



**Comments and Responses on ARC 7631B/ARC 7732B**

Medicaid Targeted Case Management

Received through May 13, 2009

The following persons and organizations provided written comments, which are included in the summary below:

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Tammy Crosthwaite, Clinton County Case Management Supervisor  
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Gina McKeag-Hall, case manager, Poweshiek County Community Services, Grinnell  
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**Federal Regulations**

COMMENT: I would like to state that the Federal moratorium on these rule changes has been extended to June 30, 2009 and I would recommend that no changes take effect until we have more information and guidance from the Federal government on how changes should take place. Making unnecessary changes could interfere with service provision and quality of services to the clients we serve. (Wishman Nalan)

COMMENT: The Federal Government has put a moratorium on the Federal rules that these State rules were written in response to. [At a recent meeting in Washington, DC] CMS staff stated that the moratorium will continue to be extended until all new administration is hired and if the moratorium is lifted, the rules will look very different than they are now written. The proposed State rules should be withdrawn until the Federal Government has lifted the moratorium and introduced the latest version of the rule to make sure they are in alignment. (Uetz)

COMMENT: ...are these changes even necessary? Currently there is a federal moratorium on the federal rule changes until June 30<sup>th</sup>...I am asking that Iowa not make any unnecessary changes or implement more restrictive rules until we know the outcome of the moratorium... (Richey, Brown)

COMMENT: We would like to encourage the Policy Board and the Legislature to not make any unnecessary changes to Chapter 90 due to the fact the Moratorium is in place until June 30<sup>th</sup>, not April 1, as the rules indicate. We would also like no changes (or any changes that are more restrictive than the rules dictate) until the outcome is known on the Moratorium of the Federal Regulations. (Nelson)

COMMENT: As you are undoubtedly aware, this moratorium on the initiation of these federal requirements was extended. Furthermore, it has been reported at the federal level that the Obama administration may extend the moratorium for additional study and possible revision. This could result in the regulations regarding case management being very different from the current proposed federal requirements. Since we have not learned if the moratorium will be extended and we do not know if the federal requirements will be rewritten, I am requesting that the proposed State rules be withdrawn until the Federal Government makes a final determination on the moratorium and the rules. (Ketcham)

COMMENT: In fact, the moratorium was extended and it is quite possible that the Obama administration will not move forward with the proposed federal regulations or extend the moratorium for further study, which could cause the regulations to be very different from the current proposed federal requirements. The proposed State rules should be withdrawn until such time that the Federal Government makes a final determination on the moratorium. (Eckerman Slack)

COMMENT: Johnson County MH/DS and Johnson County Targeted Case Management Program believe it is prudent to have the State of Iowa withdraw its proposed rules until such time as the Federal requirements are determined. (Artley, Shaw, Juetten, Wollum, Guard, Cory)

COMMENT: The moratorium was extended and it appears probable that the Obama administration will not move forward with the proposed federal regulations, or will extend the moratorium for further study. The proposed State rules should be withdrawn until the Federal Government has established a final outcome for the moratorium and the rules as they are written. (McGrane)

**RESPONSE:** On December 4, 2007, the Centers for Medicare and Medicaid Services (CMS) published new federal regulations redefining the scope of case management. The effective date of the regulations was to be March 3, 2008. In order to give states time to come into compliance with the regulations, Congress enacted a moratorium that delayed the effective date until April 1, 2009. On February 17, 2009, the American Recovery and Reinvestment Act (ARRA) was signed into law and included a provision that further extended the moratorium until July 1, 2009.

On May 1, 2009, CMS issued a new proposed regulation, CMS-2237-P, which will rescind certain portions of the December 2007 regulations. With the exception of the 15-minute billing unit, the rescinded portions are inconsequential to Iowa policy and do not require changes in these rules. Because these portions are being rescinded before the expiration of the moratorium, we must assume that the moratorium will not be extended again, and the remaining regulations will be effective July 1, 2009.

Waiting until the moratorium expires to initiate these changes would cause Iowa to be out of compliance with federal regulations for many months and would put the state in jeopardy of recoupment of federal funds. This approach would be irresponsible to the citizens of Iowa, as well as to the recipients of case management services.

More importantly, these rules provide important changes for Iowa's community-based system for persons with disabilities. While most of these rule changes center on the federal compliance, the rules also address weaknesses in the overall service system by adding protections for the health, safety, and welfare of consumers. There are many positive changes in these rules that benefit the vulnerable members in Iowa's system. Therefore, we believe Iowa should keep moving forward.

COMMENT: The Notice of Intended Action indicates that the State is redefining the scope of case management services to closely match the language of previously proposed federal requirements. Since the publication of these rules, the federal government has made a partial rescission of the case management interim final rule, which includes the requirement for payment methodologies (15 minute billing unit) for case management. Specific reasons for this, given in CMS's rescission, include "the requirement for payment methodologies (15 minute increments) may be administratively burdensome, may result in restrictions on available providers of case management services, and general beneficiary access to services may be affected by the limitations of the payment methodology."

The Iowa Medicaid Enterprise has consistently stated that the changes to Chapter 90 are in direct response to the CMS Interim Final Rule. In light of the rescission of these, it makes sense for Iowa to discontinue the implementation of the Chapter 90 rules. (Curtis)

COMMENT: CMS is proposing to rescind parts of the Case Management Interim Rule as posted May 6, 2009 on the Federal Register. Please consider postponing rule amendments to Iowa case management service until the CMS rules are settled and effective. (Keleher)

COMMENT: Since the Administrative Rules Review Committee discussed these rules at their last meeting, the federal government has rescinded the rules upon which these rules were based. The department's sole reason for pursuing these rules was to match Iowa's language with the proposed federal requirements. In light of the decision at the federal level to rescind the proposed rules, Iowa's proposed rules should be withdrawn.

This would be a good time for the Iowa Medicaid Enterprise to convene a group of stakeholders to determine what, if anything, Iowa plans to do in regard to redefining the scope of case management services under Iowa's Medicaid program. A discussion of what the State of Iowa wants to change and why would be a good basis for moving forward with changes in the future. Until the problems we are trying to address are clarified, no changes should be made. (Hinton)

COMMENT: We urge that these rules be withdrawn. From the very beginning of the rule making process for these rules, the Department of Human Services has said that the rules were necessary to implement changes in federal regulations. On May 6, 2009 the Federal Register notice rescinding the rules said, "In light of concerns raised about the adverse effects that could result from these regulations, in particular the potential restrictions on services available to beneficiaries, potential deleterious effect on state partners in the economic downturn, and the lack of clear evidence stating that the approaches taken in the regulations are warranted, CMS is proposing to rescind the two final rules in full, and to partially rescind the interim final rule."

The federal government is right. Our case managers report that the documentation necessary to bill in 15-minute increments instead of the current monthly rate requires approximately 3 hours per case manager per week. Polk County has 100 case managers. To devote 300 hours per week to ADDITIONAL documentation is the equivalent of taking 7 1/2 case managers away from clients to do paperwork EVERY WEEK of the year. Why would IME require this if it is no longer included in the federal regulations?

There is clearly no basis for these rules to go forward. The premise on which they were developed no longer exists. Further, if the federal government does go forward with their rule, the fact that they are seeking input on how to change them indicates that any final federal regulations will look very different. These rules should be withdrawn. (Uetz)

COMMENT: The Department of Human Services has stated that the rule changes were necessary to match the language of the proposed federal requirements. Since the Notice of the Intended Action to adopt ARC 7632B, the federal government has rescinded the rules upon which these were established. Specific reasons given by the federal government for the rescission include "the requirement for payment methodologies may be administratively burdensome, may result in restrictions on available providers of case management services, and general beneficiary access to services may be affected by the limitations of the payment methodology." In light of the decision of the federal government to rescind the proposed rules, Iowa should withdraw the proposed rules. (Eckerman-Slack)

COMMENT: I would urge the Legislative Administrative Rules Committee to not adopt these rules. We have been told by DHS personnel that the proposed changes are a result of the Federal Government Centers for Medicare & Medicaid Services (CMS), HHS, proposed rules for case management. Currently, there is a moratorium on the Federal rules and in the Federal Register, Vol. 74, No. 86, published Wednesday, May 6, 2009, CMS is proposing to rescind these proposed rules noting that in discussions with States about the implementation of case management requirements, we have become concerned that certain provisions of the interim final rule may unduly restrict beneficiary access to needed covered case management services, and limit State flexibility in determining efficient and effective delivery systems for case management

services. In particular, we are concerned that the interim final rule may be overly narrow in defining individuals transitioning to community settings, and we are concerned that beneficiary access to services may be affected by the limitations in the interim final rule on payment methodologies, on provision of case management activities, and on coverage of services furnished in different settings. ...Therefore, we propose to rescind certain provisions of the December 4, 2007 interim final rule...because we believe the requirement for payment methodologies in this provision may be administratively burdensome, may result in restrictions on available providers of case management services, and generally may limit beneficiary access to services. (Blair)

**COMMENT:** The IME has consistently stated that the changes to Chapter 90 are in direct response to the CMS Interim Final Rule. In light of the rescission of these, it makes sense for Iowa to discontinue the implementation of the proposed Chapter 90 rules. As identified by CMS, there are three major concerns identified in the proposed rules which include, limiting beneficiary access to needed services, limiting the states flexibility in determining efficient and effective service systems and limiting the access to case management providers due to the increase the administrative burden on these providers. It doesn't make sense for Iowa to have rules more restrictive than what is mandated at the federal level, especially when it will have such a negative impact on Iowa's most vulnerable citizens. I recommended that these changes are not accepted into the Iowa Administrative Rules. (Hill)

**RESPONSE:** The proposed regulation changes from CMS do not rescind the case management regulations in their entirety, but do propose to rescind certain portions. Rescinded portions of the regulations include:

- Removing the provisions that shorten the allowed coverage of transitional case management services from 180 days to 60 days. Iowa previously covered only 30 days but will extend coverage to 60 days under our proposed rules.
- Removing the requirement that case management be provided by only one case manager.
- Removing the provision that prohibits case managers from authorizing or denying other services in the consumer's plan.
- Removing several provisions that prohibit case management activities that are an integral component of another Medicaid service or prohibit activities that may be performed under other programs.

Current Iowa policy is already in line with the above, so our proposed rules will be largely unaffected by these changes. However, the new regulation also rescinds the requirement that the unit of reimbursement cannot exceed 15 minutes. Iowa currently allows reimbursement with a fixed, monthly fee per member. Our proposed rule changes would require a 15-minute billing unit.

Without a clear regulation in place, the only federal standard is Section 1902(a)(30)(A) of the Social Security Act, which requires CMS to review state reimbursement rates to ensure that they are economic and efficient. This leaves a large amount of leeway, and as such, we have been in contact with CMS to determine what will be allowed.

CMS has informed us that they will not approve the use of monthly units for any non-institutional services, including case management. They have advised that daily, hourly, or 15-minute (or smaller) units would be acceptable. We have asked CMS to confirm this in writing. We have also asked CMS about the possibility of leaving the current system of monthly reimbursement in place for one year to allow time to implement a more case-sensitive payment such as 15-minute and/or hourly units.

## Assessment Forms

COMMENT: 90.5(1)"a" This section specifies a specific assessment form that will be required, and the form is quite detailed. Case Managers are already required to do a FASST Assessment for the State, and we have our own process that is useful in developing Essential Lifestyle Plans. We do not object to the new form, but believe it would help if the FASST could be eliminated as a requirement for admission to the program. As indicated earlier, case managers already spend too much time doing paperwork and not enough time with members. I recommend dropping the FASST requirement. (C. Wood)

COMMENT: In reference to the Assessment needing to be used by Case Managers and referencing the form 470-4694, our hope is that is the only form needed by all Case Management agencies for the assessment of a person accessing TCM. We oppose any additional forms and useless paperwork requirements that prohibit the ability of Case Managers to do their job. Instead of completing countless mounds of paperwork that takes time away from helping people obtain the services needed to lead productive lives. We need less paper, less countless hours of documentation and more freedom to do the important work of a TCM! (Nelson)

COMMENT: Is this assessment to determine service plan needs OR is the Initial Assessment? My concern as a supervisor is that it appears we are duplicating documentation and placing more unbillable demands on case managers. We should assume that one assessment is enough to identify the needs of the consumer. (Kuehl)

COMMENT: This Assessment duplicates many of the question areas asked in the IME Level of Care that is completed for the member's need for service, and, based on that assessment the Iowa Medicaid Enterprise medical services units has determined that the member is in need of home-and community based habilitation services. Examples of duplicating sections are: Medications, Emotional & Behavioral Risk Factors, Abuse/Neglect, Environmental Safety Risk Factors, Daily Living Skills Risk Factors, Diagnosis, Source's of Information that assisted in completing this information. (Kuehl)

COMMENT: Currently, Case Managers are completing two comprehensive assessments on each member, the FASST and an annual review. I would hope that this Risk Assessment would replace one or both of these documents to avoid duplication of documentation. (Koehler)

COMMENT: As a case manager I do annual assessments, initial assessments, social histories, case notes, quarterly progress notes, BIWAT assessments, Fasstools assessments, crisis and safety plans. All of these forms are redundant in and of themselves. Often times the information in these reports can be seen throughout our files, especially from the assessments to the social histories. It is my understanding that there are now suggestions about adding another assessment called a "risk assessment" to the paper work. In my opinion, there needs to be some consideration given to whether the assessment asks the same questions that we already cover in our current paper work or if there is a way to combine this assessment so that we are not doing two different assessments. (Crawford)

**RESPONSE:** The assessment form that has been developed is very detailed and comprehensive. The form will be used for development of the comprehensive service plan and the crisis intervention plan. We realize that case managers currently complete several assessments for different purposes. Our intent is that this will be the only assessment that case managers will need to complete. The form is currently being refined so that it can be used in place of the level of care assessments used for mental retardation and brain injury waiver level of care determinations and for the needs-based assessment for habilitation services. This approach should reduce the amount of paperwork required of case managers.

COMMENT: Under assessment there is a form number listed (470-4694). It is not listed as of yet on the IME web site. Are we required to use this exact form or can we use our own CARF accredited form adapted to include the contents listed? (Rieck, Bertogli)

COMMENT: While use of a statewide comprehensive assessment may be warranted, case management agencies have not reviewed or examined this form or been given the opportunity to provide input on the development of the forms. Furthermore, it does not appear this referenced form is on the DHS website at this time. (Ahrens)

COMMENT: Has this form [470-4694, Targeted Case Management Comprehensive Assessment] been made available to case management agencies to review? If not what is the estimated timeline for making this form available? (McHone)

COMMENT: **90.5(1)"a"** Refers to Form 470-4694 – I have been unable to locate this form; is it available on a website? Case managers are currently assessing the member’s areas of need, strengths, preferences, and risk factors. Is it necessary to require case managers to make another change in the paperwork that is expected of them? (Bopes)

COMMENT: 90.5(1) “a” Indicates that the case manager “perform a comprehensive assessment using Form 470-4694 Targeted Case Management Comprehensive Assessment...” Where and what is this form? There are 64 Counties in the state that provide targeted case management, and yet there was no consultation regarding the use of a standard form or what it might look like. Although I may not necessarily disagree with the possibility of a standard statewide assessment, I do feel that input from County case management should be considered when designing or choosing said assessment. The federal rules specify that the assessment should be comprehensive and to address all areas of need, the individual’s strength and preferences, and consider the individual’s physical and social environment. I believe that County Case Management does complete a comprehensive assessment in regards to addressing all areas of need, strengths preferences and the physical and social environment. (Eckerman Slack)

COMMENT: Ch. 90, It states that an assessment must be completed by the Case Manager in determining services and it list a form (470-4694) in Section 90.5(1). I have looked for this form and have been unable to find it. Is this form new and something that is being develop that is universal for all Waivers and where is this form located? (Cairney)

COMMENT: I find it difficult to comment on this proposed change since the risk assessment form that is to be used has not been developed and cannot be viewed at this time. (Riedel, Rewerts, Redies, Metzger, Merz, Van Horn, Long)

**RESPONSE:** The assessment was developed by DHS to include comprehensive measures for all major life areas and to include a risk assessment to identify risk factors for the individual. The covered domains were based largely on those already in use by county case management services (CCMS), so they should be familiar to many case managers. The risk assessment was tested with several case management entities including DHS Case Management, CCMS, and Southeast Iowa Case Management.

The assessment form is not yet finalized because we are trying to assure that it can be used in place of the level of care assessment used for mental retardation and brain injury waiver level of care determinations. However, the draft version of the form has been sent to providers who have requested it and it has been added to the IME website at:

[www.ime.state.ia.us/HCBS/TargetedCaseManagement.html](http://www.ime.state.ia.us/HCBS/TargetedCaseManagement.html).

COMMENT: The Assessment is not user friendly. When boxes are required to be checked, there is a prompt to have to go into the program, click check box and go back to the page, and do this over again each question. (Kuehl)

COMMENT: What is the typical length this assessment should take? -The one I completed took 2 hours. (Kuehl)

**RESPONSE:** The form has been updated several times since the initial testing by case managers, and is now more user-friendly. Feedback from those who have used the assessment indicate that it can take from 1-2 hours depending on the needs of the consumer. The assessment was designed to be done directly with the consumer or the guardian, and when completed as such the time would be directly billable for the case manager.

COMMENT: When is this assessment to be completed on the consumer?

