ARC 7732B

HUMAN SERVICES DEPARTMENT[441]

Amended Notice of Intended Action

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

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

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services proposes to amend Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Chapter 83, "Medicaid Waiver Services," and Chapter 90, "Case Management for People With Mental Retardation, Chronic Mental Illness, or Developmental Disabilities," Iowa Administrative Code.

This filing amends the Notice of Intended Action published in the Iowa Administrative Bulletin on March 11, 2009, as **ARC 7631B**, by substituting a new Item 27. In the original publication, Item 27 inadvertently duplicated rules 441—90.6(249A) and 441—90.7(249A) on terminating case management services and appealing adverse decisions instead of proposing new rule 441—90.8(249A) on provider standards for targeted case management. That proposed new rule, including standards for incident reporting, emergency coverage, and quality assurance activities, was published on the Department's policy Web site.

In addition, in Item 10, the phrase "Effective July 1, 2009," has been added to subparagraph 79.1(24)"a"(1) to clarify that the new billing unit and cost methodology are intended to take effect for state fiscal year 2010. Also, a correction was made to Item 24, paragraph 90.5(1)"b," to clarify the basis for development of the comprehensive service plan. The first sentence of the paragraph now reads as follows: "The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment."

The proposed amendments make the following changes related to the provision of case management services under the Medicaid program:

• Redefine the scope of case management services to closely match the language of federal regulations published at 72 Federal Register 68,077 (December 4, 2007) that, following a moratorium, became effective on April 1, 2009. These amendments will ensure that case management services funded by Iowa Medicaid are consistent with the federal regulations.

• Clarify the role of the case manager in ensuring the health, safety, and welfare of members, including requirements for monitoring in response to incident reports.

• Remove the requirement for preauthorization for members not covered under the Iowa Plan managed behavioral care contract and add quality assurance oversight.

• Lengthen from 30 days to 60 days the period that case management may be provided to Medicaid members before they transition from an institution to a community setting.

• Change the basis of reimbursement for case management from a monthly unit to a 15-minute unit as required by federal regulations.

• Delete the scope of service for case management for the home- and community-based (HCBS) habilitation services and elderly and brain injury waiver programs and instead refer to the case management scope of service in 441—Chapter 90. Case management services provided through the HCBS habilitation services program and the HCBS brain injury waiver and elderly waiver programs will be required to meet the same service requirements as case management provided under 441—Chapter 90.

Specific waivers are not provided because the changes are required by federal regulations, which do not allow for exceptions, or should apply to all targeted case management services. Requests

for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

Any interested person may make written comments on the proposed amendments on or before May 12, 2009. Comments should be directed to Mary Ellen Imlau, Bureau of Policy Analysis and Appeals, Department of Human Services, Hoover State Office Building, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Comments may be sent by fax to (515)281-4980 or by E-mail to policyanalysis@dhs.state.ia.us.

The Department will also hold a public hearing for the purpose of receiving comments on these proposed amendments on Wednesday, May 13, 2009, from 10 to 11 a.m. at Iowa Medicaid Enterprise Room 128, 100 Army Post Road, Des Moines, Iowa. Persons with disabilities requiring assistive services or devices to observe or participate should contact the Bureau of Policy Analysis and Appeals at (515) 281-8440 in advance of the scheduled date to request that appropriate arrangements be made.

These amendments are intended to implement Iowa Code sections 249A.4, 249A.26, and 249A.27.

The following amendments are proposed.

ITEM 1. Amend paragraphs **78.27(2)"d"** and **"e"** as follows:

d. Needs assessment. The member's case manager has completed an assessment of the member's need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule ~~24.4(2)~~ 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. Plan for service. The department has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department 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). A service plan may change at any time due to a significant change in the member's needs.

~~(2) The member shall receive at least one billable unit of service other than case management per calendar quarter.~~

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

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

ITEM 2. Amend paragraph **78.27(5)"e"** as follows:

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility, except case management provided when the member is transitioning from the institution to a community setting as provided in 441—Chapter 90.

