

**HUMAN SERVICES DEPARTMENT[441]**

**Adopted and Filed Emergency After Notice**

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,” Chapter 83, “Medicaid Waiver Services,” and Chapter 90, “Case Management for People With Mental Retardation, Chronic Mental Illness, or Developmental Disabilities,” Iowa Administrative Code.

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

- Redefine the scope of case management services in 441—Chapter 90 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 July 1, 2009. These amendments ensure that case management services funded by Iowa Medicaid are consistent with the federal regulations.
- Delete the scope of service for case management for the home- and community-based (HCBS) habilitation services and for the elderly and brain injury waiver programs and instead refer to the case management scope of service in 441—Chapter 90. This will ensure that case management provided through these programs meets the same service requirements as case management provided under 441—Chapter 90.
- 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 of service to a 15-minute unit.

Notice of Intended Action on these amendments was originally published in the Iowa Administrative Bulletin on March 11, 2009, as **ARC 7631B**. An Amended Notice of Intended Action was published in the Iowa Administrative Bulletin on April 22, 2009, as **ARC 7732B**. The Department held a public hearing on each of these filings and received written comments from 78 people. In response to these comments, the Department has made the following changes to the amendments as published in the Amended Notice of Intended Action:

- Deleted the proposed change to paragraph 78.27(5)“e” (Item 2 in the Amended Notice of Intended Action), because transitional case management is not an allowable service under HCBS habilitation services.
- Deleted the proposed phrase “who reside in a community setting or are transitioning to a community setting” from the introductory paragraph of subrule 78.27(6). The addition of this phrase is unnecessary because there is no eligibility for transitional case management.
- Added language to subrule 79.1(2), provider category “HCBS waiver service providers,” numbered item “17,” to make the upper rate limit for case management provided through the elderly waiver the quarterly update of the reimbursement rate for a 15-minute unit instead of a flat limit of \$70 per month. Legislation at 2009 Iowa Acts, House File 811, section 1(2), transfers additional funds to the Department to fund this service and provides for quarterly adjustment of the reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted for the fiscal year.
- Changed the wording of numbered paragraph “7” in the definition of “Major incident” in rule 441—90.1(249A) to read “Involves a member’s location being unknown by provider staff who are assigned protective oversight.” The change is intended to clarify that the rule does not require each provider to know the member’s location at all times and is congruent with revisions to incident reporting requirements for home- and community-based habilitation and waiver services.

- Replaced most of the proposed amendment to subrule 90.2(3) with a cross reference to qualifications for transitional case management set forth in subrule 90.5(3).
- Added new paragraph “a” to subrule 90.5(3) to clarify that only adult members who qualify for targeted case management under the mental retardation, developmental disability, or chronic mental illness targeted population are eligible to receive transitional case management. Transitional case management is not an allowable service under the brain injury waiver, elderly waiver, or HCBS habilitation services. The succeeding paragraphs are relettered accordingly.
- Revised language in subrule 90.8(1) to conform to the final incident reporting procedure adopted for home- and community-based services providers. Changes from the noticed language include restriction of external reporting to major incidents, extension of the time frame for reporting from 24 hours to the end of the next calendar day, and addition of references to the planned automated reporting system.
- Added language to subrule 90.8(2) to clarify the expectations for emergency coverage and to delay the effective date of that provision to October 1, 2009. The intent of this subrule is for the case management agency to be the final “back-up” resource in case the provisions of the individual crisis plan fail.

Specific waivers are not provided because these amendments should apply to all Medicaid 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).

The Council on Human Services adopted these amendments on June 23, 2009.

The Department finds that these amendments confer a benefit on Medicaid members and the public by bringing the rules into compliance with federal requirements and meeting the Department’s commitments for increased oversight of members’ safety and welfare. The amendments also benefit case management providers under the elderly waiver by allowing more funding for cost-based reimbursement. Therefore, these amendments are filed pursuant to Iowa Code section 17A.5(2)“b”(2), and the normal effective date of these amendments is waived.

These amendments are intended to implement Iowa Code sections 249A.4, 249A.26, and 249A.27 and 2009 Iowa Acts, House File 811, section 1(2).

These amendments became effective on July 1, 2009.

The following amendments are adopted.