- -After the IME Fasst tool (IME LOC Assessment)?
- -Before the Initial Assessment? (Kuehl)

**RESPONSE:** The assessment form is what will be used for the initial assessment and in place of the level of care assessment (FASST), so for most members there will be only one assessment to complete.

COMMENT: Will there be prompts in ISIS? (Kuehl)

COMMENT: Who are they [the assessments] forwarded to? (Kuehl)

**RESPONSE:** These processes are not being changed by the rules. Case managers will continue to respond to ISIS prompts and process assessments as they currently do.

COMMENT: Clarify whether or not the Assessment 470-4694 is required. It would be of benefit to have an assessment form that all case management providers are required to use as long as it addresses all of the criteria required by the federal rules and addresses the specific areas unique to different populations. The same assessment for MR/MI/DD, the children's mental health waiver and the elderly waiver may not be realistic. There are great differences between these populations.

Elderly Waiver Case Management providers are using a different assessment at this time. There is substantial cost and time needed to amend the software that is currently in use and contains the current assessment utilized by Elderly Waiver Case Management to accommodate this change. July 1, 2009 is unrealistic for making this change not only due to budget constraints during an economic downturn where budgets are being cut, but the time it will take to upgrade software. DHS will also need to have time to train providers on using this new assessment for those who are not familiar with it. A more realistic expectation for implementation time frame would be July 1, 2010. (Keleher)

COMMENT: The new form 470-4694 is a new assessment tool that is significantly different compared to the current assessment tool utilized under the Case Management for the Frail Elderly Program (CMPFE). The current tool is utilized by the Area Agencies on Aging and the network of contract providers working with them for both Medicaid and non-Medicaid clients. Together, they provide 83% of the elderly waiver case management services. In order to continue the use of just one assessment tool for both sets of clients, the Department will need to re-program the Department's SEAMLESS computer system based on the new assessment tool, which will result in a significant cost – approximately \$200,000 -- for the Department and is a task that cannot be accomplished by July 1, 2009.

After the new assessment tool is finalized, the Department anticipates that ten months will be needed to develop a test version and that an additional one to two months will be needed for thorough testing before the actual roll out to avoid problems with the SEAMLESS system, which is expected to take until July

2010. If the DHS is aware of a less cumbersome, less time-consuming, and less costly method for implementing the new tool, the Department is ready to collaborate with the DHS to work toward the goal of implementing the new tool in as efficient a manner as possible. (Burk)

**RESPONSE:** All case managers will use the assessment for targeted case management, as well as case management provided through the elderly waiver, brain injury waiver, and habilitation services. We have been in contact with the Department of Elder Affairs (DEA) about these changes, including discussion of changes required in their SEAMLESS system. The appropriations bill that covers both DHS and the DEA (83GA, HF 811) has appropriated money for those changes. We will work with DEA in accomplishing this. In the interim, the current level of care assessment will continue to be used for the elderly waiver.

**COMMENT:** Since Case Managers develop the assessment, service plan, and crisis plan, the IAC Chapters that regulate service providers should be revised to state the providers will secure these documents from the Case Manager – not develop their own....redundant... (Nelson)

**RESPONSE:** The assessments, service plans, and crisis plans developed by service providers are different than those developed by case managers. The case management assessment, service plan, and crisis plan are all comprehensive in nature, taking into account the broad array of services and supports needed to help the individual accomplish the individual's goals. The service provider documents are more narrowly focused on the specific services to be provided and are typically more detailed than case management plans.

**COMMENT:** Chapter 90 also adds risk assessment to address health and safety issues for our clients. While this also sounds fair the majority of the information in the risk assessment has already been covered in the clients assessment, emergency plan, social history and individual comprehensive plan that sacs manager's complete...Case Managers also have to follow Chapter 24 rules so it is important to have Chapter 90 and Chapter 24 remain similar in their requirements... We don't want to be ...doing one thing for Chapter 24 and another for Chapter 90. (Richey, Brown)

**COMMENT:** On page 3, d(1) strikes the reference to Chapter 24.4(2) for the assessment and identifies Chapter 90.5(1) as the standard. This needs based or risk assessment that will be used, doesn't meet the Chapter 24 rule for assessment as this needs to be completed in a narrative format. Will there be changes to Chapter 24 as they are the accrediting body? (Harrison)

**RESPONSE:** There will naturally be some overlap between the assessment and the service plan and crisis plan, because the service plan and crisis plan are developed based on the assessment. We believe the new assessment form will meet the Chapter 24 requirement for narrative format because narrative comments are required to provide explanation and detail for items that have been checked. We are currently working with staff in the Department's Bureau of Accreditation to ensure that the assessment will meet accreditation standards.

**COMMENT:** We can not lose sight of the fact that members have the right to refuse treatment and services, have the right to take reasonable risks in their life, and recognize there is inherent conflict between ensuring member's health and safety and not restricting the members rights. Is it a restriction of a member's rights if they need staff supervision, assistance, or support to participate in something they want, yet they do not have the abilities to do so, and it is a health and safety issue if they do so without staff? This should not be considered a limitation of rights. Health and safety of members is of the utmost importance in our society and Iowa as this time.

It is not appropriate for a member to reside in an unsafe place, to reside in filth, to smell bad, to inflict harm on oneself or others, to refuse to take their medications indicated for a life threatening medical condition, to

forgo medical attention for a serious and curable health problem, to engage in dangerous, antisocial, and sometimes criminal behaviors that could jeopardize their freedom, or to be allowed to self neglect as a result of life choices.

I have not seen the assessment case managers will be using, what criteria is used to determine if the risks a member is taking are too severe? I would hope this would be a team decision, taking into account a number of factors, including but not limited to, is the member their own guardian or not, is the member truly able to give informed consent, does the member have the skills and abilities to take the risks and know when to stop, does the member know when or how to get help if needed, will the member learn from the naturally occurring consequences, etc.

The team, including the member, guardian, and case manager, need to be sure they support the person in evaluating personal risks. The team has a responsibility to do whatever it takes to assist the person in making fully informed decisions involving risks. Many times provider staff providing support in a particular situation allow the personal risk to be more reasonable. The team may feel a struggle between overprotecting the member all the way to letting the member experience natural consequences which could be harmful to the member with no learning value. Neither of these ideas are acceptable. Unfortunately, team member values influence and often control what the member may believe or support. The team needs to find the best balance between the member's right to self determination and their health, safety, and welfare. Generally, there is a common ground here. (Aberg)

**RESPONSE:** The assessment is designed to be completed by the case manager with the consumer or the consumer's guardian. The development of the comprehensive service plan and the crisis intervention plan will still be done by the interdisciplinary team, and will still take into account each individual's unique strengths, needs, and risk factors. A risk that is reasonable for one member may not be for another, and it is the responsibility of the interdisciplinary team, led by the case manager, to arrange services and supports needed to address those risks.

## **Development of Comprehensive Service Plan**

**COMMENT:** Since when do we develop a plan based on risk factors? Our plans are developed from consumer desires. Yes, we take the risk factors into consideration when developing the plan, but it isn't the basis for our plan. (Curtis)

**COMMENT:** One concern I have in developing goals based on risk assessment is that they will not be client driven and if they are goals that the client does not want to work on, there will be very little progress. Crisis Plans should identify risks and what to do with being prepared for risks and what to do in the event of a situation that poses risks. The rest of the plan should be client driven about skills they would like to learn, develop, and maintain in order to live in the community successfully. The plan needs to be a plan they were active in developing, one they can understand and a plan they want to work on. I have experienced that there were goals that clients wanted to work on that ensured their safety in the community, but they were the ones who brought it up as a need and wanted a goal (Woodward)

**COMMENT:** My concern is that the development of goals based on the results of a risk assessment is not client driven and consumers may be forced to work on goals that they do not feel are necessary. These types of goals are much more provider driven and do not take into account the consumers wishes or address quality of life issues. What the assessment identifies as a risk may not necessarily be what the consumer considers to be a risk. Developing service plans in this manner can and will lead to a lack of participation by the consumer as they feel what they really want to do in their life does not matter. (Rewerts; similar comments from Riedel, Redies, Moberly, Metzger, Long, Van Horn)

COMMENT: In developing a service plan with our clients and the team, it is imperative that the plan be client-driven and client centered. Goals that are developed must stem from the consumer and be thought out based on his/her needs and desires. My fear in developing a plan based solely on risk is that the plan becomes less client-driven; that is unless the consumer identifies specific risks they have, which they would like to develop into goals. My point is, that the drive to complete a goal must come from within.

We have all been in situations where we are told that we must or should work on a goal personally and professionally. For example, for those who choose to smoke; it is a risk and should be addressed to ensure greater health benefits, but will a person quit smoking if the goal of quitting is developed for them based on this risk? I think not; the desire to quit must come from within. This is not to say that client risk should not be addressed in our plans, because I feel that it is presently adequately addressed both in the goals and in the crisis plan within the Individual Service Plan itself. The goals are not, however, derived solely from any noted or historical risks associated with any client. We must continue to deliver a client-driven service if we have any hope of helping the individuals we work with buy into, and want, change. (Reich)

COMMENT: If these new rules are put into place, we will have more unsatisfied consumers because we will no longer meet them where they are at and allow them to drive their services. Instead we will walk in to their homes with the idea that we know what is best for them and that they will have to blindly follow (which will not work in helping them gain skills to discontinue case management services). This will lead to more problems for the consumers! (Metzger)

COMMENT: I have worked as a case manager in Iowa since 1998 and the State of Iowa has always stressed consumer choice. This would be a major step back if this rule were to be enforced. (Merz)

COMMENT: The major issue with the wording of this rule change is that the service plan will be based on risk identified in the assessment. This is a totally different mentality than Case Management has viewed goal writing in the past. The service plan goals have always been "Consumer Driven". This new rule will take away the member's choice. It will eliminate the ability to assist them with creating a better quality of life based off of their desires. The rule also reads; "the Case Manager will ensure the active participation of the member to develop goals". If the Member has no choice in the goals, it will be very difficult to "ensure" that they will participate. If we are forcing them to work on identified Risk factors and they do not see them as Risks or they do not want to work on them, are we not infringing on their right to choose? (Koehler)

**RESPONSE:** When the rules were published in ARC 7631B, an editing error occurred that removed part of a sentence, which made the language appear as though the consumer's service plan would be based *only* on identified risk factors. The actual intent is that the case manager will complete a comprehensive assessment, which includes a risk assessment, and will subsequently use the comprehensive assessment to develop the service plan while basing the crisis intervention plan on the risk assessment.

When the filing was amended in ARC 7732B, the sentence was corrected to read, "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."

COMMENT: **90.5(1) "b" 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." Essentially I read this to mean the service providers need to supply the case manager with these backup support plans to be included in the service plan. Is that correct? (Eckerman Slack)

**RESPONSE:** The crisis intervention plan does not need to include an actual document from a service provider, but does need to identify the provider agency's backup staff or a process that the consumer can use if provider staff are delayed or unable to provide services.

COMMENT: My understanding there are three types of goals that can be developed for a member, skill building goals, maintenance goals, and support goals. My understanding is that goals and supports are determined by the member's needs, including their desires for certain goals. My understanding, from case management training I have attended (Linda Kemp does an outstanding job with training on goal writing and case management), is skill building goals need to be monitored for progress, and maintenance and supports goals do not require progress. Maintenance goals and support goals focus on maintaining skills and/or ensuring the members needs are met. We need to be very careful to say progress toward achieving the goals implies the member has to be learning new skills. We do not provide active treatment in HCBS programs.

We need to remember that Habilitation is services designed to assist members in acquiring, retaining, and improving self help, socialization, and adaptive skills necessary to reside successfully in home and community based settings. Basically, our goal is to keep members out of institutions and residing in the least restrictive setting possible. For members who are aging, with health complications and severe disabilities, that may very well be helping them maintain skills and prevent regression.

We need to remain cognizant of the concepts of basic learning theory as it relates to members who experience disabilities, particularly moderate to profound disabilities. Members experience intellectual and cognitive problems, short and long term member deficits, complications of aging, health and medical complications, mental health and Psychiatric conditions, and behavior problems, which can and do interfere with new learning, and even effects the members ability to even maintain skills. I must be honest, our agency has found through the years that we can help members maintain good health through supports and good medical care, and we can truly make a difference with reducing problem behaviors, and find that new learning is very difficult to achieve. As a member ages, and their disabilities worsen, this becomes even more difficult. We find when the member is healthy, their mental health needs are being met, and problem behaviors are well supported, the member demonstrates more skills and is more independent. We must be realistic regarding members services and expectations for progress and new learning to occur. (Aberg)

**RESPONSE:** The rules do not make a distinction between different types of goals. However, case managers must monitor progress for all goals. This does not imply that monitoring progress requires the member to be learning new skills. If an individual goal is to maintain a certain level of skill, the case manager can still monitor progress by checking to see if the member's skill level is declining or staying the same, and by monitoring the amount and type of service needed to maintain the skill.

## **Choice of Providers**

COMMENT: 90.4 (1) speaks to informing the member in writing of their right to choose their TCM and that this form shall be kept on file for 5 years. Is this true only if they select our TCM unit or would you also need to keep it if they choose another TCM unit? (Harrison)

COMMENT: 90.4(1): "The provider shall inform applicants in writing of their right to choose their 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". Is this a statewide list? (Eckerman Slack)

COMMENT: Has it been determined that DHS service workers for the ill and handicap waiver and physical disability waiver will not be targeted case managers? Who will manage those cases if the member is eligible for Targeted Case Management, the TCM or the DHS service worker? (Karminski)

COMMENT: It has always been our understanding that the consumer could choose from any case management agencies in the county of legal settlement or the county of residence. Here it appears they would be able to choose ANY agency they want. Clarification? (Curtis)

COMMENT: This rule is too broad in nature and needs some established parameters – i.e. within the respective county of applicant’s residence. Due to budget constraints, case management providers are no longer able to serve consumers located any and everywhere in the State of Iowa. (Artley, Shaw, Juetten, Wollum, Guard, Cory)

COMMENT: We would like clarification regarding a member’s choice of case management provider. Often case managers are the ones holding a member accountable. Does choice mean that a member can request a different case manager at any time and that the request must be granted? Does choice mean that a member can choose a case management provider from anywhere in the state regardless of county of legal settlement or residence? (Anderson-Noel)

COMMENT: The provider shall inform applicants in writing of their right to choose their provider of case management services, and at the applicants request, shall provide a list of other case management agencies from which the applicant may choose. The provider will maintain this document for at least 5 years. – We are a small county. We are the only case management agency besides the elderly waiver- what do we offer them. Will we get a list of all case management agencies? Who completes this form? Does the case manager get a copy? Whose file must maintain this document??? (McKeag-Hall)

**RESPONSE:** The federal regulations for case management that will be effective on July 1, 2009, allow the state to restrict enrollment of providers for persons with a developmental disability (including mental retardation) or chronic mental illness. This allows Iowa to continue the practice of limiting provider enrollment for these populations to DHS, counties, or consortiums of counties. However, the state is not allowed to restrict an individual’s right to choose from enrolled, qualified providers. Guidance issued by CMS with the regulation states this explicitly:

“States may limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services. We note, however, that a State's decision to restrict case managers for these populations does not impinge on targeted individuals' rights to choose freely among those individuals or entities that the State has found qualified and eligible to provide targeted case management services.”

This does not mean that a case management provider is required to serve every consumer that applies for services. For example, if a case management provider in Council Bluffs receives a referral for a consumer residing in Dubuque, the provider can decline to serve the consumer if providing the service would not be cost-effective because of the distance. However, neither the IME, nor a county, nor another provider can restrict a consumer from applying for services with whichever provider the consumer chooses.

The rule references the case management provider, which is the entity that is enrolled with Iowa Medicaid, not the individual case manager, so the rule does not require a provider to assign a different case manager at any time a consumer requests a change. However, it is good practice to assign a case manager that is able to work well with the individual consumer, and we would encourage providers to accommodate the consumer’s wishes to the extent that is practical.

An up-to-date list of enrolled case management agencies can be accessed at any time from the IME website at: <https://dw.dhs.iowa.gov/providersearch/>. Selecting “MEP CASE MANAGER” from the dropdown box for “Type” will produce a statewide list. If the consumer requests a more geographically limited list, this can be provided by additionally selecting a county or metropolitan area from the applicable drop-down boxes.

The provider who receives payment for providing the service should maintain documentation that the consumer has been given a choice of providers. This may mean that in some instances both providers will need to maintain documentation, such as when a consumer is served by one provider and then changes to another.