ITEM 3. Amend subrule 78.27(6) as follows:

78.27(6) *Case management.* Case management assists members who reside in a community setting or are transitioning to a community setting in gaining access to needed ~~home- and community-based habilitation services, as well as~~ medical, social, educational, housing, transportation, vocational, and other appropriate services~~, regardless of the funding source for the services~~ in order to ensure the health, safety, and welfare of the member.

a. Scope. Case management services shall be provided as set forth in ~~rule~~ rules 441—90.5(249A) and 90.8(249A). ~~The case manager shall be responsible for the following activities:~~

~~(1) Explaining the member's right to freedom of choice.~~

~~(2) Ensuring that all unmet needs of the member are identified in the service plan.~~

~~(3) Retaining the comprehensive service plan, as specified in rule 441—79.3(249A).~~

~~(4) Explaining to the member what abuse is, and how to report abuse.~~

~~(5) Explaining to the member how to make a complaint about the member's services or providers.~~

~~(6) Monitoring the service plan, with review occurring regularly.~~

~~(7) Meeting with the member face to face at least quarterly.~~

~~(8) Assessing and revising the service plan at least annually to determine achievement, continued need, or changes in goals or intervention methods. The review shall include the member using the service and shall involve the interdisciplinary team.~~

~~(9) Notifying the member of any changes in the service plan by sending the member a notice of decision. When the change is an adverse action such as a reduction in services, the notice shall be sent ten days before the change and shall include appeal rights.~~

b. Exclusion. Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

ITEM 4. Amend subrule 78.37(17) as follows:

78.37(17) *Case management services.* Case management services are services that assist ~~a consumer~~ Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services ~~needed for the consumer to remain in the consumer's home~~ in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the ~~consumer~~ member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall ~~include:~~ be provided as set forth in rules 441—90.5(249A) and 90.8(249A).

~~(1) A comprehensive assessment of the consumer's needs, which must be made within 30 days of referral to case management.~~

~~(2) Development and implementation of a service plan to meet those needs.~~

~~(3) Coordination, authorization, and monitoring of all services.~~

~~(4) A face-to-face meeting by the case manager with the consumer at least quarterly.~~

~~(5) Monitoring of the consumer's health, safety, and welfare.~~

~~(6) Evaluation of outcomes.~~

~~(7) Periodic reassessment and revision of the service plan as needed but at least annually.~~

~~(8) Assurance that consumers have a choice of providers.~~

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management ~~activity~~ services performed on behalf of the consumer during a month when the consumer is enrolled.

~~*d.* A unit of service is one month.~~

ITEM 5. Amend subrule 78.43(1) as follows:

78.43(1) *Case management services.* Individual case management services means ~~activities provided, using an interdisciplinary process, to persons with a brain injury to ensure that the consumer has received a comprehensive evaluation and diagnosis, to give assistance to the consumer in obtaining appropriate~~ services ~~and living arrangements,~~ that assist members who reside in a community setting or are transitioning to a community setting in gaining access to ~~coordinate the delivery of~~ needed medical, social, educational, housing, transportation, vocational, and other appropriate services~~, and to provide monitoring~~ in order to ensure the ~~continued appropriate provision of services and the appropriateness of the selected living arrangement~~ health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 90.8(249A).

b. The service ~~is to~~ shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks ~~which~~ that are a typical part of life, and fully participate as members of the community.

c. ~~It is essential that the~~ The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. ~~Those~~ Members who are at the ICF/MR level of care ~~where the~~ whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, are not eligible for case management as a waiver service.

~~Case management services shall consist of the following components:~~

~~*a.* — Intake, which includes ensuring that there is sufficient information to identify all areas of need for services and appropriate living arrangements.~~

~~*b.* — Assurance that a service plan is developed which addresses the consumer's total needs for services and living arrangements.~~

~~*c.* — Assistance to the consumer in obtaining the services and living arrangements identified in the service plan.~~

~~*d.* — Coordination and facilitation of decision making among providers to ensure consistency in the implementation of the service plan.~~

~~*e.* — Monitoring of the services and living arrangements to ensure their continued appropriateness for the consumer.~~

~~*f.* — Crisis assistance to facilitate referral to the appropriate providers to resolve the crisis. The intent and purpose of the individual case services are to facilitate the consumer's access to the service system and to enable consumers and their families to make decisions on their own behalf by providing:~~

~~(1) Information necessary for decision making.~~

~~(2) Assistance with decision making and participation in the decision-making process affecting the consumer.~~

~~(3) Assistance in problem solving.~~

~~(4) Assistance in exercising the consumer's rights.~~

ITEM 6. Amend paragraph **79.1(1)"d"** as follows:

d. ~~*Monthly fee*~~ *Fee for service with cost settlement.* ~~Providers~~ Effective July 1, 2009, providers of ~~MR/CMI/DD~~ case management services ~~are~~ shall be reimbursed on the basis of a payment rate for a ~~month's provision~~ 15-minute unit of service ~~for each client enrolled in an MR/CMI/DD case management program for any portion of the month~~ based on reasonable and proper costs for service provision. The fee will be determined by the department with advice and consultation from the appropriate professional group and will reflect the amount of resources involved in service provision.

