not have a fiscal impact.
☐This is a new process or policy that was reflected in revised capitation rates and implemented July 1, 2020

Sincerely,

Account Manager
Managed Care Account Manager

Attestation:

I hereby attest to receipt and understanding of this communication including all requirements and due dates.

Name_____ Date_____.
The department will monitor progress towards implementation and may impose remedies for failure to implement.