### **15-Minute Billing Unit**

COMMENT: My current understanding is that it is not in writing requiring states to move to this billing unit, but that verbally Iowa has been directed to do so. If this has been a verbal recommendation, could Iowa at least wait to implement a change until a final decision is made at the federal level on the moratorium? The time it takes the staff to track their time in real minutes is taking away valuable time from working directly with the members. (Bopes)

COMMENT: The proposed Federal Rules do not mandate 15 minute reimbursements for TCM, so we do not know why the state is requiring this procedure. Case Management is an atypical Medicaid service and as such needs not provide 15 minute billable "clinic" time. (Nelson)

COMMENT: With the federal legislation regarding the 15 minutes under a moratorium, why does Iowa continue to move forward on implementing the 15 minute increments when there is the potential for the moratorium to be extended or for the federal legislation to be rescinded? Also how do the 15 minute increments enhance the quality of care as it primarily just recreates more documentation/paperwork? (Karminski)

COMMENT: Case Management services in Iowa are reimbursed on federally accepted reimbursement principles and are cost based in nature. Proposed changes to billing increments will only increase the paperwork and tracking time of case management staff requiring case managers to track actual minute by minute time. Since the Federal Moratorium is still in place, final decisions have not been reached, and changes may occur, it seem logical to wait until there is more finality. (Ahrens)

COMMENT: The monthly rate currently utilized is already calculated using a cost-based program. The proposed changes would simply increase paperwork to track actual minutes. This creates less time for us to spend helping the consumers we serve. It is our understanding that the Obama administration has not approved the proposed changes. We feel the state of Iowa should delay making changes in these rules until the federal government has made a final decision. (Richie, Bruce, Carlson, Shull)

COMMENT: As I understand the cost are already cost based. Changing the system to a 15 minute unit only serves as more tracking, more paper work. The recommendation is not to make changes until the moratorium is finalized and federal regulations and changes are defined. (McKeag-Hall)

COMMENT: We strongly oppose the 15 reimbursement process versus the one monthly billing unit. TCM is not a clinic, hospital, or a law office, nor on any other normal Medicaid payment plan. We are social workers who are trying to coordinate services for members. We are not set up by 15 minute appointment times and we are not a service who works in this manner. (Nelson)

COMMENT: The proposed amendment to section 79.1(1)d, changing the billable unit of service from one month to 15 minute increments will cost more money, if, in fact providers are paid on a cost-based system, as we currently are. We have been involved in testing this system out, and we see two negative results: 1) case managers are spending less time with consumers and more time doing paperwork, and 2) the need for administrative support time is going up in order to process additional paperwork. I recommend keeping the monthly billing unit so long as the federal regulations allow it. (C. Wood)

COMMENT: My concern is that Case Manager's are now attempting to track what they do every minute of the day to determine what is and isn't billable. ...We are spending at least 45 minutes to an hour of our day filling out time tracking sheets. Over the past 12 years I have witnessed the focus of Case Management increasingly being all about the paperwork shifting way from our clients...I am concerned about the costs to the counties... While some clients may bring in fewer dollars most, especially our chronic mentally ill clients, could easily cost more. While I agree that we need to justify with our paperwork what we do when receiving Medicaid and county dollars, there has to be a compromise. (Richey, Brown)

COMMENT: Currently case management is reimbursed on a monthly unit, based upon reasonable and proper costs of operation in accord with federally accepted reimbursement principles (OMB A-87 principles). Therefore, the current program is cost based. There are no "bundled" services in this rate. Changing the billing unit to 15 minute increments only serves to increase the paperwork/tracking time for case managers to track their time in real minutes throughout the day. Until the actual outcome of the moratorium is final, it does not make sense to make changes to a system that is already cost based and efficient. (Ketcham, similar comments from Eckerman Slack)

COMMENT: I would like to express my concerns regarding the 15 minute billing units for case management. ... from my personal case management perspective this is such a hard way to keep track of what a case manager actually does throughout their day. I really never realized how much I do that will be considered not billable. Meaning, I really never realized how much paper work I actually create in a day and how much filing and how much time some of my CMI client's utilize. So, I will say that as a time study, I have learned a lot.

Frankly, the \$222.17 per case management unit per person per month is not enough. In my opinion, I think the state and federal government will find that the case management rates were cheap for what they were getting. I feel very strong about this issue because there are so many interruptions and so much multi-tasking going on in our job that breaking it down into 15 minute increments seems so difficult, not to mention the time it takes out of the day to actually sit down and enter it into the computer, which again in my opinion is a waste of time and money. (Crawford)

COMMENT: Amended language to change the presently established, cost-based, monthly reimbursement rate for Targeted Case Management to a 15 minute unit rate creates a labor-intensive methodology of time-tracking for staff members. This diminishes a case manager's ability to provide efficient services to his/her clientele. Although TCM services operate under a medical model through Medicaid, actual service provision does not lend itself well to how physicians provide services to their medical patients.

In a given 15 minute time period, a case manager may handle five to ten various items for various consumers. Other times, they may only be handling one consumer's needs during the time frame. There is no consistency. Taking the time to document minute-for-minute detracts immensely from a case manager's ability to provide effective and efficient case management service. If, at some time in the future, this minute-by-minute approach to time-tracking becomes a Federal mandate, then will be the time to re-vamp Iowa's protocol. (Artley, Shaw, Juetten, Wollum, Guard, Cory)

COMMENT: I believe in being accountable and support a reasonable amount of direction and oversight. I believe most people, most taxpayers, and the majority of legislators, would assess documentation in one-minute increments of time, and data entry of that time quite unreasonable. (Hundreds of case managers have been doing this in Iowa since October, 2009.) I doubt that many would consider this a good use of taxpayer dollars. I doubt that many would be willing to document their own time in one-minute increments. A change in the billing unit only services to increase the paperwork/tracking time for case managers. We already have an inefficient Targeted Case management system, based on time spent with consumers and providers, compared to time spent on documentation (20:80 ratio) (McGrane)

COMMENT: We have concerns regarding the 15 minute billing increments and the amount of time case managers spend tracking and reporting their time to the minute. There is also confusion regarding how to track time on e-mail, fax, and written correspondence documenting goal progress (Anderson-Noel)

COMMENT: Item 6. Sub-rule 79.1(1)"d" by substituting, effective July 1, 2009, a fee for service in place of a monthly fee through the proposed reimbursement of case management services on the basis of a payment rate for a 15-minute unit of service. The 15-minute billing unit of service was proposed in Iowa to comply with a proposed federal requirement contained in the Interim Final Rule at *72 Federal Register 68,077 (December 4, 2007)*, Sec. 441.18(a)(8)(vi). This federal rule was subsequently frozen by two Congressional moratoria with a new effective date of July 1, 2009, and now has been proposed for rescission by the Obama Administration in *74 Federal Register 21232, No. 86 (May 6, 2009)*. Accordingly, there will no longer be a federal requirement requiring Iowa to adopt the 15-minute billing unit.

The Iowa Medicaid Enterprise (IME), in a 5/8/09 memo to TCM agencies, ... indicated that it will now have more flexibility in the way in which the 15-minute billing unit will be implemented and will work with TCM providers to explore ways in which their administrative burden, due to the new billing unit, can be lightened. IME also indicated that it is looking at the practices of other states that are already using 15-minute units, and IME believes that it can build in efficiencies that will reduce administrative requirements for case managers.

DHS TCM is heartened by this commitment because without flexibility and changes to the 15-minute billing unit as IME has defined and interpreted it, up to now, DHS TCM will lose increments of time under 15 minutes which will result in higher costs per 15-minute unit of time. Therefore, we support adding an optional half unit, or the "7-1/2-minute half unit," which will allow us to recover eligible time that otherwise would be lost. This is consistent with the Interim Final Rule, which permitted smaller units of time as alternatives in addition to the 15-minute unit.

DHS TCM also supports more flexibility in defining which activities qualify for federal financial participation (FFP) at the full rate and which activities do not. For example, time incurred for transportation by the case manager to attend meetings with the consumer or consumer's family/guardian and with providers that pertain to the provision of services which are authorized under Chapter 90 should be reimbursable at the full FFP as part of case management services. Transportation is included in the billing unit by the State of Missouri for its TCM providers. DHS TCM also believes that the typing of consumer assessments, care plans, and progress notes which pertain to case management services should be included in the billing unit as fully reimbursable expenses since they are required and necessary for the administration of the program.

Without making these changes, our reimbursement rates will become artificially too high, with administration too burdensome, and may result in the budgetary effect of limiting beneficiary access to case management services that otherwise would not be limited. Therefore, DHS TCM proposes the following changes to Sec. 79.1(1)"d":

In the first paragraph, the first sentence will be amended to read: "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 and a 7-1/2-minute half 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."

Under Sec. 79.1(1)"d"(3)"4", the paragraph will be amended to read: "~~(4) 4.~~ Costs of operation shall include only those costs which, including time for transportation by the targeted case manager to meet with the member, the member's family or guardian, or providers that pertain to the provision of services which are authorized under rule 441—90.3(249A)."

Item 10. Amend Subparagraph 79.1(24)"a"(1) – ~~“A-Effective July 1, 2009, a unit of case management is one month 15 minutes.”~~ DHS TCM supports this amendment by adding after “15 minutes” the words “and a half unit of case management is 7-1/2 minutes.” (Diamond)

COMMENT: It appears these Federal proposed rules will be rescinded. Why then, would the State of Iowa want to adopt these rules? I am particularly concerned about the amendment for Chapter 79, which defines the unit of service. Currently, a unit of service is one month. It has been a one month unit of service since we began Medicaid Case Management in 1989. THERE HAS NEVER BEEN A PROBLEM WITH THIS. In fact, a few years ago we had a Federal audit of Medicaid Case Management. The monthly unit of service was not an issue. We were told to prepare our case managers for transitioning to the 15 minute unit of service. Our case managers have done this for the past three months and are spending one hour of each eight hour day documenting there time. This is quite ludicrous--not cost effective and certainly not good use of the case managers' time. (Blair)

COMMENT: As the provider of Case Management Services for Muscatine County we have been very concerned with the proposed changes by CMS in regard to the case management requirements. Even though many of the areas of concern have been rescinded by the Federal Government, including the requirement for a billing unit not to exceed 15 minutes for case management it appears that Iowa Medicaid Enterprise plans to implement using this 15 minute increment. We urge you to rescind the requirement for billing case management services in 15 minute increments. The requirement for payment methodologies in this provision will be administratively burdensome, may result in restrictions on available providers of case management services, generally may limit beneficiary access to services, and will add cost. We would urge you to vote so that Iowa will be consistent with the Federal rules as rescinded and not require billing in 15 minute increments. (Anderson-Noel)

COMMENT: We have submitted written responses but I did want to go on record that in general we are in support of the changes that are being purposed. In regards to the 15 minute time increment, we would ask that IME consider adding to that a half-unit of time that could be used to capture the brief contacts that are so much a part of case management work. We are concerned that with a 15-minute unit of time, even with rounding, that those brief contacts will be lost and we won't be able to be paid for our time during those conversations or emails or whatever the instance is. So we would ask for, in addition to the 15-minute period, a half-unit of 7 1/2 minutes or less.

We would also ask that IME reconsider their position on documentation of contacts not being an allowable billable unit as so much of the case mangers time is spent in documentation. In talking to other states, which are also part of our CMS region, specifically, Missouri, Kansas and Nebraska; Kansas and Missouri both do allow time for documentation. Missouri also allows for travel. We are not asking for the travel consideration at this time but we do ask for reconsideration of documentation. (Conrad)

COMMENT: I, obviously, don't think that the 15-minute unit is a good use of the case manager's time. My concern is for them to be able to have the time with the consumers that they need to have in a positive way and to have the consumer's needs met.

I'm glad that they mentioned the cost to the counties. I should of thought of that without being prompted. You know the time when Grinnell received the growth dollars that the state had promised and many, many towns I know was the last to fall, if you would, are facing waiting lists, which we haven't had to have for years. Now it's not uncommon for a county to have to go to waiting lists because of increased response in services and not getting the growth dollars that were promised. We don't want waiting lists, we don't want to not be giving services to people in our community. (Austin)

COMMENT: We are still concerned about the 15 minute billing unit. With the rules be rescinded and I know its been explained to me only that the direct – 15 minute unit has been rescinded but it still will not be a bundled rate. But when reading through the Federal Registry, it defines a bundled rate “a Federal

payment methodology when the state pays a single rate for more than one service furnished to an eligible individual during the mixed period of time. The way Iowa does try to make this case management is one service. They're not bundling more than one service in the rate that we bill.

Costs reports are being submitted by federally reimbursed principles so that what we bill right now is cost based. Costs reports that we use, where 15 minute increment or better, the monthly billing unit is no different – it is just divided up on the allowable costs of these things.

There's been some response from IME that the 15- minute billing rule will affect the OIG in 2007. My recollection is that there is nothing in that audit that referred to the monthly cost fees. It was directly based on the concept of the narratives that we used to bill and that's not going to change no matter what you use for billing. (Eckerman-Slack)

**RESPONSE:** The federal regulations for case management, which have an effective date of July 1, 2009, initially required a unit of payment not to exceed 15 minutes. On May 1, 2009, the Centers for Medicare and Medicaid Services (CMS) issued a new proposed regulation, CMS-2237-P, which will rescind the 15-minute unit requirement.

Without a clear regulation in place, the only federal standard is Section 1902(a)(30)(A) of the Social Security Act, which requires CMS to review state reimbursement rates to ensure that they are economic and efficient. This leaves a large amount of leeway, and we have been in contact with CMS to determine what will be allowed.

CMS has informed us that they will not approve the use of monthly units for any non-institutional services, including case management. They have advised that daily, hourly, or 15-minute (or smaller) units would be acceptable. We have asked CMS to confirm this in writing. We have also asked CMS about the possibility of leaving the current system of monthly reimbursement in place for one year to allow time to implement a more case-sensitive payment such as 15-minute and/or hourly units.

Additionally, we have already taken steps to reduce the amount of other paperwork required of case managers. This includes eliminating the use of multiple assessments that are used for determining level of care for the mental retardation and brain injury waiver programs and allowing case managers to complete a single, comprehensive assessment that will be used for multiple purposes. The rules will also eliminate the need for case managers to pre-authorize case management for consumers other than those covered by the Iowa Plan for Behavioral Health. This should help to reduce the amount of time spent on administrative activities.

## **Administrative Costs**

COMMENT: 79.1(1)"d"(3)1... is not being changed under this proposal; but, due to all of the changes incorporating activities that will require additional clerical support activities that are not billable, I would recommend allowing a 25% indirect administration maximum. We are already pushing the 20% limit, and anticipate exceeding it under these new rules. We understand that some providers are planning on issuing laptops to case managers and having them do clerical work in the presence of the members so that the time is billable, but we see that as disrespectful to the member. As these rules state, it is important to develop a relationship with the member; and it is difficult to do that when the focus is on the laptop. (C. Wood)

COMMENT: With the 15 min billing, it is my understanding that we can bill for a phone calls to the provider (talking about services), to the person (talking about goals and services), or a face to face meeting with the person. Also letters and e-mails now. My question is why aren't we paid for the paper/computer work that Medicaid requires us to do?? Which is becoming more and more. To me that is like me wanting my police services, military, postal, etc but I won't pay taxes. (Nickum)

COMMENT: As Director of Case Management I just want to truly express my desire to have all policy makers try to understand what Case Management truly is and why Case Management is not your typical Medicaid service. These increasing procedures and rules do nothing to advance the work of Case Management, they advance secretarial Case Management that instead of doing what is best for the members to live, work and socialize in the community while maintaining their health, safety and well being.

Case Managers need to watch the clock to make sure they document their exact 15 minute time, while needing to stay in the office more to complete countless hours of paperwork. Instead they should be doing the real work of being with members and establishing relationships with the very people they are there to assist in being more productive citizens of their communities.

Please if you are to spend countless hours deciding how to change rules, make them more simple. Make them less time consuming, less narrative in nature, give the Case Manager more time to do their jobs, and follow the Medicaid guidelines but not be so rigid that all the time is spent doing paperwork when the time spent should be with the people! (Nelson)

COMMENT: Currently Targeted Case management programs are paid based upon a cost report with a cost settlement at the end of each fiscal year. Thus the program is cost based in nature. Case management programs bill monthly for any billable contact made by the case manager to a client. Revisions to Chapter 90 are moving from a monthly unit to a Quarter hour or 15 minute unit. As a result case managers now have to track activities they perform minute by minute.

Our case managers are spending 45 minutes each day entering time studies on their activities. This equates to 3 hours a day or 15 hours a week or 780 hours a year that is spent tracking their time. If this is multiplied across all programs in the state the number of man hours being wasted is staggering. In addition we have had to increase administrative or indirect costs to capture their nonproductive time and assist them in meeting their other administrative burdens.

Case Management Units are being squeezed from both ends. They are being told, through administrative rules, to provide more and more documentation of their activities while also being told at the other end that the program can only provide a certain level of support through administrative caps on indirect expenses. We need to put these inefficient requests to a stop before the program is destroyed and made useless. (Hill)

COMMENT: I would also like to encourage all policy makers to first talk with Case Management agencies and find out the best way to provide services. Listen to ISAC Case Management Specialists and listen to Case Managers in what they feel is the best way to provide services to the members they serve in an efficient, cost effective manner that continues to ensure the health, safety and welfare of all TCM members. (Nelson)

COMMENT: Case managers are already drowning in documentation, mandates, assessments, proof of eligibility, funding requirements, outcome expectations, provider needs, IVRS denials, computer input, etc. did I mention consumers' needs? These additional regulations are "like throwing an anchor to someone who is already drowning". It is past time to give this program a life jacket.

The State should conduct an extended study of our current system and ways to improve this program. We need to stop and, as we are doing nationally, press the reset button. I would suggest we start with focus groups, consisting of consumers and line staff, in addition to supervisors and administrators.

