441—90.4(249A) Case management services. Rule 441—90.4(249A) applies to all categories of case management and all populations covered by case management.

90.4(1) *Covered services.* The following shall be included in case management services provided to members, whether FFS members or MCO-enrolled members:

a. Assessment. Initial assessments and regular reassessments must be done for each applicant and member to determine the need for any medical, social, educational, housing, transportation, vocational, or other services. The assessments and reassessments shall address all of the applicant's and member's areas of need, strengths, preferences, and risk factors, considering the person's physical and social environment. Applicants and members will receive individualized prior notification of the assessment tool to be used and of who will conduct the assessment. The assessment and reassessment will be done using the core standardized assessment or another tool as designated in 441—Chapter 83 for each waiver population and 441—Chapter 78 for the habilitation population. Initial assessments must be face to face. Reassessments using the interRAI must be done face to face. Only the Supports Intensity Scale® assessment can be done telephonically, and then only when the situation meets the criteria outlined by the American Association on Intellectual and Developmental Disabilities (AAIDD). The off-year assessment (OYA) for the intellectual disability waiver can be done telephonically. A reassessment must be conducted at a minimum every 365 days and more frequently if material changes occur in the member's condition or circumstances. Case managers may participate during the assessment or reassessment process at the request of the applicant or member; the case manager does not assume the role of the assessor.

b. Person-centered service plan. At least every 365 days, the case manager shall develop and revise a comprehensive, person-centered service plan in collaboration with the member, the member's service providers, and other people identified as necessary by the member, as practicable. The person-centered service plan will be developed based on the assessment and shall include a crisis intervention plan based on the risk factors identified in a risk assessment. The case manager shall document the member's history, including current and past information and social history, and shall update the history annually. The case manager shall gather information from other sources such as family members, medical providers, social workers, guardians, representatives, and others as necessary to form a thorough social history and comprehensive person-centered service plan with the member. The person-centered service plan may also be referred to as a person-centered treatment plan.

(1) The person-centered service plan shall address all service plan components outlined in this chapter and in 441—Chapter 83 for the waiver in which the member is enrolled or 441—Chapter 78 for members enrolled in habilitation.

(2) Person-centered planning shall be implemented in a manner that supports the member, makes the member central to the process, and recognizes the member as the expert on goals and needs. In order for this to occur, there are certain process elements that must be included in the process. These include:

1. The member, guardian or representative must have control over who is included in the planning process, as well as have the authority to request meetings and revise the person-centered service plan (and any related budget) whenever reasonably necessary.

2. The process is timely and occurs at times and locations of convenience to the member, the member's guardian or representative and family members, and others, as practicable.

3. Necessary information and support are provided to ensure that the member or the member's guardian or representative is central to the process and understands the information. This includes the provision of auxiliary aids and services when needed for effective communication.

4. A strengths-based approach to identifying the positive attributes of the member shall be used, including an assessment of the member's strengths and needs. The member should be able to choose the specific planning format or tool used for the planning process.

5. The member's personal preferences shall be considered to develop goals and to meet the member's HCBS needs.

6. The member's cultural preferences must be acknowledged in the planning process, and policies/practices should be consistent with the National Standards for Culturally and Linguistically

Appropriate Services in Health and Health Care (the National CLAS Standards) of the Office of Minority Health, U.S. Department of Health and Human Services.

7. The planning process must provide meaningful access to members and their guardians or representatives with limited English proficiency (LEP), including low literacy materials and interpreters.

8. Members who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns.

9. There shall be mechanisms for solving conflict or disagreement within the process, including clear conflict of interest guidelines.

10. Members shall be offered information on the full range of HCBS available to support achievement of personally identified goals.

11. The member or the member's guardian or representative shall be central in determining what available HCBS are appropriate and will be used.

12. The member shall be able to choose between providers or provider entities, including the option of self-directed services when available.

13. The person-centered service plan shall be reviewed at least every 365 days or sooner if the member's functional needs change, circumstances change, or quality of life goals change, or at the member's request. There shall be a clear process for members to request reviews. The case management entity must respond to such requests in a timely manner that does not jeopardize the member's health or safety.

14. The planning process should not be constrained by any case manager's or guardian's or representative's preconceived limits on the member's ability to make choices.

15. Employment and housing in integrated settings shall be explored, and planning should be consistent with the member's goals and preferences, including where the member resides and with whom the member lives.

(3) Elements of the person-centered service plan. The person-centered service plan shall identify the services and supports that are necessary to meet the member's identified needs, preferences, and quality of life goals. The person-centered service plan shall:

1. Reflect that the setting where the member resides is chosen by the member. The chosen setting must be integrated in, and support full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving HCBS.

2. Be prepared in person-first singular language and be understandable by the member or the member's guardian or representative.

3. Note the strengths-based positive attributes of the member at the beginning of the plan.

4. Identify risks, while considering the member's right to assume some degree of personal risk, and include measures available to reduce risks or identify alternate ways to achieve personal goals.

5. Document goals in the words of the member or the member's guardian or representative, with clarity regarding the amount, duration, and scope of HCBS services that will be provided to assist the member. Goals shall consider the quality of life concepts important to the member.

6. Describe the services and supports that will be necessary and specify what HCBS services are to be provided through various resources, including natural supports, to meet the goals in the person-centered service plan.

7. Document the specific person or persons, provider agency and other entities providing services and supports.

8. Ensure the health and safety of the member by addressing the member's assessed needs and identified risks.

9. Document non-paid supports and items needed to achieve the goals.

10. Include the signatures of everyone with responsibility for the plan's implementation, including the member or the member's guardians or representatives, the case manager, the support broker/agent (when applicable), and providers, and include a timeline for review of the plan. The plan must be

discussed with family, friends, and caregivers designated by the member so that they fully understand it and their roles.

11. Identify each person and entity responsible for monitoring the plan's implementation.

12. Identify needed services based upon the assessed needs of the member and prevent unnecessary or inappropriate services and supports not identified in the assessed needs of the member.

13. Document an emergency back-up plan that encompasses a range of circumstances (e.g., weather, housing, and staff).

14. Address elements of self-direction through the consumer choices option (e.g., financial management service, support broker/agent, alternative services) whenever the consumer choices option is chosen.

15. Be distributed directly to all parties involved in the planning process.

c. Referral and related activities. The case manager shall assist, as needed, the member in obtaining needed services, such as by scheduling appointments for the member and by connecting 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 person-centered service plan.

d. Monitoring and follow-up. The case manager shall perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the person-centered 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 regardless of the service funding stream. Monitoring shall also include review of service provider documentation. Monitoring of the following aspects of the person-centered service plan shall lead to revisions of the plan if deficiencies are noted:

(1) Services are being furnished in accordance with the member's person-centered 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 among providers is occurring, as practicable, to ensure coordination of services;

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

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

e. Contacts. Case managers shall make contacts with the member, the member's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements:

(1) The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly;

(2) The case manager shall have at least one contact per month with the member or the member's guardians or representatives. This contact may be face to face or by telephone;

(3) Community-based case management contacts will be made in accordance with the Medicaid contract MED-16-019, or subsequent Medicaid managed care contracts with the department, in those instances where the contract specifies contacts different from this rule.

90.4(2) *Exclusions.* Payment shall not be made for activities otherwise within the definition of case management services 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; or

(5) Foster care programs.

c. The activities are components of 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) Conducting home investigations;

(6) Providing transportation related to the administration of foster care;

(7) Administering foster care subsidies; or

(8) Making placement arrangements.

d. The activities for which a member may be eligible are a component of 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.

[**ARC 4897C**, IAB 2/12/20, effective 3/18/20]