(1) Providers are reimbursed throughout each fiscal year on the basis of a projected ~~monthly~~ unit rate for each participating provider~~,~~. The projected rate is based on reasonable and proper costs of operation, pursuant to federally accepted reimbursement principles (generally Medicare or OMB A-87 principles) ~~with~~.

(2) Payments are subject to annual retrospective cost settlement based on submission of actual costs of operation and service utilization data by the provider on ~~financial and statistical reports~~ Form 470-0664, Financial and Statistical Report. The cost settlement represents the difference between the amount received by the provider during the year for covered services and the amount supported by the actual costs of doing business, determined in accordance with an accepted method of cost appointment.

(3) The methodology for determining the reasonable and proper cost for service provision assumes the following:

~~(1)~~ 1. The indirect administrative costs shall be limited to 20 percent of other costs.

~~(2)~~ 2. Mileage shall be reimbursed at a rate no greater than the state employee rate.

~~(3)~~ 3. The rates a provider may charge are subject to limits established at 79.1(2).

~~(4)~~ 4. Costs of operation shall include only those costs ~~which~~ that pertain to the provision of services which are authorized under rule 441—90.3(249A).

ITEM 7. Amend subrule **79.1(2)**, provider category "HCBS waiver service providers," numbered item **"17,"** as follows:

Provider category	Basis of reimbursement	Upper limit
17. Case management	Fee schedule with cost settlement. See 79.1(1)*"d."*	For brain injury waiver: ~~$598.68 per month~~ Retrospective cost-settled rate. For elderly waiver: $70 per month.

ITEM 8. Amend subrule **79.1(2)**, provider category "Home- and community-based habilitation services," numbered item **"1,"** as follows:

Provider category	Basis of reimbursement	Upper limit
1. Case management	Fee schedule ~~based on MR/CMI/DD case management rates as set under~~ with cost settlement. See 79.1(1)*"d."*	~~$598.68 per month.~~ Retrospective cost-settled rate.

ITEM 9. Amend subrule **79.1(2)**, provider category "MR/CMI/DD case management providers," as follows:

Provider category	Basis of reimbursement	Upper limit
~~MR/CMI/DD~~ Targeted case management providers	~~Monthly fee~~ Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

ITEM 10. Amend subparagraph **79.1(24)"a"(1)** as follows:

(1) ~~A~~ Effective July 1, 2009, a unit of case management is ~~one month~~ 15 minutes.

ITEM 11. Amend subparagraph **79.3(2)"d"(33)** as follows:

(33) Case management services, including HCBS case management services:

1. Form 470-3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.
2. Notice of decision for service authorization.
3. Service notes or narratives.
4. Social history.
5. ~~Individual treatment~~ Comprehensive service plan.
6. Reassessment of member needs.
7. Incident reports in accordance with 441—subrule 24.4(5).

ITEM 12. Amend paragraph **83.22(2)"a"** as follows:

a. Case management. ~~As a condition of eligibility, all consumers~~ Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to 441—subrule 77.33(21). Case management services shall be provided as set forth in rules 441—90.5(249A) and 90.8(249A). ~~The case manager shall be responsible for doing the following:~~

~~(1) Making a comprehensive assessment of the consumer's needs within 30 days of referral to case management.~~

~~(2) Initiating development and review of the service plan as required by this subrule.~~

~~(3) Ensuring that the consumer exhausts all services available under the state Medicaid plan before accessing the waiver.~~

~~(4) Ensuring that all unmet needs of the consumer are identified in the service plan.~~

~~(5) Explaining the following to the consumer:~~

~~1. What abuse is and how to report abuse.~~

~~2. How to file a complaint about the consumer's services or providers.~~

~~3. The consumer's right to freedom of choice.~~

~~(6) Verifying that providers of consumer-directed attendant care are adequately skilled to meet the needs of the consumer.~~