I would like us to spend our time coming to common, reasonable agreements concerning what rules and documentation are actually necessary to provide quality case management services. I would like all of the respective stakeholders" (consumers, family members, case managers, providers, IME, IDHS, the Counties, IVRS, Magellan CCMS, etc.) to meet with the intent purpose of reducing burdensome requirements. Consumer and from line case managers' input needs to be genuinely requested and listened to. They need to be provided with a safe environment to share their truths, frustrations and experiences. Focus groups

may be a starting point. We could also establish work groups to address the 80:20 ratio. A minimum guideline would be to achieve a 40:60 ratio, with 40% of case management time spent on documentation and mandates, and 6 % of our time spent with consumers, providers and family members. (McGrane)

**RESPONSE:** Time spent on non-billable activities can be built into the case management rate as an indirect administrative cost. The limitation on these costs to 20% of other costs is already present in the existing case management rules, and is not being changed in the proposed rules. We realize that having case managers keep track of their time in 15-minute increments may require more time. However, much of this has been attributed to completion of the Billable Activity Report (BUR).

Although IME has offered the BUR as a tool for tracking time, it is not a required form. If a case management provider has a less-intensive way of tracking billable units, that method can be used rather than the BUR. This could include options such as using a template for progress notes that automatically summarizes contact times from the narrative, using a billing system that can generate a summary report of billable units, or even developing your own time-tracking sheet that would better meet your needs.

Additionally, we have already taken steps to reduce the amount of other paperwork required of case managers. The rules mandate use of a detailed assessment tool; however, we are working to eliminate the use of other assessments that are used for determining level of care for the mental retardation and brain injury waiver programs. This will allow case managers to complete a single, comprehensive assessment that will be used for multiple purposes. The rules will also eliminate the need for case managers to pre-authorize case management for consumers other than those covered by the Iowa Plan for Behavioral Health. This should help to reduce the amount of time spent on administrative activities.

## **Prior Authorization**

COMMENT: While getting rid of the prior authorization initially sounds like less paperwork for the Case Managers, IME will be implementing look behind audits. My concern with this is the potential for payback after a service has already been provided. I would prefer to know in the beginning if the client is eligible for services, not six months or even years later. With the risk of having to pay back those months of services that was provided. (Richey, Brown)

COMMENT: We are also questioning the withdrawal of Prior Authorizations through IME because when they began the Prior Authorization process it was mentioned by many Bureau Chiefs and other DHS personnel that you could not provide a Medicaid service without prior authorization, now it appears as if that is changed and though these newly proposed rules, if the service plan has been validated through ISIS Case Management shall be considered approved by the department. Which as director it is fine with me, I just want IME to be sure, since we have changed this process more than once and I am concerned with an audit that the State may say they weren't authorized and agencies would be needing to pay back. Just want to be sure the authorization process would not be a detriment to clients or agencies. (Nelson)

COMMENT: Having services go through a prior authorization seems like the best way to provide quality assurance oversight versus doing a retrospective oversight left up to interpretations, why does the state see the need to make a change? (Karminski)

COMMENT: Several years ago case managers were required to start doing prior approval authorizations for our client's case management services. At the time there was a lot of complaining going on about this additional form and information, but I will tell you that in my opinion this helped case management tremendously so that we were able to have that prior knowledge as part of our reassurance that the client was meeting the criteria for our services. We have come to rely on the prior authorization process and now

it is my understanding that there is now a request to change that process and do “look behind” quality assurance reviews.

So, in my opinion the change would require new individuals to be hired to order paper work from various case management agencies to do desk reviews. This would in-turn cause case managers additional work to copy and send the requested paperwork to the reviewers, and in turn increase the office supply budget for copies and mailing or faxing. Then, if the information was not sufficient they would then require the case management agency to payback for those months of service which then causes the agency even more difficulties in their line item budgets. Again, this does not make sense to me, and again seems like it could be a tremendous waste of time and money for all involved. (Crawford)

**COMMENT:** While getting rid of the prior authorization initially sounds like less paperwork for the Case Managers, IME will be implementing look behind audits. My concern with this is the potential for payback after a service has already been provided. I would prefer to know in the beginning if the client is eligible for services not six months or even years later. Not running the risk of having to pay back months of service that was provided. (Brown)

**RESPONSE:** The purpose of eliminating preauthorization for non-Iowa Plan consumers is to reduce amount of administrative activity and paperwork required of case managers. We are not implementing “look-behind audits”; rather, we are implementing quality assurance activities will have several components, including post-payment reviews, review of incident reports, review of reports of abuse or neglect, and technical assistance in determining the need for service.

The focus of the post-payment reviews is not intended to be a billing audit with recoupment as the goal, but rather will focus on helping case management agencies utilize best practices for the provision of quality services. If these activities were to reveal fraudulent or abusive practices, they would be referred to our SURS unit for further action, but this is not the intended purpose of the quality assurance activities.

**COMMENT:** In regard to the pre-authorization process which Magellan (or Iowa Plan managed behavioral care contractor) will continue, we have concerns about how will this be handled with the 15 minute increments as opposed to the current monthly unit. Will the Iowa Plan contractor authorize for a set number of units per month or a maximum number of units not to be exceeded over a certain time period? (Anderson-Noel)

**RESPONSE:** It is within the purview of the Iowa Plan contractor to decide how they will authorize services.

### **Billable Activity**

**COMMENT:** We agree that written communication (letters, email, faxes) should be billable. What about when family, consumer, or provider leaves a detailed voice mail for case managers, can this be billed? (Nelson)

**COMMENT:** 90.5(1) e (2): Describes the monthly contact that is required, but is this contact (if by written communication, letters, email and fax) a billable contact? (Eckerman Slack)

**COMMENT:** Are the required contacts considered to be billable activity; in particular, the written communication? Clarification is needed regarding the definition of billable activity; in particular, is written communication billable. (Bopes)

COMMENT: Billable contacts, per se, need to be clearly defined if Iowa pursues the 15-minute billable unit rate. Unfortunately, Cost Report Training which providers received earlier this year did not satisfactorily address this issue and providers are at a loss as to how to prepare the next projected Cost Report. (Artley, Shaw, Juetten, Wollum Guard, Cory)

COMMENT: Please clarify if...letters, emails and fax...would be considered billable contacts...It was previously indicated that voicemail messages of significance would also be considered as items above. However this is not indicated in this section. Please provide clarification of this type of contact as well. (Ahrens)

**RESPONSE:** These rules do not allow for contacts to be by voice mail message. Written communication will be billable if it directly pertains to needs of the member. Written administrative activities such as faxing a Notice of Decision or a service plan are not billable. As a general guideline, if the communication would be billable when done in person or over the phone, then it should also be billable when done in writing.

Additionally, contacts must be of sufficient time to warrant billing for 15 minutes of activity (for example, a single email exchange of 4 minutes total duration would not be billable, but three email exchanges of 5-minutes duration each would be billable). A copy of the written communication must also be placed in the consumer's file.

### **Amount of Service Allowed**

COMMENT: Page 4, 78.27(2), the new #2 under "e" indicates that "the member's habilitation services shall not exceed the maximum number of units established for each service in 441---sub rule 79.1(2). What is maximum unit established for case management? (McKeag-Hall)

COMMENT: **78.27(2), the new #2 under "e"** indicates that "the member's habilitation services shall not exceed the maximum number of units established for each service in 441---subrule 79.1(2). Does this include targeted case management as a service within Habilitation, and if so, how will the unit maximum be established with a 15 minute billing unit? (Eckerman Slack)

COMMENT: For Brain injury waiver- Is there a limit on the number of units allowable – how will this be defined as a service under the waiver? How will this impact the monthly caps?? (McKeag-Hall)

**RESPONSE:** For case management provided as a habilitation service, 441—79.1(2) limits only the maximum rate per unit. However, ISIS will enforce a limit on the number of units that can be added to a service plan. At this time, we expect that limit to be set at 696 15-minute units per month, which amounts to 40 hours per week. IME can adjust that limit in either direction if circumstances warrant it. Case management provided as a brain injury waiver service will still count toward the monthly cap.

COMMENT: As a Case Manager for the Elderly Waiver I find it hard to understand the limiting of reimbursement for Case Management Services. I do not believe a relationship can be developed between a case manager and the member in 15 minute intervals every three months. If I am understanding the rules correctly, Elderly Waiver Case managers will only be reimbursed \$70 for 15 minutes spent with a member. So any time spent after developing a relationship with the consumer (as stated in 78.43(1)c) falls on the Case Managers time. (Cairney)

COMMENT: Item 17 CASE MANAGEMENT to establish an upper limit for elderly waiver of \$70 per month is potentially out-dated as there are proposed legislation bills to authorize a maximum of \$115/month for reimbursement. (Artley, Shaw, Juetten, Wollum, Guard, Cory)

COMMENT: My only comment is concerning, specifically, the elderly waiver with the inclusion of being included in the scope of case management and following all regulations that TCM, CMI and MR and DD are following now. If that is the requirement, we are to follow the same regulations, my comment would be that the reimbursement rate currently is capped by the legislature and I know that there's been bills proposed, however, if you are going to require it to be the same as the other programs, that the reimbursement be based on actual costs or projected costs instead of the current capped rate be considered seriously because a lot of providers currently providing that service at the \$70 cap, are not going to be able to continue to provide that service with our agency being one of them. (Collier)

**RESPONSE:** The rate paid per 15-minute unit will not be \$70, but will be set based on the provider's cost as demonstrated on their cost report. The limitation of \$70 per month is the total that can be paid for an elderly waiver consumer regardless of the number of units. This limitation is set by the Legislature, not by IME.

However, 2009 Iowa Acts, House File 811, which set the appropriations for both the Department of Elder Affairs and DHS, contains a provision that if these rules are enacted, will eliminate the \$70 per month cap. The cap would be replaced with a system in which rates can be adjusted on a quarterly basis in order to keep overall expenditures within the amount set in the Medicaid budget. This would allow more equitable payment for elderly waiver case management providers, as they will be able to bill more units for more intensive consumers and fewer units for less intensive consumers, while the overall effect on the budget will be cost-neutral.

### **Services During Transition to Community**

COMMENT: Are institutional stays referencing nursing home placements, rehab placements, mental health institutes, ICF/MR? Or does this also include local hospitals for instance someone going in for medical care due to a medical condition or someone on the psychiatric unit to stabilize? (Karminski)

COMMENT: Does this include transitioning from a Medicare covered stay (as in skilled services) as well? (Rieck, Bertogli)

COMMENT: Will a prior authorization be required prior to providing case management during this 60 day period? Also (d) indicates that claims for reimbursement shall not be submitted until the member's discharge. If the discharge does not take place for some reason, does that mean case management will not be reimbursed? (Eckerman Slack)

COMMENT: 90.2(3)c: How does one define successful? (Curtis)

COMMENT: 90.2(3) "c" States "Eligibility for persons transitioning to a community setting is contingent upon a successful transition." I assume this means that the individual has actually moved to a community setting? (Eckerman Slack)

COMMENT: 90.2(3)c.... states that "eligibility for persons transitioning to the community is contingent upon a successful transition". Does this mean that if a member is unable to succeed in the community and returns to the institution, the Targeted Case Management provider will not be paid? If so, do we have a specific definition of "successful"? Is there a length of time involved? For example, suppose the member needs to return in a month? What about 6 months? What about a year?

It seems to me that this provision will discourage providers from taking risks that might be necessary in order to move people with intensive service needs. There are a number of reasons a member might not succeed or that a community might not succeed in serving a member, and it might be the supported living provider's fault. Do they get paid? In my view, subsection "c." is not needed. Subsection "b." limits

eligibility to “60 days BEFORE DISCHARGE”. If there is no discharge, the 60 day requirement is not met. I recommend deleting subsection “c.”. (C. Wood)

**RESPONSE:** Medical institutions include intermediate care facilities for the mentally retarded (ICF/MR), the four state mental health institutes (MHI), nursing facilities (NF), nursing facilities for the mentally ill (NF/MI), psychiatric medical institutions for children (PMIC), and skilled nursing facilities (SNF). Successful discharge occurs when the member has been discharged from the institution and resides in the community. If transitional case management has been provided but through no fault of the case manager the member is not discharged from the institution, the case management provider can request an exception to policy to be reimbursed for the services provided.

COMMENT: We too are ok with the lengthening of the time for working with members who may be transitioning from an institution to the community; our only hope is that the billing side of IME gets on board with this as members are always denied due to being in an institution. If TCM can bill while they reside in an institution, IME and Income Maintenance will need to code ISIS the right way for payment. We have waited 4-6 months to be able to restart a person’s services once they have left the MHI because the codes and ISIS are not right. (Nelson)

COMMENT: Item 2: 78.27(5) “e” Page 4 - This references case management being reimbursable while a client resides in a nursing home.

Item 4: 78.37(17) “c” Page 6 - This states that case management payment can only be made during a month a consumer is enrolled.

Item 23: 90.5(3) “a-d” Page 22 - This references case managing clients before they are discharged from the nursing home into the community.

While a client lives in a nursing home, they cannot be enrolled in the Elderly Waiver. The two items [78.37(17)“c” and 90.5(3)“a”-“d”] contradict each other. There would need to be a change in rules and ISIS for case management to be reimbursable. Many elderly people enter a nursing home for less than 60 days to rehabilitate from a surgery or illness. Criteria would need to be set to determine when case management would be appropriate. There could easily be a problem with discharge planners at nursing homes wanting case management to do their duties. There also can be instances of clients wanting to return home and not having this be a realistic expectation. In the end, they might not return home and then case management would not get paid for. (Keleher)

**RESPONSE:** We are working on a process to allow ISIS to authorize payment for the transitional time. We expect that there will be alternate procedure codes that will need to be used for transitional case management. We will provide details on the billing process to all case management agencies when the procedures have been finalized and tested in ISIS.

Due to federal rules on eligibility for HCBS services, transitional case management will be allowed only for members who qualify for targeted case management under the mental retardation, developmental disabilities, and chronic mental illness targeted groups. Transitional case management will not be an allowable service under the brain injury waiver, elderly waiver, or habilitation services.

COMMENT: DHS TCM supports these amendments to the extent that the language is not more restrictive than the revised proposed CMS rule, published at *74 Federal Register 21232, No. 82 (May 6, 2009)* which allows states more flexibility to provide coverage up to 180 days to potential consumers who are transitioning to a community setting by rescinding federal Sec. 440.169(c) and 441.18(a)(8)(viii), for whom TCM services are covered under Sec. 40.169(a). This would entail re-examining Sec. 90.5(3) which defines the transition to a community setting with certain restrictions and requirements.

**RESPONSE:** Transitional case management is currently allowed only for 30 days; these rules will extend this to 60 days. Because the discharge planner at the institution can do much of the transition planning, we feel 60 days is adequate for transitional case management.

## **Documentation**

**COMMENT:** Once the 15 minute billing unit takes effect July 1, which will be our billing documentation; the BUR or the case notes? (Rieck, Bertogli)

**RESPONSE:** The Billable Unit Report (BUR) form is used only for tracking and verification of billable units for cost reporting purposes. It is not to be used as documentation. All existing documentation rules, such as those in 441 IAC 79.3(2), are still applicable as are any other program-specific documentation requirements, such as with waiver services.

Additionally, the BUR is not a required form. Case management providers may use other means of tracking billable units, such as an alternate time-tracking form, or even use a summary of the billable units based on their progress notes documentation.

**COMMENT:** If communication is made via an email correspondence regarding the needs of the member a copy must be printed out and filed in the case file along with documenting the communication content in contact notes in order to verify the time in and out of the service that was communicated via email? (Karminski)

**RESPONSE:** Yes, the written communication must be kept in the case file as well as noted in the progress notes.

**COMMENT:** Also we would like to recommend that IME would address their ways of receiving documentation from TCM agencies and accept scanned documents. Email of items instead of faxing items to IME that generally get lost and do not comply with HIPAA requirements as a fax is the least confidential method of sending information. Scanning documents and sending to IME via email would be an excellent way to do paperless work as well as emailing FASST tools and all other documentation required by IME. Emailing incident reports to the Bureau of Long Term Care would greatly decrease postage costs and staff time, and would be far more secure than fax and the US Postal Service. (Nelson)

**RESPONSE:** Problems with receipt of faxed documents is a known issue that we are working on. We are developing a provider portal as an add-on to ISIS. One of the planned components is a way for providers to send documents to IME securely. The provider portal is tentatively scheduled to go live in September 2009.

**COMMENT:** Providers experience so much accountability and monitoring anymore. A lot of it is good for the members, yet a lot of it results in added indirect costs and inefficient and ineffective waste of tax dollars for both case management and providers. Services documentation does not result in improved services or outcomes to members, it is strictly regulatory compliance and convincing CMS, OIG, and DHS/IME a member is getting a good service by what is written. That is why talking to the member, guardians/family, provider staff, and on site observations are a far more reliable determinant of quality versus looking at paper.

It is reasonable, though, for monitoring to include a review of provider documentation as long as there is an understanding the role is to monitor, not audit. IME should not expect case managers to be auditing provider services documentation. This would result in conflict when we need case managers and providers working cooperatively together for the benefit of the members.

The bigger question I have for IME is this? Does IME's expectations regarding services documentation now far exceed what OIG or CMS requires? Something is wrong when the majority of agency providers still can not comply with these rule with a reasonably high percentage rate of success. Any failure in documentation can result in recoupment on an audit.