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 subrule 78.27(6) as follows:

**78.27(6) Case management.** Case management assists members 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 441—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 3. 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 441—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 4. 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 441—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 5. 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 6. Amend subrule **79.1(2)**, provider category “HCBS waiver service providers,” numbered item “17,” as follows:

| <u>Provider category</u> | <u>Basis of reimbursement</u>                             | <u>Upper limit</u>   |
|--------------------------|---|--|
| 17. Case management      | Fee schedule <u>with cost settlement. See 79.1(1)“d.”</u> | For brain injury waiver: <del>\$598.68 per month</del> <u>Retrospective cost-settled rate.</u> For elderly waiver: <del>\$70 per month</del> <u>Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.</u> |

ITEM 7. Amend subrule **79.1(2)**, provider category “Home- and community-based habilitation services,” numbered item “1,” as follows:

| <u>Provider category</u> | <u>Basis of reimbursement</u>  | <u>Upper limit</u>   |
|--------------------------|--|--|
| 1. Case management       | Fee schedule <del>based on MR/CMI/DD case management rates as set under</del> <u>with cost settlement. See 79.1(1)“d.”</u> | <del>\$598.68 per month.</del> <u>Retrospective cost-settled rate.</u> |

ITEM 8. Amend subrule **79.1(2)**, provider category “MR/CMI/DD case management providers,” as follows:

| <u>Provider category</u>                                       | <u>Basis of reimbursement</u>   | <u>Upper limit</u>               |
|--|---|----------------------------------|
| <del>MR/CMI/DD</del> <u>Targeted</u> case management providers | <del>Monthly fee</del> <u>Fee for service with cost settlement. See 79.1(1)“d.”</u> | Retrospective cost-settled rate. |

ITEM 9. 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 10. 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 11. 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 441—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 12. Amend **441—Chapter 90**, title, as follows:

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

ITEM 13. 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 14. Rescind the definition of “MR/CMI/DD case management” in rule **441—90.1(249A)**.

ITEM 15. 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 16. 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. Involves a member’s location being unknown by provider staff who are assigned protective 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 and 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 members. Case management is provided to a member on a one-to-one basis by one case manager.

ITEM 17. 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 from a medical institution qualifies for transitional case management as set forth in subrule 90.5(3).

**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 18. Amend rule 441—90.3(249A), catchwords, as follows:

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

ITEM 19. Rescind and reserve subrule **90.3(1)**.

ITEM 20. 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 21. Rescind and reserve subrule **90.3(4)**.

ITEM 22. 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 23. 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 the history 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 programs 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 may bill for contacts with non-eligible persons if the contacts 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 a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management under a targeted population. Transitional case management is not an allowable service under the HCBS brain injury waiver, the HCBS elderly waiver, or HCBS habilitation services.

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

c. 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.

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

e. 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 24. 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 25. Strike "consumer" wherever it appears in rules **441—90.6(249A)** and **441—90.7(249A)** and insert "member" in lieu thereof.

ITEM 26. 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 case management services:

(1) The case management provider shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The case management supervisor.
2. The member's legally authorized representative.

(2) By the end of the next calendar day after the incident, the case manager who observed the incident shall also report as much information as is known about the incident to the department's bureau of long-term care either:

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

(3) The following information shall be reported:

1. The name of the member involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all case management staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present 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.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) The case manager shall monitor the situation as required in paragraph 90.5(1) "d" to ensure the member's needs continue to be met. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager.

(5) The case management provider shall maintain the completed report in a centralized file, with a notation in the member's file.

b. When an incident report for a major incident is received from any provider, the case manager shall 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.*** Effective October 1, 2009, 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. Expectations and parameters for emergency coverage are as follows:

*a.* The emergency on-call system should be one component of the member's individualized crisis intervention plan and should not be the only emergency resource for the member. The system should not replace emergency services such as 911, crisis intervention lines, or emergency services from provider agencies.

*b.* The case manager should never provide direct service, but rather is expected to arrange and coordinate services to make sure the member is safe.

*c.* Case management providers may screen calls to identify nonemergency calls that can wait until regular business hours or to divert calls to other resources when appropriate.

*d.* Time spent on responding to calls is billable time for the case management provider. Overhead costs may be included in the case management rate as an indirect cost.

**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.* Postpayment 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.

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