ITEM 13. Amend **441—Chapter 90**, title, as follows:

TARGETED CASE MANAGEMENT ~~FOR PEOPLE WITH MENTAL RETARDATION, CHRONIC MENTAL ILLNESS, OR DEVELOPMENTAL DISABILITIES~~

ITEM 14. Amend **441—Chapter 90**, preamble, as follows:

PREAMBLE

These rules define and structure medical assistance targeted case management services provided in accordance with Iowa Code section 225C.20 for ~~consumers~~ Medicaid members with mental retardation ~~(MR)~~, chronic mental illness ~~(CMI)~~, or a developmental disability ~~(DD)~~ and ~~consumers~~ members eligible for the home- and community-based services (HCBS) children's mental health waiver. Provider accreditation standards are set forth in 441—Chapter 24.

Case management is a method to manage multiple resources effectively for the benefit of Medicaid ~~consumers~~ members. The service is designed to ~~help consumers gain~~ ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social ~~and~~, educational, housing, transportation, vocational, and other services. ~~Case management ensures that necessary evaluations are conducted; individual service and treatment plans are developed, implemented, and monitored; and reassessment of consumer needs and services occurs on an ongoing and regular basis.~~

ITEM 15. Rescind the definition "MR/CMI/DD case management" in rule **441—90.1(249A)**.

ITEM 16. Amend rule **441—90.1(249A)**, definitions of "Adult" and "Targeted population," as follows:

"Adult" means a person 18 years of age or older on the first day of the month in which service begins.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of mental retardation, chronic mental illness or developmental disability; or

2. A child who is eligible to receive HCBS mental retardation waiver or HCBS children's mental health waiver services according to 441—Chapter 83~~; or~~.

~~3. A child who has a primary diagnosis of mental retardation or developmental disability, resides in a child welfare decategorization county, and is likely to become eligible to receive HCBS mental retardation waiver services.~~

ITEM 17. Adopt the following **new** definitions in rule **441—90.1(249A)**:

"Major incident" means an occurrence involving a member using the service that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital; or

2. Results in a member's death or the death of another person; or

3. Requires emergency mental health treatment for the member; or

4. Requires the intervention of law enforcement; or

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; or

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3."

7. Results when a member's location is unknown by provider staff who are assigned responsibility for oversight.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a person may share a residence.

"Targeted case management" means services furnished to assist members who are part of a targeted population who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other services in order to ensure the health, safety, and welfare of the member. Case management is provided to a member on a one-to-one basis by one case manager.

ITEM 18. Amend rule 441—90.2(249A) as follows:

441—90.2(249A) Eligibility. A person who meets all of the following criteria shall be eligible for ~~MR/CMI/DD~~ targeted case management:

90.2(1) The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35).

90.2(2) The person is a member of the targeted population.

90.2(3) The person ~~does not reside~~ resides in a ~~medical institution~~ community setting or is ~~within 30 days of discharge~~ transitioning to a community setting from a ~~medical institution~~ Medicaid-covered short-term or long-term institutional stay.

a. In the case of a short-term institutional stay of less than 180 consecutive days, a person may be considered to be transitioning to a community setting during the last 14 days before discharge.

b. In the case of a long-term institutional stay of 180 or more consecutive days, a person may be considered to be transitioning to a community setting during the last 60 days before discharge.

c. Eligibility for persons transitioning to a community setting is contingent upon a successful transition.

90.2(4) The person has applied for ~~MR/CMI/DD~~ targeted case management in accordance with the policies of the provider.

90.2(5) The ~~person has been authorized~~ person's need for ~~MR/CMI/DD~~ targeted case management has been determined in accordance with rule 441—90.3(249A).

ITEM 19. Amend rule 441—90.3(249A), catchwords, as follows:

441—90.3(249A) ~~Authorization and~~ Determination of need for service.

ITEM 20. Rescind and reserve subrule **90.3(1)**.