I do believe there is nothing wrong with the chapter 79.3 rules the way they are written, rather the problem is the many different views of what rules mean, along with the constantly moving target of what the rules mean. How can the rules be interpreted differently for the various Medicaid services when the way the rule is written is the same for each Medicaid service? At times there is not agreement within IME on the meaning of these rules, ex: different view of how specific to be for location for CDAC versus SCL. (Aberg)

**RESPONSE:** This rule filing does not make any changes to the documentation rules in 441 IAC 79.3(2) for service providers other than case managers, and the only changes to documentation for case managers is to correct the terminology for the comprehensive service plan and to add incident reports to the required items.

Proposed rule 441—90.5(1)“d” allows case managers to review service provider documentation as part of their monitoring activities. IME has always allowed and encouraged this practice, but it has never before been stated in the administrative rules. This review by the case manager is not a billing audit, but is for the purpose of monitoring the provision of services. If in the course of monitoring service provision, case managers become aware of billing irregularities, they should report those to the IME, as is the current practice.

COMMENT: Targeted case managers are currently spending over 80% of their time meeting documentation requirements for various government regulators. This a *system* problem. It is an inefficient system, emphasizing quality documentation over quality services. These onerous regulations are adding to the cost of the Medicaid program and are reducing the ability of case managers to develop relationships with our consumers. Consumers are weary of signing papers and would like to spend more meaningful time with their case managers. Policy makes may or may not be interested in the professional burdens on case managers in their stress levels, moral, job satisfaction, empowerment in effecting change with consumers, and costs in staff turnover, etc. There is also an actual cost in time for the documentation and computer input that may be more compelling.

I do not believe, as some have suggested, that the answer for becoming more efficient is to bring our laptops into our consumer's homes and type while meeting with them. Consumers need a safe space created to share their traumas, their hurts, their fears, their needs and their goals. Case managers need to be attentive and fully present for our consumers, not multitasking. We have systematically been dehumanizing human services. This needs to step. We do not need someone who is experiencing symptoms of paranoia, acute distress from a recent sexual assault, fear about losing their homes, and any number of concerns, wondering what case managers are typing. (McGrane)

COMMENT: As the proposed changes stand, DHS wants to add additional requirements and documentation over and above what the federal government requires. Also, the federal government currently has a moratorium on the rules and it is the federal government that funds the services outlined in Chapter 90. DHS is adding work that is not related to direct consumer service. This additional work will reduce the time we have to provide direct service and instead spend time on paperwork that is unnecessary and duplicative. It will be hard to tell families and consumers that I cannot help them with disability needs because I have to get the required paperwork done. These proposed changes do not take into consideration the changes that will occur when President Obama, and his administration, make their changes (Lauferweiler)

**RESPONSE:** The only additional documentation required by these proposed rules is the completion of incident reports when a major incident occurs during the provision of case management.

Having case managers keep track of their time in 15-minute increments may require more time. However, much of this has been attributed to completion of the Billable Activity Report (BUR). Although IME has offered the BUR as a tool for tracking time, it is not a required form.

If a case management provider has a less-intensive way of tracking billable units, that method can be used rather than the BUR. This could include options such as using a template for progress notes that automatically summarizes contact times from the narrative, using a billing system that can generate a summary report of billable units, or even developing your own time-tracking sheet that would better meet your needs.

Additionally, we have already taken steps to reduce the amount of other paperwork required of case managers. The rules mandate use of a detailed assessment tool; however, we are working to eliminate the use of other assessments that are used for determining level of care for the mental retardation and brain injury waiver programs. This will allow case managers to complete a single, comprehensive assessment that will be used for multiple purposes.

The rules will also eliminate the need for case managers to pre-authorize case management for consumers other than those covered by the Iowa Plan for Behavioral Health. This should help to reduce the amount of time spent on administrative activities.

## **Incident Reports**

COMMENT: This year DHS TCM decided not to oppose (as we did in 2006 in the Chapter 24 amendment) the "major incident" vs "minor incident" definitions and the somewhat speculative causation when a prescription medication error allegedly leads to other major incident outcomes and when it allegedly does not and is, therefore, only a "minor incident." We decided not to oppose this because all of the chapters appear to be moving in the direction of "major incident" vs "minor incident," and we decided it was going to be a "life or death" issue. However, I find it curious that the amendment to Chapter 90 does not include a definition of "minor incident". I suppose it was just an oversight, but if there is a definition and procedure for "major incident," the chapter begs for a definition and procedure for "minor incident." (Perret)

COMMENT: Why would we need to designate "major" vs "minor" when we aren't required to do incident reports for minor incidents? (Curtis)

COMMENT: Item 17, which includes new definitions under section 90.1 for "major incident," "member," "rights restriction," and "targeted case management." DHS TCM supports this amendment. However, there appears to be an error of omission in that there is no definition of "minor incident," which is obviously needed to differentiate from a "major incident" and both major and minor incidents are referred elsewhere in the chapter. For example, 90.8(1)"a"(2)"3" refers to the information which is recorded on an incident report form as: "a description of the incident, including designation of the incident as a major or minor incident." DHS TCM would support inclusion of a definition that is similar to the definition of "minor incident" in other chapters.

**RESPONSE:** The definition of major incident being used for case management is identical to the definition being implemented for HCBS programs through another rule filing. We believe using the same definition provides consistency within the overall service system, which should be more efficient for case managers. We are revising the proposed rules to include the definition of "minor incident."

COMMENT: It makes sense and we are glad to see that the Elderly Waiver Case management incident reporting has been clarified in Chapter 77 although further clarification is needed on when an incident happens and reportable by a case manager. Separate comments have been made to the proposed amendments to Chapter 77. (Keleher)

COMMENT: 90.8(1)a indicates an incident report form must be completed “when a major incident occurs during the provision of TCM services.” However, 90.8(1)a(2), as well as 24.4(5)a and 24.4(5)b(14) indicate one needs to be completed by “who first became aware of the incident.” These two contradict each other. (Curtis)

**RESPONSE:** 441 IAC 90.8(1)“a” requires case managers to complete an incident report when a **major incident** happens during the provision of case management services. This section has been re-written to match the proposed incident reporting rules for HCBS waiver services closely, but the language “who first became aware of the incident” has been removed.

441 IAC 90.8(1)“b” specifies the case manager’s responsibilities when **receiving** an incident report from a service provider. Those do not include additional reporting, but do require the case manager to monitor the situation as to the health, safety, and welfare of the consumer, which is one of the central functions of case management.

COMMENT: Under Major Incident #7, "Results when a member's location is unknown by provider staff who are assigned responsibility for oversight." Is this referencing a 24hr program as we have hourly community living providers that may call case managers because a member misses an appointment is their location technically unknown although members have the right and freedom to come and go as they wish. Is there a time frame for how long the unknown location needs to be for instance if the member's whereabouts are unknown for 24 or 48 hours? What does assigned responsibility for oversight mean, that the provider staff is providing oversight of the housing, or the member's 24 hour care? (Karminski)

COMMENT: How does this requirement apply for staff that are providing hourly home-based habilitation where the member lives in his/her own independent housing and services are provided on an hourly basis (not daily). These services may be provided everyday, or periodically throughout the week, but are not provided 24 hours. Thus, (example) if a member chose to go out of town with family or friends and was not home for several days (and did not communicate this with us, thus missed appointments) would the staff still be required to complete an incident report? (Johnson)

COMMENT: Suggested wording in order to avoid any misunderstandings of what this means: During the course of service provision a member's location is unknown by provider staff who are assigned responsibility for protective oversight.

I understand these rules are for Case Management, yet felt I needed to ask this question. My question is this, now for a member receiving CCO, the member could get lost or the CCO contract personnel not provide protective oversight, and IME would not want to know about this? Why? I really feel the incident report rules on major incidents need to apply to CCO, or what happened at Atalissa, or something bad could happen someday and tarnish CCO. DHS/IME could experience tremendous second guessing and criticism for this. Why would CMS not want to know of deaths in CCO? Why would IME not want to know about any physical injuries that necessitate physician treatment or emergency room care that occur during service provision? Why would IME not want to know about emergency mental health services needed during services provision? How can the Case Manager monitor the member's health and safety without CCO providers needing to at least complete incident reports for major incidents? Would IME want to know if the CCO contract personnel are reporting dependent adult abuse or child abuse regarding the primary caregiver in the home? (Aberg)

COMMENT: 90.1 for Major incidents.....adding a 7th reportable incident. Is this only applicable to 24 hour services? I think it would be difficult to monitor this for hourly members as they are able to be mobile in their community and just because they may not be easily located by staff at their scheduled time, doesn't mean that their location is unknown. If a member is missing, most agencies would contact the police and do an Attempt to Locate and this would be satisfied under #4 for incident reports. (Harrison)

**RESPONSE:** The intent of this language was to apply only to times when the provider is supposed to be working with or supervising the member. In order to clarify this, the language of the rule will be revised as follows:

“7. Involves a member’s location being unknown by provider staff who are assigned protective oversight.

COMMENT: Does the Bureau of Long Term Care need to have an additional copy of an incident report that is generated from TCM? This incident as history shows would be a call from a family member stating the member was home for the weekend and went to the ER for a cut, headache, cold, ECT. We do not see the need for these incident reports to be sent to the Bureau of Long Term Care, there are instances where adult members live in the parental home and get ill, the family is certainly not going to complete an incident report so days later they call the Case Manager and tell them they took the person to the doctor, ER, etc. for the flu or some other ailment. We believe good judgment needs to prevail in the constant sending of incident reports for minor events, unless the issue constitutes an incident report. (Nelson)

COMMENT: I question the appropriateness of sending private consumer information to the Bureau of Long-Term Care unless there is a specific purpose. The incident reports are already kept on file for reviewers to audit. This would appear to be an additional task without any real benefit. (Kuehl)

**RESPONSE:** Case managers are required to submit incident reports to the Bureau of Long Term Care only when a **major incident** happens during the provision of **case management** services. Incidents occurring when a service provider is attending to the individual will be reported by that service provider.

Incidents are reported to the Bureau because we are responsible for monitoring consumer health and safety on a system-wide level. The Bureau collects this data and analyzes it for trends that could indicate a need for more training or quality assurance activity. The Bureau also coordinates with other parts of the Department and with other agencies, such as the Department of Inspections and Appeals, to ensure that follow-up is occurring for any health and safety issues.

COMMENT: Re: Changes in the requirements to report major incidents to case manager, guardian and the Bureau of Long-Term Care within 24 hours: We provide services 7 days per week, in member's home. While working in the field, provider staff do not always have access to a copy or fax machine. It is a hardship to expect a report to be filed within 24 hours. Supervisors are already notified within 24 hours. A 72 hour requirement for the Case Manager and Bureau is more reasonable. Case Managers are not available to be notified on weekends, and their offices are only open monday - friday anyway (Johnson)

COMMENT: 90.8(3) 2. Send a copy of the report to BLTC within 24 hours of the incident. Language in other chapters identify that a copy of the report is sent to BLTC within 72 hours of the incident. Also, are Waivers still sent to BLTC and Habilitation are sent to IME? Are you requiring that minor incident reports be sent as well? This has not been the standard. (3)c. states that a re-evaluation of risks factors in the risk assessment is done based on a major incident report being completed.....would this be done through documentation in progress notes or does it mean that you would complete another assessment. (Harrison)

**RESPONSE:** It is important that major incidents be reported as promptly as possible, but because 24 hours may not always be possible, we are changing the language to allow until the end of the calendar day following the incident. This rule applies only to major incidents that occur during the provision of case management services; major incidents occurring under a service provider's care will be reported by that provider. Case managers do not need to report minor incidents.

COMMENT: Under the incident report changes it states that an Adult Protective report is an incident reportable to the client, the legal representative and others. What if the client themselves or the legal representative is the focus of that Adult Protective report? This could compromise the case managers ability to effectively advocate in the clients' best interest and destroy the anonymity of the reporting process. (Rieck, Bertogli)

**RESPONSE:** We believe that this should not be an issue, since the member or guardian would be informed of the adult protective report independently of the incident report. However, if at any time a case manager believes that complying with this requirement could endanger a member, the case manager should request an exception to policy to ask for an exemption in that case. The case manager may delay sending the incident report pending a decision on the exception to policy.

COMMENT: We oppose 90.8(1) 4 letter c "When any major incident occurs, the Case Manager shall re-evaluate the risk factors identified in the risk assessment portion of the comprehensive plan as required in paragraph 90.5 (1) "a" in order to ensure the continued health, safety, and welfare of the member. We receive numerous incident reports and after having to record every second of our day with the 15 minute billable requirement, we should be out ensuring a members health and safety and not tied to a computer completing another form. (Nelson)

COMMENT: We have some consumers who have major incident reports on a weekly basis. This is being addressed but with the new rule, would this require reevaluating the risk assessment each time and developing new plans. What does that, mean to reevaluate- My definition would be to make changes in order that the problem does not occur. I know for one individual who has factious disorder- he goes to the hospital or has a major incident weekly. This is being addressed but is limiting due to not being able to restrict the individual. (McKeag-Hall)

COMMENT: When any major incident occurs, we have to re-do the risk assessment? For some people, this will need to be redone on a weekly (sometimes daily) basis, which is not eve feasible. (Curtis)

COMMENT: We have concerns about the requirements for risk assessments needing to be completed after major incident reports. There are situations where a member with a medical condition may have multiple major incident reports but the risk factors and crisis intervention plan would not change as this is an on going condition. We are always concerned with redundancy in our work. (Anderson-Noel)

**RESPONSE:** The rule does not require that the risk assessment form be completed every time a major incident occurs. It does require the case manager to **re-evaluate** the risk factors that have already been identified. This re-evaluation could result in changes to the assessment and the service plan or crisis intervention plan, but it is also possible that no changes would result. The case manager should document in the consumer's progress notes when the plan is re-evaluated.

## **24-Hour On-Call System: Utility**

COMMENT: My other big concern is the emergency coverage portion – where a Case Manager can be accessed 24 hours a day, 7 days a week. This would become a direct service which Case Managers are not allowed to do. It would duplicate services – the client has a Crisis Plan which includes phone numbers, access to service providers who can do direct service. Clients may abuse being able to contact Case Managers anytime of the night and day – instead of calling service provider, they could call Case Manager and provider is not aware of situation. The Case Manager would then contact Service Providers. The Crisis Plan would identify to call Service Providers. (Woodward)

COMMENT: We have concerns about this in that our role as case managers is to foster independence and community integration for our clients. This rule would encourage the client to contact a case manager instead of the appropriate emergency response persons. Our clients all have emergency plans that identify who they contact in what emergency and this rule circumvents the implementation of these plans. For true emergencies we are concerned that this could delay needed fire, ambulance and law enforcement because the client would call us and then we would call 911 for the client.

The Department of Human Services has yet to identify what type of emergency that a case manager would be required to respond too. By federal and state rule, case managers cannot provide direct services, we only coordinate services. DHS has stated that maybe a client needs a ride to the store on the weekend. We are unsure of how this would be an emergency that we would meet. We give the clients the contact information for the transit and we have no other contact information. This is the only example that they could come up with when questioned.

... neither of my case managers is a mental health counselor, psychologist, psychiatrist, or licensed independent social worker. They are not a medical doctor, pharmacist, nurse, law enforcement officer, fire fighter or other emergency response professional. The rules do not require this. They cannot provide direct service such as transportation, socialization, supported community living, day habilitation, supported employment, medication management, or residential services. (R. Wood, Mckee, Moberly)

COMMENT: This is clearly a direct service which is something that case managers are not allowed to do. Each consumer has a crisis plan that is developed with their interdisciplinary care team to assist them in crisis situations. These plans contain phone numbers to 24 hour crisis lines and hospital phone numbers if necessary. Consumers also typically have a crisis plan which they have developed with their provider and most providers have a 24 hour on call system in place to address issues when they occur outside of normal business hours. Therefore I do not see a need for a duplication of these services that are already being provided in the community in which the consumer resides. (Rewerts, Riedel, Redies, Moberly, Metzger, Merz, Van Horn, Long)

COMMENT: 90.8(2) This section requires a provider to have an “on-call system” such that consumers can access a case manager 24 hours per day seven days per week including holidays. It is unclear why a case manager would need to be available in all cases to members, especially those served by supported community living providers, on a 24/7 basis. Most crisis plans (which are required by these rules) identify the people the member can contact in case of emergencies, and it is usually the SCL provider for the first level. Case managers are prohibited by these rules from providing a direct service such as transporting somebody to the hospital or even providing crisis counseling; so it is not clear why they need to have an “on-call system”. Our providers know how to contact case managers and case management supervisors during off hours if there are programming decisions that need to be made overnight. (C. Wood)

COMMENT: We strongly disagree with the emergency coverage requirement. The requirement calls for an on-call system available 24 hours a day including weekends and holidays. Case Management is not a direct service provider. It is unrealistic to assume that a case manager would have access to respond to emergency situations during non-office hours. They could not make contact with the funder during this time and service changes which might be requested are not available at a moments notice because they do require planning and coordination. Case Managers are coordinating with direct service providers who are already operating under a current crisis plan developed by the interdisciplinary team which promotes independence versus the dependence that would be created by requiring a case manager to be available for every perceived emergency 24 hours a day. (Watson)

COMMENT: I am concerned that individual will automatically call their case managers instead of following their detailed crisis plan, which could cause two events to occur: The first being frustration to the consumer who is in crisis when their case manager is not the person who answers the call. Every individual served has a provider who is paid to be on call and is one of the first people to call in the event of a crisis or emergency. The provider is a person who they are used to talking to and feel comfortable with. The other concern is that it could more easily lead to direct care occurring from case management which is against the federal rules and regulations of CMS. (Waters)

COMMENT: ... We spend a lot of time with interdisciplinary teams developing very thorough crisis plans. I'm not sure where we would "fit" in this crisis plan, as we are not allowed to do "direct service." If section 90.8(2) remains in as written, I think a very clear line needs to be developed on what the expectations are, so we do not cross over this line and be cited the next time we have our Ch 24 survey. I would encourage the Department to reconsider and remove [this provision] (Spilde)

COMMENT: am not sure what type of service or benefit the client would receive to have a case manager on call. Case Managers are not to provide direct services and if I were called, I would simply refer them else where or inform them that they would need to wait until the next working day (depending of the situation). In the example provided it suggests transportation arrangements. In our rural county ..., the transportation options are limited. All of the agencies we work with are not available over the weekend and holidays. (Smith)

COMMENT: A provider of case management shall have an on-call system to assure that in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays." This is clearly a direct service which is something that case managers are not allowed to do. Each team already develops a safety/crisis plan with the consumer and these safety/crisis plans contain phone numbers to 24 hour crisis lines, 24 hour on call numbers for providers, and hospital phone numbers if necessary. Currently as a case manager I do not have the capability to provide emergency funding for services or to get emergency court orders for placements. Our abilities to assist in crisis situations are very limited and would simply be a duplication of services that are already being offered. (Riedel)

COMMENT: Case management was not intended to be an emergency response for our clients. We are not allowed to provide direct services...This is the provider's role; they are with clients on a more frequent basis. For smaller agencies like ours the requirement of having an on-call person 24-7 will be expensive. With our main office located in the ...courthouse with the county jail, we don't have easy access...on evenings and weekends when the courthouse is closed. All emergency situations are covered in our emergency plan. (Richey, Brown)

COMMENT: This change is unnecessary. As part of each of our consumers crisis plans, there are both natural and professional supports noted that will assist a consumer with a crisis. All providers that I am aware of, have their own 24-hour lines, and can provide billable direct care to the client who is in a crisis situation. Case managers are not allowed to provide direct care to the consumers with whom we work. If a provider is not available, we have various 24-hour crisis lines that a person can access.

For example, the Richmond Center in Story County has a 24-hour crisis line with trained therapists ready to assist and de-escalate if this is necessary. If such a service is unavailable in smaller counties, there are federally funded hotlines such as the suicide prevention lifeline for our consumers who are having thoughts of self-harm. In cases in which a case management agency feels that an on-call network is necessary, the agency should be left to choose whether or not establishing an on-call network is beneficial or necessary. This choice, however, should be based on the individual needs of each case management agency and their consumers; not applied unnecessarily across the board. (Reich)

COMMENT: Emergency coverage shouldn't be provided by Case Management. In developing the crisis plan with "members", Case Managers should discuss and list who should be contacted in an emergency such as the provider, natural supports, agencies in the community (hospital, mental health centers, etc...). Emergency coverage is inconsistent with the rule that Case Managers don't provide direct service to the "member"

There is the continual mention that Case Management does not include the provision of direct service, which takes us to strong opposition of to the emergency provisions of Case Managers being on call 24 hours a day, 7 days a week including holidays and weekends. Currently there are far too many paperwork demands, far too many time constraints, and far too many regulations that have nothing to do with taking care of our members and nothing to do with providing good Case Management services. Such as huge caseloads, and now you want TCM's to be on call. We are not allowed, by law, to provide direct service. All members have access to 24 hour help lines, providers, police, sheriff (911), friends, family, and a crisis plan. (Nelson)

COMMENT: Also, as a case manager in a 24 hour crisis line situation, what do you propose that we "do" for the consumer? We cannot drive them anywhere, we cannot authorize funding for them in the middle of the night, we cannot go to their home to provide counseling, and so what is our role? Are we not going to undermine their relationship with their direct care providers? It has been discussed among case managers that our role will be to refer them to the hospital, call the police for a well-check, or refer them back to their direct care provider. This will be a PAID duplication of services as most direct care providers already provide on-call services or there are hotlines for other needs. (Metzger)

COMMENT: I feel that it is not necessary for case managers to be on call 24 hours a day. I believe that if contacted in the middle of the night that a case manager is all but helpless. With all other offices closed until normal business hours the next day the managers can not assist. Please reconsider this mandate. (Manternach)

COMMENT: The proposed new requirement to have a case manager on call 24 hours every day including weekends and holidays does not seem to be necessary. In fact, there are very few emergencies and these have been planned for in their own emergency plans. The case worker cannot solve the emergency, they can only make arrangements for the care. (Luhman)

COMMENT: The majority, if not all of the consumers are already involved with therapy services or other providers who already have on-call services available for the consumers in the event of an emergency. Such emergency calls are more appropriate for provider services than for case managers, in my opinion. (Kuehl)

COMMENT: Case managers are not allowed to provide a direct service. Therefore, the only emergency coverage that a Case manager could offer would be to make additional referrals to other emergency services available. This information is already contained in the Crisis plan that the member and providers receive with their service plan and that they assist in developing. The Case manager is not capable of providing emergency funding for services or to get emergency court orders for placements. Providers generally have an on call system in place and this information is also included in the crisis plan.

Our abilities to assist in Crisis situations are very limited and would simply be a duplication of services that are already being offered. I understand the desire that this rule is based in but it would be better served to make the Crisis plan rule more specific in nature and make these plans much more user friendly. Because with a well developed Crisis plan a member or provider would already have tried all options short of hospitalization or police intervention. In which a Major Incident would have occurred and the Team would revisit the plan and readdress issues that occurred. (Koehler)

COMMENT: Each member yearly, and when a significant change has occurred with their residency/and/or services, has an updated emergency/crisis plan set up with them to assist them in the event of a fire, tornado, medical, mental health, or any other stated emergency in the plan. This plan includes service providers, medical and psychiatric professionals, names and phone numbers that the member is able to, and is familiar with accessing in the event of a crisis. Case Management is prohibited from being a "direct care" provider, which the implementation of this rule would clearly violate. The member has access to their "direct care" provider(s) through the implementation of the emergency/crisis plan that Case Management does with the client at least yearly.

I cannot find discussion in the federal regulations that indicates Case Management is supposed to provide 24-hour coverage to their members. It seems to me this is a regulation that the state wants to implement without any warrant from federal regulations. (Knight; similar comments submitted by Hythecker, Huennekens)

COMMENT: Rules do not allow case managers to provide direct service, so what could the case manager do in the event of an emergency? Current case management rules require a crisis plan for each consumer be in place to address who to call and/or what to do in the case of emergencies. These crisis plans are individualized and are contained in each consumer's service plan. Consumers and their providers know these plans and invoke them in the event of an emergency. Continuing this practice of utilizing the individualized crisis plans already in place makes sense and should be retained. I fear that adding a rule to contact a case manager will only slow down the response to a consumer's emergency and add an additional layer of phone calls to the process. (Ketcham)

COMMENT: We fully recommend omitting Elderly Waiver Case Management in regards to requirement of a 24/7 emergency on-call system. Case management is not an emergency service and emergency services should be considered a direct service. While the case manager should be notified if an emergency has occurred following the incident reporting guidelines, the client or their informal supports follow their care plan, specifically the crisis/emergency plan where persons are listed that should be notified in the event of an emergency or need for help, or call 911. Provider agencies do not take referrals in the middle of the night, and will not take a referral without a Notice of Decision. Most have an intake process before they can start services.

The emergency plan that the case manager completes with the client is supposed to be used by the client in the case of an emergency. Having case management providers also provide an emergency system is a duplication of service for active case management clients that have a crisis/emergency plan. There is no provision for direct reimbursement of emergency services for consumers who are or are not enrolled in the Elderly Waiver. The potential for call from persons not enrolled in the Waiver is high. This provision will undoubtedly drive the indirect cost to provide case management up considerably. In a time of economic downturn and budget cuts, this standard should be eliminated. (Keleher)

COMMENT: In an event of an emergency why does it seem that having access to a case manager would be a need? Case managers complete crisis plans that include emergency plans and many agencies involved or communities have emergency systems set up in place to address those needs such as crisis lines or 211, seems like a duplication of services? Why couldn't a case management agency collaborate with an on call emergency system, what is the need to have the on call person be a "case manager"? (Karminski)

COMMENT: In regards to having an on-call system with case management providers, when the team meets this is discussed and a crisis plan is put in place with the service provider being the contact as they provide direct services to the client. The case manager is contacted by the service provider when there is a major incident or when needed and the case manager provides guidance and changes in the plan as needed. Case managers cannot provide direct service to clients and having them on-call is only delaying the service needed by the client. The crisis plan is discussed in depth and steps of what should be done and who should be contacted are written on the Individual Comprehensive Plan. Many service providers have on-call administrative staff for the crisis situation and will consult with the case manager if needed.

Case managers strive to do their best in planning for a crisis for any client and are available for service providers and the client to contact for guidance. Case managers and the service providers many times are able to work together and know when a client may have a crisis and have set up steps in order for the client to remain safe and in the least restrictive environment. We are aware of our clients' needs and plan for crisis situations so that if and when a crisis occurs those steps are already in place and the client and service provider know what should and needs to be done and will follow through with those steps. (Heitland)

COMMENT: I am confused as to how Case Managers being on call 24 hours per day 7 days per week 365 days per year will be a safety or security "net" to the people we serve. Case Managers are not allowed to perform direct service. In a small county such as Bremer, we do not have many of the services that are available in large metropolitan areas, such as transportation, especially on the weekends or even outside of "normal" business hours.

Every consumer has some other service; almost always that service is Supported Community Living. That SCL staff would be the person called in an emergency situation. That provider has the ability to provide direct care, and is paid through the county and state to provide that service. I am having difficulty understanding how a Case Manager being available to an individual on an on-call basis will benefit that person without causing them great confusion and frustration. If I could have some examples of how this would be utilized, especially in rural counties, perhaps I would not be as confused. (Heidemann)

COMMENT: Under the Service Plan for crisis intervention, it is made extremely clear that a very detailed plan is created for the member to follow in the event of an emergency/crisis. If this plan is followed, then the need for a case manager to be accessible 24 hours per day, including weekends and holidays is redundant. Case Managers will unlikely be able to coordinate any service for a member after 5 pm or on weekends or holidays due to providers of service not being available at these times. (Harrison)

COMMENT: It is unclear to me what the purpose of having access to a case manager 24/7 is; Case Management cannot provide direct service, therefore what could the case manager do in the event of an emergency except to add another layer of phone calls to address the emergency. We already provide a crisis plan in the service plan that addresses this. It seems to make much more sense to have a crisis plan to address this, so that the member is aware of what to do to address the emergency, not to add another layer of phone calls to perhaps delay the response to the emergency. (Eckerman Slack)

COMMENT: Case managers are not direct service providers. This is why we write a crisis plan with our consumers. This is why we link our consumers with provider agencies. We already have arrangements ' plans made to deal with issues that may arise during "non-business" hours. Anything that is not an emergency should be able to wait until the next working day. (Curtis)

COMMENT: At their annual ICP meeting (or more often as circumstances change), Case Management includes in the plan a very detailed and comprehensive Emergency/Crisis Plan that includes what the member would do in the event of a tornado, in the event of a fire, in the event of a medical emergency and in the event of a mental health emergency.

Natural supports are listed (name and phone number), coping skills, symptomatology (what symptoms they experience, what the triggers are for each symptom and what their coping skills are for those symptoms), medical personnel names and phone numbers, therapist/psychiatrist/psychiatric nurse name and phone numbers, provider name and phone number, as well as after hour phone numbers for these contacts.

Case Management is not a direct care service. That is what the providers of the actual Habilitation and Waiver services do. All the Case Manager would do would be to tell the member to call their direct care provider, which they already know. They receive a copy of this Emergency/Crisis Plan and the intent of this was that it is something they can have at home to refer to with all of their emergency contacts/information on one sheet.

All direct care providers have staff availability 24 hours/day, including weekends and holidays. Having Case Management also do this would be a duplication of service and in my mind, a waste of money. I believe it would also lead to confusion for the members when they have become accustomed to the current protocol. In addition, federal regulations do not indicate that Case Management is required to provide 24-hour on-call coverage, so I'm questioning how and why the State would consider implementing this. (Crosthwaite)

COMMENT: currently understand the role of the case manager to be one of coordinating, monitoring, referring and advocating for the individuals we work with. It is also our job to assure their safety and health in their daily lives. This is done by us by communicating to the provider they have, monitoring their services, and developing with them a crisis plan for them to access services they would need. This crisis plan already includes staff/providers/agencies that have 24 hour support services in place.

If a case manager has completed the crisis planning sufficiently, the individuals do not need us when we are not in the office. I am unsure what case management would be able to do when receiving calls from individuals other than refer them back to their provider. I live in a rural community that offers minimal services and would not have access to services during non working hours either. At that time I would access in case of an emergency, ambulances and sheriff just as is discussed in most crisis plans. (Crooks)

COMMENT: The rules prohibit any type of direct service from being provided. Case managers currently develop an extensive crisis plan that is distributed to all team members. We do not have the training to assist consumers in an actual crisis. There are other community entities, including the local emergency rooms and community mental health centers to assist in an emergency situation. (Richie, Bruce, Carlson, Shull)

COMMENT: I understand that case management services are intended to meet the member's needs in order to ensure the health, safety, and welfare of the member. I feel that the crisis intervention plan ensures that, without having an on-call system for case managers.

The description of the crisis intervention plan, 90.5(1)b(5), states that the plan identify the supports available to the member in an emergency. It goes on to state in **90.5(1)b(5)1**, that the plan shall identify "any health and safety issues applicable . . ." and in 90.5(1)b(5)2 "an emergency backup support and crisis response system, including emergency backup staff designated by providers . . .when support services are interrupted or delayed or the member's needs change".

If the crisis intervention plan addresses these necessary issues, it seems to me that should be sufficient to ensure the health, safety and welfare of the member. Therefore, there would not be a need to have yet another level of emergency coverage by a case management agency. As we all are aware, the case management agency is not to provide any direct service, so it would seem to me that the provider agency is one of the logical resources in the event of an emergency, in addition to the other emergency responses available in all communities (ie: fire, police, ambulance). (Bopes)

COMMENT: ” This requirement is problematic in that targeted case managers “monitor” services but are not allowed to provide direct service. (Artley, Shaw, Juetten, Wollum, Guard, Cory)

COMMENT: We would like to see clarification regarding the role of the case manager with regard to being on call 24/7. Since case managers do not provide direct services what would the requirements be for a case manager to respond to an emergency? Most members currently contact a provider, family member or emergency system (police, ambulance, fire department). (Anderson-Noel)

COMMENT: While our agency currently provides on-call assistance 24 hours per day, I believe that this section requires clarification. Case Management is unable to provider direct services. Crisis intervention is specifically listed as a prohibited service under the 1996 DHS memo describing Targeted Case Management. While the case management agency may provider triage or contact other providers, they can not be the “first line” in crisis situations. I believe clarification of the intent for emergency coverage is warranted. (Ahrens)

COMMENT: Now not all providers have on call systems to respond to emergencies, depending on the type and nature of the HCBS waiver, remedial, or HCBS Habilitation service provided. Opportunity Village has on call systems for nights and weekends for SCL daily and HBH daily sites, SCL hourly and HBH hourly when a member resides in an apartment in a community where we have an office, and for community employment. Generally, members who reside in homes that provide supervision and structure are dependent adults. The priority for our emergency services must be for those SCL and HBH daily rate settings where members need supervision and structure, and to respond to emergencies with adults we serve on SCL and HBH hourly services who reside in apartments in communities where we have an office.

Opportunity Village does not have emergency on call systems for hourly SCL for children, in home respite services, and SCL for adults when they reside in their own home. We provide services in the actual personal homes of about 120 children and adults throughout North Central Iowa. In those cases, this is really no difference with service provision and philosophy from Consumer Choice Option, if you think about it. In these cases the parents, family members, and spouses provide emergency natural supports. These personal homes are dispersed in about 26 different small communities in 12 North Central Iowa counties, with many personal homes in very rural settings. In this case if a staff can not work we may not be able to have a staff work with the member. The focus of our services provision and emergency supports must be with dependent adults and adults who reside in apartments in the communities where we have an office. (Aberg)

COMMENT: The proposed rule 90.8(2) requires a provider of case management to 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. Currently, this is not a requirement. What is required is that each person have a crisis plan that addresses a plan of action for a variety of crisis situations. Case Managers cannot provide direct service. It seems bizarre to have a case management agency provide a 24/7 on call system when they cannot physically provide any service. What the case manager will be able to do is call another person/agency to physically work with the person. This should not be adopted. It will increase the cost of case management services. (Blair)

COMMENT: The 24/7. I think bottom line is – 1. We’re not a direct service 2. The cost of it is going to incur both the county and the provider of the 24 hour service.