ITEM 21. Amend subrules 90.3(2) and 90.3(3) as follows:

90.3(2) *Need for service.* Assessment of the need for targeted case management is required at least annually as a condition of payment under the medical assistance program. The ~~department~~ case management provider shall determine the initial and ongoing need for service based on ~~evidence presented by the MR/CMI/DD case management provider, including~~ diagnostic reports, documentation of provision of services, and information supplied by the ~~consumer~~ member and other appropriate sources. The evidence shall be documented in the member's file and shall demonstrate that all of the following criteria are met:

a. The ~~consumer~~ member has a need for ~~MR/CMI/DD~~ targeted case management to manage ~~multiple resources pertaining to~~ needed medical, ~~and interrelated~~ social, ~~and~~ educational, housing, transportation, vocational, and other services for the benefit of the ~~consumer~~ member.

b. The ~~consumer~~ member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.

c. The ~~consumer~~ member is not receiving other paid benefits under the medical assistance program or under a Medicaid managed health care plan that serve the same purpose as ~~MR/CMI/DD~~ targeted case management.

90.3(3) *Managed health care.* For ~~consumers~~ members receiving ~~MR/CMI/DD~~ targeted case management under ~~a Medicaid managed health care~~ the Iowa plan for behavioral health as described in 441—Chapter 88, Division IV, the department delegates authorization and determination of need for service to the ~~managed health care~~ Iowa plan contractor.

a. The ~~managed health care~~ Iowa plan contractor shall ~~authorize~~ determine the need for targeted case management services according to the criteria ~~and procedures set forth~~ in ~~this chapter~~ subrule 90.3(2).

b. The Iowa plan contractor is not required to pay for targeted case management services that it has not authorized or that are provided during a month of Medicaid ineligibility.

ITEM 22. Rescind and reserve subrule **90.3(4)**.

ITEM 23. Amend rule 441—90.4(249A) as follows:

441—90.4(249A) Application. The provider shall process an application for ~~MR/CMI/DD~~ targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department's service unit if other services are needed or requested.

90.4(1) *Application ~~record~~ process and documentation.* The application shall include the ~~consumer's~~ member's name, the nature of the request for services, and a summary of any evaluation activities completed. The provider shall inform the applicant in writing of the applicant's right to choose the provider of case management services and, at the applicant's request, shall provide a list of other case management agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

90.4(2) No change.

90.4(3) *Delayed services.* The application shall be approved and the ~~consumer~~ member put on the referral list for assignment to a case manager when ~~MR/CMI/DD~~ targeted case management cannot begin immediately because there is no opening on a caseload. The provider shall notify the applicant or the applicant's legally authorized representative in writing of approval and placement on the referral list. If an applicant is on a referral list for more than 90 days from the date of application, this shall be considered a denial of service.

90.4(4) *Denying applications.* The provider shall deny applications for service when:

a. to *d.* No change.

e. The applicant is receiving ~~MR/CMI/DD~~ targeted case management from another Medicaid provider; or

f. The applicant does not have a need for ~~MR/CMI/DD~~ targeted case management.

ITEM 24. Rescind rule 441—90.5(249A) and adopt the following **new** rule in lieu thereof:

441—90.5(249A) Service provision.

90.5(1) *Covered services.* The following shall be included in the assistance that case managers provide to members in obtaining services:

a. Assessment. The case manager shall perform a comprehensive assessment and periodic reassessment of the member's individual needs using Form 470-4694, Targeted Case Management Comprehensive Assessment, to determine the need for any medical, social, educational, housing, transportation, vocational or other services. The comprehensive assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment. A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member's condition. The assessment and reassessment activities include the following:

(1) Taking the member's history, including current and past information and social history in accordance with 441—subrule 24.4(2), and updating it annually.

(2) Identifying the needs of the member and completing related documentation.

(3) Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member.

b. Service plan. The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment. The case manager

shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop the goals. This plan shall:

(1) Document the parties participating in the development of the plan.

(2) Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.

(3) Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services.

(4) Document services identified to meet the needs of the member which the member declined to receive.

(5) Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify:

1. Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment.

2. An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(6) Include a discharge plan.

(7) Be revised at least annually, and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.

c. Referral and related activities. The case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link the member with medical, social, educational, housing, transportation, vocational or other service providers or other programs and services that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the service plan.

d. Monitoring and follow-up. The case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation. Monitoring shall be conducted to determine whether:

(1) Services are being furnished in accordance with the member's service plan, including the amount of service provided and the member's attendance and participation in the service.

(2) The member has declined services in the service plan.

(3) Communication is occurring among all providers to ensure coordination of services.

(4) Services in the service plan are adequate, including the member's progress toward achieving the goals and actions determined in the service plan.