I agree with what Deb stated. I was thinking about that earlier today in terms of the 15 minute billing. Typically the entities that are doing 15 minute billing are those that provide direct services. If you don’t provide a direct service, I am curious as to why we would break it down that much. This is the only service we provide and we break it down for a cost report, I think the overall results federally, the Iowa paybacks were much better than other states nationwide, and so that should mean something for us, that we are doing some good things already. I would like to say that it is going to be a lot of additional work for case

managers; but they are starting used to it now, having done test runs, but it's a lot of extra attention to the paperwork and the time it going to take away from the clients. (Murphy)

**RESPONSE:** These rules increase the role and responsibilities of case managers to strengthen the safety net for Iowans with disabilities and reduce fragmentation in our system. Just as society's thinking about who can live in the community has changed over the last 10 years, so has our collective expectations of the quality, safety, and necessary requirements for the key features of the systems that support elderly and disabled persons in the community. These rules represent the evolution of the role of case managers in our system.

There are three key developments within the last two years that show how the community standard is evolving in similar directions, but from different sources and which have come together in the form of these rules. We have developed these rules with communication and input from providers and stakeholders, to respond to the needs for system improvement identified by these three developments.

1. Federal regulations. There are new federal regulations from CMS that are much more prescriptive of the role of the case manager. These regulations increase the requirements for the assessment. States must ensure that the assessment is comprehensive, which necessarily includes assessing risks to the individual's health, safety, and welfare. The regulations also increase the requirements for the service plan to clearly identify goals to address the needs for medical, social, educational, housing, transportation, vocational, or other services and clarify responsibilities for monitoring the individual's progress and the provision of services.
2. U.S. Department of Justice. As part of its investigation into civil rights issues at the state resource centers, the Department of Justice (DOJ) has assessed community services available for persons leaving the resource centers. A report from the DOJ's independent consultant described the fragmented nature of services in the Iowa system. While most of these rule changes center on the federal compliance, the rules also address the weaknesses identified by DOJ. These rules were presented as part of Iowa's compliance with the consent decree and were favorably received.
3. Governor's Dependent Adult Abuse Task Force. For the Dependent Adult Abuse Task Force, DHS evaluated current systems in place for protecting vulnerable populations, including case management services, and further identified the critical nature of case management in protecting vulnerable populations. These rule amendments are part of DHS's plan to the Task Force.

The key point for both the DOJ and the Task Force is the recognition of the role that case management plays as the key connection point in Iowa's service and protective system, assuring that all of the linkages happen and the services get delivered as expected. The case manager truly is the 'frontline' that holds Iowa's system together. Case managers are in contact with consumers, families and guardians, service providers, schools, employers, doctors and other professionals. They are the essential piece that holds all of the others together, and as such, they are in the best position to assist the consumer when others cannot.

The comments indicate that this language has been interpreted to be much more burdensome than intended. The rule requires the provider to have a 'system' in place, so that there is a 24-hour number that can be accessed by the consumer or family in the case of an emergency.

This is not to replace other emergency services such as 911, crisis intervention lines, or emergency services from provider agencies. In fact, case management should never be the first option in a consumer's crisis intervention plan. This is simply a number to call to get in touch with the case management agency if all of the other options in the crisis plan fail. This doesn't happen very often, but sometimes things fall apart, and having a 24-hour phone number and way to get in touch with the case management agency is important in those relatively rare instances.

With the increasing number of consumers who are served by individual providers rather than provider agencies, it is increasingly important for the consumer to have access to someone who can arrange services if the provider fails to show up. The case manager would never be expected to provide direct service, but rather would be expected to arrange and coordinate services to make sure the individual is safe. We believe this is an important part of the safety net for members. We are adding language to the proposed rules to clarify these expectations.

## **24-Hour On-Call System: Effect**

COMMENT: I was a case manager when we carried beepers in the past and although we had originally thought it to be a good idea, with time; it turned out to be problematic. In the end my county got rid of the system for good reason.

1. Consumers were confused and called their case managers instead of providers (or worse yet a consumer would call us when they should call 911). Since then our personal plans have gone to great detail to list who a disabled person (even when in 24-hour care); the plan indicates who the client is to call first; second, third etc. This pushes the responsibility on training through the provider (the actual trainer and direct service worker) to actually do the direct service (training or support as laid out in the plan).
2. Providers “slacked” as they viewed case management as able to “cover for the provider”; when providers were understaffed or responded inappropriately to a given emergency....Ca
3. It “Muddied the waters” between the work of case management and direct care. With current Iowa law, the provider carries the responsibility of the needed direct service worker and we should introduce no grey areas tied to case management that may “Muddy up” these waters, when concerning matters of emergency. There really wasn’t anything (when situations arose) that could not wait until the next business day.
4. Case Management cannot be a “direct care” provider...I know now the importance of having 3rd party case management to “Oversee”; and not become “part of the care”. Outside of “all the planning” we do first with the consumer, second with the consumer providers and family and other caregivers. There is an “Unspoken arm” of case management relying on judgment, experience and the use of second hand information to help with decision-making problem solving and recognizing manipulation. When we were carrying beepers (or I heard some places may get answering services) this lent to manipulation by introducing a 3rd party “Too early” in the care of the person.
5. If the feds aren’t requiring we do this, then I vote against it as well ... I also update my emergency plan whenever anything significant changes in the clients life as needed anyway; however I still expect the provider to follow through with the written plan and hold them accountable when they don’t. Case Management is not 24-hour service and should not be in the future. (Cost will only go up and we don’t need that.
6. The system we now have lends it self to keeping experienced people. Not working on weekends or carrying beepers allows staff to have “away time”, which is therapeutic and helps with staff retention. We need experienced case managers to eloquently assert themselves and direct the team without encumbering “the burn out” which will destabilize case managers like it destabilizes providers. Some one needs to be “whole and together” while at the table and when away. Someone needs to direct in a proactive manner without being on “the call list”. This is why case managers have not done direct services in Iowa and why we are more effective than if you “too close” to the situation. (Wulf)

COMMENT: Having access to Case Manager 24/7 would not encourage clients to work with providers, natural supports, nor help them with becoming more independent – it could foster a dependency to call a Case Manager and could cause some friction between Case Management and Service Providers/Natural Supports. Another big problem I see with this is that whoever has the duty during those non working hours

probably does not work with the client and would not be aware of all the issues the client has. It would take time to research the client and help make a good decision whereas the Service Provider would be aware of the clients needs/wants and can resolve the issue much more quickly and safely. (Woodward)

COMMENT: The whole premise behind providing case management to individuals is that they will eventually develop the skills necessary to do things on their own and to encourage them to be more independent. This type of 24 hour system does not encourage someone to use or develop their natural supports but instead fosters dependence on their current level of service involvement. (Riedel)

COMMENT: There is also concern that consumers will abuse the ability to speak with a case manager 24 hours a day as many of our consumers lack boundaries and thus the time spent with them on the phone will be more conversational in nature than crisis oriented. The whole premise behind providing case management to individuals is that they will eventually develop the skills necessary to do things on their own and to encourage them to be more independent. This type of 24 hour system does not encourage someone to use or develop their natural supports but instead fosters dependence on their current level of service involvement. (Rewerts, Redies, Moberly, Merz, Van Horn, Long)

COMMENT: The so called normal citizen doesn't have an on call person in their lives, things happen, if we want members to live independently than we teach them skills to do so! We will not support this idea in any form for Case Management. As mentioned in Rule b on the top of page 7 "the consumer is to take risks that are a typical part of life." (Nelson)

COMMENT: Case Managers do not provide direct service to members on their case load and this appears as though it would be a direct service provision. While some members would perhaps never utilize this service, others would take great advantage and inundate their case manager with inappropriate calls. We are striving for these members to be as independent in their community as possible, not creating dependency.

Case Managers would also need to create and carry a reference "binder" that contains each members cover sheet, current medication list, crisis plan and on-call numbers for provider agencies. They would also need to have incident reports in this "binder." This "binder" would need to be carried and protected by each case manager who would be responsible for being on-call daily. The information contained in this "binder" should be the most current available, but with the ever changing needs of members, may not be. This factor alone could make it extremely difficult for a case manager who is not familiar with the member to act appropriately. (Harrison)

COMMENT: They are asking us to take "advocacy" out of our scope of things that we do for our clients. They are asking us to include, "ensuring health, safety and welfare", but yet we are not to be considered direct care staff, which is confusing in and of itself when there is also a suggestion that case managers be put "on call" so there is access to us 24-hours a day. As part of our current duties we are required to follow up on incident reports and hospitalizations. Now, there is talk of a requirement for case managers to be on-call. I can tell you that our office is considered a small office and I still do not know all of the clients that we serve.

Another problem would be the fact that we have no access to funding, as it is done and approved through the CPC office, so I really do not see what the benefit of on-call case managers would be. The other point is that the provider's (direct care staff) is the individuals that are paid to monitor and work through major incidents and crisis. In my own opinion, I would think that 24-hour on call case management would be a duplication and an unnecessary use of funds. (Crawford)

COMMENT: Cost aside, the case manager has the responsibility of making sure that the client has an emergency plan in place. Are we confusing that client in regards to their individual emergency plan by giving them the case manager as an alternative choice to call for emergency. The concern is that the client

will tend to keep a single plan in mind and if they already see the case manager as the go to person, will they call them first in an emergency and possibly waste precious time getting to the provider that is actually going to respond. (Rieck, Bertogli)

COMMENT: Current program process requires the development of an individualized “crisis plan” for each consumer. Adding another entity to the mix (the case manager) would merely add confusion to the consumer’s situation when attempting to handle an emergency. (Artley, Shaw, Juetten, Wollum, Guard, Cory)

**RESPONSE:** The requirement for emergency on-call coverage centers on ensuring the health, safety and welfare of consumers. Although it is not required under the federal regulations for case management, it is part of the Department's efforts to provide assurance to the Department of Justice that there are system-wide protections in place for consumers. We believe this is an important part of the safety net for members.

The purpose of providing 24-hour on-call coverage is not to replace other crisis services such as 911 or provider-run emergency services. The intent is that the case manager will be the “back-up plan for the back-up plan” and should be accessed only when the other options in the crisis plan fail. We believe that all of the objections raised in these comments can be dealt with in the way that case management agencies implement their on-call system.

- Concerns about fostering dependency, confusing consumers, and having consumers take advantage of the on-call number: Providing access to a case manager only when it is appropriate should alleviate these concerns. Writing good crisis intervention plans will be a key factor in making this process work. Crisis plans should make it clear to the consumer what resources to use in certain situations and how to contact each resource. Plans should specify when it is appropriate to contact the case management on-call system.

Additionally, case management agencies can take measures to screen calls in order to screen out non-emergency calls that can wait until regular business hours or to divert calls to other resources when appropriate.

- Concerns about providing direct service: The intent of this rule is not that case managers would provide direct service in the event of an emergency. The case management agency would perform only case management activities to deal with the situation. This would typically involve assessing the situation and making contacts to providers or other appropriate resources to resolve the situation.
- Unfamiliarity with other consumers: There are a variety of ways an on-call case manager could access information on consumers. Carrying an on-call notebook, accessing the information through a secure website, or carrying an encrypted laptop or PDA with basic summaries for each consumer would be reasonable.

### **24-Hour On-Call System: Cost**

COMMENT: Funding is another issue. During these times of big budget cuts, compensation would be a problem for all the extra hours. Service Providers are already being paid for these services (direct services) and paying another layer for Case Managers during these times is not cost effective. Case Managers could end up going through the burn out phase that would lead to turnovers in personnel, costs in hiring/training new Case Managers. This is probably the worst idea I have heard in my 12 years as a Case Manager. (Woodward)

COMMENT: ... there would be a substantial cost to implement this. Currently our case managers are paid on an hourly basis. Requiring them to cover nights, weekends and holidays would require us to compensate them under FLSA. And, as a small agency with only two case managers, it would require my case managers to be on call every other week. This seems onerous at best. (R. Wood, Mckee)

COMMENT:...to assign staff to be "on-call", or to hire an agency to field calls, would add to the cost of providing service. The additional cost would not be billable and would be one of those items that push us over the 20% limit of indirect administration. I recommend deleting this section. (C. Wood)

COMMENT: The cost associated with any on-call system is going to increase the cost of case management services further increasing the cost to Medicaid and the non-federal share to counties. To ensure a continued interdisciplinary team approach and promote independence it is essential that the crisis plan be followed and any needed changes can be made during normal business hours. (Watson)

COMMENT: I am concerned about small rural agencies such as ours who operate on a limited budget and have low number of case managers to be available on call 24/7. The cost of implementing an on call system that is currently not in the county budget would be difficult. Due to the hilly terrain and many "dead spots" where many case managers live we would have to find an on call system that would reach in these areas as cell phones do not. The case managers would need to be reimbursed for time being on call which is also not in the budget for the next year. (Waters)

COMMENT: We have 3 staff in our agency. One ...will be taking ...off for medical reasons...I am not sure, logistically, how 2 of us will accomplish the "24/7" coverage for all our consumers. We also operate under a very tight budget, with...a waiting list for any new county-funded services. I am not sure how I will work into our already approved budget, the funds for either a designated cell phone or beeper... I also don't know how our Board of Supervisors will decide to handle paying for "on call" time, when we already have no extra money to pay for services. ... even if we had a designated cell phone, our area is so rural, there are many pockets where there is not cell phone coverage, and this could be very frustrating to an individual in crisis. (Spilde)

COMMENT: ...[Having] a case manager ...on call 24 hours a day 7 days a week...is not cost prohibitive. In economic times such as we are having now it doesn't seem logical for you to add more stress and money to our economy by adding this. Please do not add this item... (Rowe)

COMMENT: ....At a time when the state is trying to cut back costs and expenses, our county mental health budgets hurting, this doesn't seem like the best time to be adding unnecessary costs to our services (Richey)

COMMENT: A rule of this nature does not seem to be cost effective considering the stress that most county budgets are experiencing during this time just so that they can simply fund the services that individuals are currently receiving. There will need to be a way to compensate employees for their on call time thus putting money towards employees rather than services for people with disabilities. Lastly, I have concern that this will lead to an even higher turnover rate in an already high stress position. High turnover can lead to less consistency and poorer quality of services for consumers. (Rewerts, Redies, Moberly, Merz, Van Horn, Long)

COMMENT: This will only increase the cost of providing services with overtime pay, pagers, and increased work load for Case Managers who will not be able to access services during the nighttime any better than calling 911 or their service provider who is already being paid for this service in caring for the individual in the community. (Nelson)

COMMENT: If the State is truly concerned with cutting costs and saving Medicaid dollars these new rules certainly don't follow that line of thinking such as additional mailings, additional on call personnel, staggering overtime, postage, etc. (Nelson)

COMMENT: I understand the concern with emergency coverage- How will this be defined. This will be a burden to small counties who do not have the budget to pay for this coverage. This will impact the cost rates. (McKeag-Hall)

COMMENT: This would be very expensive to accomplish in this year of very limited appropriations, and the money could be better spent for other more needed expenses. (Luhman)

COMMENT: As a supervisor of both Case Management and Therapy services, this is the policy proposal that I am most concerned about. If we require our case managers to rotate on-call service I fear that we are placing an unnecessary burden on case managers, and an unnecessary burden on the tax payers. On-call services would have to be reimbursed and could lead to overtime expenses for agencies. Additionally, many agencies have a very limited number of case managers which would make the on-call rotation limited to the extent that an individual case manager may be on-call at an overly burdensome rate. In my experience, this is a service that is best provided by service providers, not case managers. We are strongly opposed to this policy proposal (Kuehl)

COMMENT: with the extensive budget cuts our state is facing, I do not see how it is justifiable to approve paying a Case Manager over time for being on-call 24/7 for clients when they already have this service offered whether it is from a therapist, psychiatrist, direct care provider etc. (Knight)

COMMENT: Emergency service provision can be construed as a direct service. There is no provision for reimbursement of emergency services for consumers who are not enrolled in the Elderly Waiver. (Keleher)

COMMENT: Currently Targeted Case Management services are not a 24 hour crisis service. The role of case management is to monitor and coordinate services for disabled individuals. This amendment moves case management into a role as a coordinator of crisis services with 24 hour availability. Targeted Case Management is not currently equipped to handle this and this change will cause a dramatic increase in rates and turn over. Our office believes that such a move should be studied before creating and administrative requirement of such. (Hill)

COMMENT: DHS has indicated that the intent of this rule is to clarify the role of the case manager in ensuring the health, safety, and welfare of members. Language is also in Chapter 90 proposed rules stating: *"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."* It is not the role of the case manager to provide the services, but rather to monitor and coordinate.

Also noted in the Chapter 90 rules, direct services on behalf of case management are prohibited. Another issue is that our role as case managers is to foster independence and community integration for our clients. In the event of an emergency, contacting a case manager would only add another layer of phone calls to address the emergency. We already provide a crisis plan in the service plan that addresses individual supports needed.

In addition, there would be a substantial cost to implement this requirement. Currently our case managers are paid on an hourly basis. Requiring them to cover nights, weekends and holidays would require us to compensate them under FLSA. Small agencies also do not have the adequate employees to cover what is being required, without being on-call the majority of their employment. It stands to reason that if the health, safety, and welfare of members have been put in jeopardy, then the persons/agencies responsible for such should be held accountable and may need to be under additional requirements.

To my knowledge, case management services not being available 24 hours per day has not put members in jeopardy. Implementing a state wide blanket response to an issue, directed at the part of the system that was responsible for the concern in the first place, seems to be a misdirected effort in what is a worthy cause, ensuring the health, safety and welfare of members. In conclusion I would like to recommend that 90.8(2) not be added to the Iowa Administrative Rules. (Hill)

COMMENT: Having an on-call system for case managers will increase the cost of providing case management services as many times a crisis will occur after the hours of a usual business day, which means adding time that is predicted in a client's rate, which will increase the rate of the client. (Heitland)

COMMENT: I would need training on how a cost report is developed around the possibility that a Case Manager who is paid by the hour is called and would then need to be compensated under Department of Labor regulations. (Heidemann)

COMMENT: This will be an additional expense that counties will have to include in their budget for their staff. Hourly case managers will be subject to overtime based on Labor Law and how would you propose that salaried case managers are compensated? Some TCM units only have 2 case managers so these individuals will be working 24/7 for at least 2 out of 4 weeks per month. How would you suggest that larger counties who serve 800 members comply with this rule? Even if they would utilize a call center, the call center would need each case managers name and caseload list, so they could contact the correct case manager (again, this goes back to working 24/7) and then who would be responsible to ensure that this list is current? (Harrison)

COMMENT: Having someone on-call is going to raise the unit rate. In rural counties, we don't have the staff to be able to spread this load. (Curtis)

COMMENT: We as county case management providers/funders, feel this will be an unnecessary expense. Emergency services are already provider through supportive community providers and community mental health services. We feel this service is managed through these options as well as individual crisis plans established each year, or on an as needed basis, at team meeting with consumer's team members. Proposed amendment 90.8(20 will add an unnecessary step in an already effective crisis plan and tie up funds that would be better services elsewhere. (Paulsrud, Hiker, Cronin)

COMMENT: In regards to the 24/7 on call system, of course cost is a concern for everyone at this time. (Rieck, Bertogli)

COMMENT: ...this would necessitate county budgets having included extra dollars for on-call service provision and/or time and a half pay. As budgets have already been prepared and submitted to the State, county case management programs are not able to absorb this additional fiscal requirement this late in the year. (Artley, Shaw, Juetten, Wollum, Guard, Cory)

COMMENT: ...there would be a substantial cost to implement this. Currently our case managers are paid on an hourly basis. Requiring them to cover nights, weekends and holidays would require us to compensate them under FLSA. (Moberly)

**RESPONSE:** Experience from case management providers who already do 24-hour coverage shows that it is not burdensome or expensive. Two of the largest case management agencies, DHS (which covers 20% of the case management members) and Polk County, already have 24-hour call systems. Despite their large and intense caseloads, they both receive only a handful of calls per month. Both agencies contract with other agencies such as the Red Cross or Answers Plus to provide an answering service that assists in screening calls.

Counties with smaller case management programs could potentially combine resources with other small counties in their area in order to provide a regional system. The time spent on responding to calls would be billable time for the case management agency, and the other costs such as an answering service can be built into the case management rate as an indirect cost.

## Other

**COMMENT:** **Preamble, Ch.90.** It is not clear to me why the last sentence of paragraph 2 has been deleted. It seems to me that these are, in fact, important components of the case management role. To remove them from the preamble is to diminish their importance. I recommend keeping this sentence in the preamble (C. Wood)

**RESPONSE:** The preamble should serve as a broad introduction to the chapter. The referenced sentences deal with specific case management responsibilities, which are delineated clearly in rule 441 IAC 90.5(249A), which covers service provision.

**COMMENT:** Chapter 90 Preamble...only references case management for mental retardation, chronic mental illness, developmental disability and children's mental health waiver. The elderly, ill and handicapped, or brain injured waivers are not listed as an eligible group for targeted case management. This is confusing given the reference in Item 12. a that states Case management services shall be provided as set forth in rules 441-90.5 to 90.7. (Keleher)

**RESPONSE:** Chapter 90 sets out the rules for case management for the mental retardation, chronic mental illness, developmental disability, and children's mental health waiver populations. The elderly waiver, the brain injury waiver, and habilitation services have their own rules in Chapters 78 and 83 which define the scope of case management for those programs by referring back to certain sections of Chapter 90.

For example, case management for elderly waiver consumers is currently defined at both 441 IAC 78.37(17) and 441 IAC 83.22(2)"a." In these rules, those sections are amended to state that case management for the elderly waiver is to be provided as set forth in rules 441 IAC 90.5(249A) and 441 IAC 90.8(249A). Similar changes are being made for the brain injury waiver and habilitation services. Thus, not all sections of Chapter 90 apply to case management provided under the elderly waiver, the brain injury waiver, or habilitation services; rather, only rules 90.5(249A) and 90.8(249A) apply.

**COMMENT:** In the Preamble, it says that the service is designed to *ensure* the health, safety, and welfare.....my comment is how are we supposed to guarantee someone's health, welfare and safety? Members have the right to make poor choices in regard to their health, so this makes it difficult to *ensure* this. (Harrison)

**COMMENT:** 90.5(1)b. Service Plan states the case manager shall *ensure* the active participation of the member.....again, I am not sure how this expectation will be met as the member has the right to make choices and it could be extremely difficult to guarantee the participation of some consumers, especially those who have a CMI diagnosis. (Harrison)

**RESPONSE:** Case managers ensure these things in the same way they ensure anything else within the scope of case management, such as ensuring that appropriate services are being provided, or ensuring that appropriate goals are in place. In other words, this is done by assessing the individual's situation and providing appropriate service planning, referral, and monitoring to meet the person's needs, taking into account each individual's unique situation.

**COMMENT: Item 8 Amend sub rule 79.1(2)**, provider category “Home and Community –based Habilitation services “numbered item “1” it states that the upper limit will be retrospective cost – settled rate. Is this defined only with the Iowa Plan for managed care or also under the habilitation services? (McKeag-Hall)

**RESPONSE:** This particular item applies only to habilitation services. However, corresponding changes are being made to subrule 79.1(2) for HCBS elderly and brain injury waivers. This means that the upper payment limit for these services will be set in the same way as it is currently for targeted case management. The effect is that all of these case management rates will be retroactively cost-settled to the provider’s allowed cost.

**COMMENT: 78.27(6) “b”**...states, “Payment shall not be made for case management provided to a member who is eligible for case management services under 441-Chapter 90”.This statement needs clarification. It does not make sense as it is stated. Consider clarifying to state payment will be made for members eligible under 441- Chapter 90 according to the eligibility and standards contained within Ch. 90 rules. (Keleher)

**RESPONSE:** This is a current rule for habilitation services that is not being changed. It means that case management can be provided as a service under the habilitation services program only when the person does not qualify for regular targeted case management. This language does not apply to case management provided to targeted groups (MR, DD, CMI) under Chapter 90, nor does it apply to case management provided as a service under the elderly or brain injury waivers.

**COMMENT: 79.3(2)“d” (33) and (33) (1) Form 470-3956** references MR, CMI, DD Case Management, yet above it says “.....including HCBS case management services.” This is confusing. Need to clarify if this form applies to the Elderly Waiver or rename the form. (Keleher)

**COMMENT: Item 11, identifies form 470-3956, MR/CMI/DD Case Management Service Authorization Request.** I thought the MR/CMI/DD language was being struck from the chapter. (Harrison)

**RESPONSE:** The MR/CMI/DD terminology is not being changed here because it is a historical reference to a form used in the past. The form referenced here is the TCM prior authorization form that was done on paper before moving the prior authorization process into ISIS. Rule 441 IAC 79.3(249A) sets out the documentation requirements for Medicaid providers, and this particular reference is noting that these forms, which were completed on paper before May 1, 2007, need to be kept in the case management file.

**COMMENT: re: 90.5(1)“b”(6)** The two most common reasons clients are discharged from case management for elderly waiver is nursing home placement or the client is deceased. Therefore, case managers do not complete discharge plans. It is not a common occurrence for a client to be discharged and still in need of services. There would need to be direction on when a discharge plan is required and what it should include. (Keleher)

**RESPONSE:** Discharge plans will be a required part of the service plan for all consumers. A discharge plan should cover a reasonable range of possibilities for the individual. If it is likely that the individual will become self-sufficient enough to reside in the community without ongoing services, then the discharge plan should prepare for that. Conversely, if it is likely that the individual will eventually be unable to remain in the community, even with supports, and would require moving to a nursing home or other facility, then the discharge plan should prepare for that.

COMMENT: 90.2(4) identifies a TCM as a provider. While I understand that we are providers, we are not direct care providers and I believe that this language will be confusing to some. (Harrison)

**RESPONSE:** Because rule 441 IAC 90.2(249A) deals only with eligibility for targeted case management, we believe the reference to the provider is clear. In other sections of Chapter 90 where such a distinction may not be clear, we have tried to highlight the different types of providers by using terms such as “service provider,” “medical provider,” or “case management provider.”

COMMENT: Since 1997, the “consumer” has been called a client, consumer, individual, and now a “member”. This is irrelevant to service provision. (Nelson)

**RESPONSE:** Medicaid is first and foremost a healthcare insurance program, so in Medicaid rules we choose to refer to recipients of service as “members,” much in the way that covered individuals on private insurance plans are considered plan members. This does not mean that case managers or any other providers have to use the same terminology.

COMMENT: 78.43(1)c: How does one define a “relationship” in this situation? (Curtis)

**RESPONSE:** This section is from the current brain injury waiver rules. The direction for the case manager to “develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated” is not being changed in these amendments. We believe that the intent is clear and the term does not require further definition.

COMMENT: 90.5(1)b(5)2: Isn't this the crisis plan, which is already part of our service plan? (Curtis)

**RESPONSE:** The language in 90.5(1)b(5) directs that the service plan will include an individualized crisis intervention plan. This is further broken down in 90.5(1)b(5)1 which specifies that the crisis plan must address the individual's health and safety risks based on the risk assessment; and in 90.5(1)b(5)2 which specifies that the crisis plan must identify the supports to be utilized in an emergency.

COMMENT: 90.5(1)e(4)2: Coordination with other case managers within the same agency? An example? (Curtis)

**RESPONSE:** Here are a few examples:

- When the assigned case manager will be on leave and another case manager will cover the case, there would need to be coordination between case managers prior to and after the leave.
- When there are two or more consumers who have a relationship with each other (e.g. spouses, roommates, etc.) and the consumers have different case managers, the case managers may need to coordinate in regard to decisions that would affect all of the consumers.
- When a case is being transferred from one case manager to another.

COMMENT: *NEW rule 441-90.8 (249A) Terminating Services...* appears to be duplicative of 90.6 (249A) which is also titled "Terminating Services" and already in place on Chapter 90. *NEW rule 441-90.9 (249A) Appeal Rights...* appears to be duplicative of 90.7 (249A) which is also titled "Appeal Rights" and already in place in Chapter 90. (Burk)

**RESPONSE:** This was an editing error, and has been corrected with the revised filing in ARC7732B.

COMMENT: Iowa Code states that case managers must have a face to face contact each calendar quarter and that it can be any time during that calendar quarter. The proposed rules state every three months. From a practical standpoint, these can be very different. Is Iowa Code the actual standard? (Rieck, Bertogli)

**RESPONSE:** The Iowa Code does not specify contact every calendar quarter. The Iowa Administrative Code (also known as administrative rules) for the elderly waiver do specify at 441 IAC 78.37(17)“a”(4) “A face-to-face meeting by the case manager with the consumer at least quarterly,” but that language is being stricken in these amendments and replaced with the requirement for every three months.

COMMENT: This is a nice definition of "rights restriction", and I truly mean this, yet could be severely misinterpreted by both HCBS Specialists, Case Managers and Agency providers. The way it is written, without some further interpretative guidelines, could result in a long list of restrictions.

As an example, being funded through HCBS and residing in an RCF/MR could easily be construed as a restriction of rights because of the "general public criteria". The RCF/MR rules in and of themselves would also be a restriction for the same reason. Now, what if the person chooses to receive HCBS and reside in a RCF/MR, then is this no longer a restriction? How can a licensed RCF/MR be viewed as not restrictive by DIA yet restrictive by DHS? We are told residing in a RCF/MR is a restriction of members rights. Members receive services because they need them, choose those services, are eligible for services, and lack the skills to be residing independently without supports.

Another example, choosing to receive day habilitation, adult day care, and prevocational services in a facility could be viewed as a rights restriction because of the "general public criteria"? What if the members chooses prevocational, day habilitation, or adult day care services in a facility, then is this no longer a rights restriction? Needing supports or services because of a disability should not equate to having your rights limited, should it, by location or nature of rules?

A final example, does the definition of rights restriction as written mean if someone needs supervision to leave their home, and there is only one staff with four members in the home, and the other roommates need supervision, that the specific member's rights who wants to walk right now are being restricted because they can not leave the home when they want? What about situations whereby the member lacks skills to independently exercise the basic right and need staff supervision and/or support to exercise the right? How can it be a limitation of a member's when they require supervision and support to leave. In this case, the provider just could not do it when the member wanted to do it. In the case that the member is a dependent adult the provider has to be very cautious so there is no denial of critical care/abuse due to the person needing supervision or support.

Providers are limited here by the available staffing, services reimbursement, and what is ordered in the ICP. Ensuring member's health, safety, and welfare are more critical than ever in Iowa because of Atalissa and the Justice Department Settlement requirement with Glenwood. We have been told that the example I have given at the beginning of this particular paragraph is a rights limitation.

The 1915C HCBS waiver information defines Restrictive Intervention as an action or procedure that limits an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights. When reviewing the 1915 C HCBS waiver information on participant rights, it talks about fair hearings, due process, grievances, and complaint processes only.

Now you may think I am taking this too far, or that I am crazy, yet when the "rubber hits the road", as one would say, these will be questions and issues. The definition of rights restriction as written could lead to a lot of the same questions I raised and result in misunderstandings. (Aberg)

**RESPONSE:** These rule define a rights restriction as “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.” This definition does not imply that services that a consumer chooses to receive are, in and of themselves, a restriction of rights.

This is the same definition that has been in use for several years in the accreditation standards for case management other providers at 441 IAC Chapter 24, and thus far there have been no issues with it. Due to the nature of the populations served by case managers and the highly individualized approach to services, it is simply not possible to predict all the various ways that rights could potentially be restricted. We believe that this definition provides a practical and workable guideline that case managers can apply on an individual basis.

**COMMENT:** Consider creating a separate chapter outlining rules specific to Case Management. Case management is a “service” despite the program or the funding that is attached to it. Cross referencing several chapters for rules that apply to case management is cumbersome and the potential for contradiction or omission when rules change is high and it creates difficulty for quality assurance and compliance. If necessary a reference can be made to one chapter for rules regarding case management provision for those chapters that require a reference be made. (Keleher)

**RESPONSE:** Case management is provided to different members in different ways:

- As targeted case management to certain targeted populations including persons with mental retardation, developmental disabilities, chronic mental illness, and recipients of children’s mental health waiver services.
- As a service under the brain injury waiver, elderly waiver, or HCBS habilitation services program.

Chapter 90 already is a separate chapter that is specific to case management. In the current un-amended rules, Chapter 90 defines the scope of services for targeted case management, while rules in Chapter 78 and 83 define the scope of services for case management as a waiver or habilitation service.

The scope of services under these sections differ from each other, which results in case managers needing to follow different sets of rules for the same service under different programs. The proposed rule changes actually simplify this and reduce the potential for contradiction by making the scope of services in Chapter 90 the overall standard, and referencing it in Chapters 78 and 83.

**COMMENT:** the revised CMS rule rescinds in Sec. 441.18, paragraphs (c)(1), (c)(4), and (c)(5) that limit the provision of case management activities that are an integral component of another covered Medicaid service, another non-medical program, or an administrative activity, because it may result in restrictions on available providers of TCM services, and generally may limit beneficiary access to services. It appears that the proposed amended Sec. 90.5(2)”a” states a restriction which has been proposed for rescission in the federal regulations, and we support its deletion from Chapter 90:

“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.”

To that extent, we also suggest that Sec. 90.5(2) – Exclusions, in particular 90.5(2)”d” be re-examined and rewritten to come into conformance with the new federal rule. (Diamond)

**RESPONSE:** We believe that to ensure program integrity, this language is necessary. There is no valid reason why we would allow payment for case management services when those same activities are being provided as part of another covered service.

COMMENT: Items 1 through 5. All pertain to Chapter 78, “Amount, Duration and Scope of Medical and Remedial Services.” We support these amendments. (Diamond)

COMMENT: Items 7 through 9. Sub-rule 79.1(2), separate numbered items 17 and 1, and unnumbered item “Targeted Case Manager Providers”, each of which deal with cost settlement for Targeted Case Management provision under the HCBS Waiver, Habilitation Services, and MR/CMI/DD Services, respectively. DHS TCM supports these amendments. (Diamond)

COMMENT: Items 11 and 12. Amending subparagraph 79.3(2)”d”(33), which lists case management services, and subparagraph 83.22(2)”a”, which references case management services as provided under Sec 90.5 and 90.8. We support these 2 amendments. (Diamond)

COMMENT: Items 13 through 16 which pertain to the title, preamble, and definitions under 441—Chapter 90. DHS TCM supports these amendments. (Diamond)

**RESPONSE:** None.

COMMENT: In light of not making any changes, we would ask that just wait, as stakeholders, sit down with IME and look at the direction that IME wants to take with these changes. (Eckerman-Slack)

**RESPONSE:** The IME has been in contact with providers throughout the process. We solicited input and shared draft versions of the rules prior to beginning the formal rulemaking process, and have sought provider input throughout the public comment period. Likewise, we will continue to work with providers throughout implementation.