(5) There are changes in the needs or status of the member. Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

e. Contacts. Case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

(1) The case manager shall have at least one face-to-face contact with the member every three months.

(2) The case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other entities or individuals. This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, E-mail, and fax, when the written communication directly pertains to the needs of the member. A copy of any written communication must be maintained in the case file.

(3) The case manager shall have contacts with non-eligible persons that are directly related to identifying the member's needs and care as necessary for the purpose of helping the member access services, identifying needs and supports to assist the member in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the member's needs.

(4) When applicable, documentation of case management contacts shall include:

1. The name of the service provider.

2. The need for and occurrences of coordination with other case managers within the same agency or of referral or transition to another case management agency.

90.5(2) *Exclusions.* Payment shall not be made for activities otherwise within the definition of case management when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

(1) Services under parole and probation programs.

(2) Public guardianship programs.

(3) Special education programs.

(4) Child welfare and child protective services.

(5) Foster care programs.

c. The activities are integral to the administration of foster care programs, including but not limited to the following:

(1) Research gathering and completion of documentation required by the foster care program.

(2) Assessing adoption placements.

(3) Recruiting or interviewing potential foster care parents.

(4) Serving legal papers.

(5) Home investigations.

(6) Providing transportation.

(7) Administering foster care subsidies.

(8) Making placement arrangements.

d. The activities for which a member may be eligible are integral to the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

90.5(3) *Transition to a community setting.* Case management services may be provided to members transitioning to a community setting during the 60 days before discharge from a medical institution when the following requirements are met:

a. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning.

b. The amount, duration, and scope of case management services shall be documented in the member's plan of care, which must include case management services before and after discharge, to facilitate a successful transition to community living.

c. Payment shall be made only for services provided by community case management providers.

d. Claims for reimbursement for case management shall not be submitted until the member's discharge from the medical institution and enrollment in community services.

90.5(4) *Rights restrictions.* Member rights may be restricted only with the consent of the member or the member's legally authorized representative and only if the service plan includes:

a. Documentation of why there is a need for the restriction;

b. A plan to restore those rights or a reason why restoration is not necessary or appropriate; and

c. Documentation that periodic evaluations of the restriction are conducted to determine continued need.

90.5(5) *Documentation.* Service documentation shall also meet the requirements set forth in rule 441—79.3(249A) and 441—subrule 24.4(4).

ITEM 25. Strike "MR/CMI/DD" wherever it appears in rules **441—90.6(249A)** and **441—90.7(249A)** and insert "targeted" in lieu thereof.

ITEM 26. Strike "consumer" wherever it appears in rules **441—90.6(249A)** and **441—90.7(249A)** and insert "member" in lieu thereof.

ITEM 27. Adopt the following **new** rule 441—90.8(249A):

441—90.8(249A) Provider requirements.

90.8(1) *Incident reporting.*

a. When a major incident occurs during the provision of targeted case management services, the case management provider shall:

(1) Notify the member's legally authorized representative within 24 hours of the incident.

(2) Record the incident on an incident report form. The form shall be completed and signed by the case manager who was directly involved at the time of the incident or who first became aware of the incident. The report shall include the following information:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident, including designation of the incident as a major or minor incident.
4. The names of all staff and others who were present at the time of the incident or responded after becoming aware of the incident. The confidentiality of other members who were involved in the incident must be maintained by the use of initials or other means.
5. The action that the case manager took to manage the incident.
6. The resolution of or follow-up to the incident.

(3) Distribute the completed incident report form as follows:

1. Forward the report to the case management supervisor within 24 hours of the incident.
2. Send a copy of the report to the department's bureau of long-term care within 24 hours of the incident.
3. File a copy of the report in a centralized location and make a notation in the member's file.

(4) Monitor the situation as required in paragraph 90.5(1)*"d"* to ensure the member's needs continue to be met.

b. When an incident report for a major incident is received from any provider, monitor the situation as required in paragraph 90.5(1)*"d"* to ensure the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the comprehensive assessment as required in paragraph 90.5(1)*"a"* in order to ensure the continued health, safety, and welfare of the member.

90.8(2) *Emergency coverage.* A provider of case management shall have an on-call system to ensure that, in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays.

90.8(3) *Quality assurance.* Providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

a. Post-payment reviews of case management services;

b. Review of incident reports;

c. Review of reports of abuse or neglect; and

d. Technical assistance in determining the need for service.