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Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, IA 50319-0114

RE: ARC 4739C – Proposing rule making related to case management services

Submitted electronically via appeals@dhs.state.ia.us

Dear Ms. Freudenberg,

UnityPoint Health (UPH) welcomes the opportunity to offer comment on the proposed rulemaking related to case management services. UPH is one of the nation's most integrated healthcare systems and provides care to patients across Iowa, Illinois and Wisconsin through 310 clinics, 39 hospitals and 19 home care locations. In addition, UPH is a provider of home- and community-based services habilitation services and children's mental health waiver services in Iowa. UPH has formal relationships with five Community Mental Health Centers (CMHC) that serve the State of Iowa through Integrated Health Homes (IHHs) for almost 5,000 adults with serious mental illness (SMI) and children with serious emotional disturbance (SED), which account for approximately one-fourth of the state's total IHH population. About 1% of UPH IHH members are Medicaid fee-for-service members. Our CMHCs and their respective IHH programs include the Abbe Center for Community Mental Health, UnityPoint Health – Berryhill Center, UnityPoint Health – Black Hawk-Grundy Mental Health Center, UnityPoint Health – Eyerly Ball Community Mental Health Services and UnityPoint Health – Robert Young Center.

Since the inception of IHHs in the state, UPH has participated in IHH development and growth. Most recently, UPH has had three representatives selected to serve on the Health Homes Stakeholder Workgroup: Kristine Karminski (Abbe Center), Aaron McHone (Berryhill Center) and Ashley Thompson (UnityPoint Health). UPH appreciates the time and effort of the Iowa Department of Human Services (DHS) in developing and ultimately proposing this new Chapter on case management services, and we respectfully offer the following comments from the perspective of UPH IHH providers and IHH members.

GENERAL COMMENTS

This rule making proposes to adopt a new Chapter 90 that clarifies the case management service activities received by various populations in the Medicaid program, including a definition of and references to a core standardized assessment (CSA) as required under the Balancing Incentive Program (BIP). This new Chapter also outlines and requires billable activities for fee-for-service members, mandates provider reporting of

minor incidents, and includes the person-centered service planning definition and service requirements. Cross references in other chapters are harmonized.

Comment: We are concerned that the revision of Chapter 90 to encompass case management services beyond targeted case management has blurred IHH case management responsibilities. While the Preamble indicates that case management services encompass IHH care coordination, it is unclear which provisions apply to IHHs, for defined care coordination activities or otherwise, given that IHH care coordination is only specifically referenced in provisions that exclude these services from targeted case management. If we are to assume case management services in this Chapter are intended to apply to IHHs, then this Chapter contains some provisions that contradict the IHH State Plan Amendment, some inconsistent and confusing terminology, and overly broad cross references. **We request that DHS consider revising this proposal to streamline language to make clear which provisions of this Chapter apply to IHHs, including intense case management services for IHH members.** We are interested in better understanding the exact rules or subrules within the new Chapter that apply to IHHs and require any affirmative duties.

INTEGRATED HEALTH HOME (IHH) CARE COORDINATION

The proposed rule defines the term "care coordination" to mean case management services provided by IHH providers to a subset of IHH members, particularly those receiving Tier 7 services or "Intensive Case Management" (ICM) services. The term "care coordination" appears four times in Chapter 90 – in the Preamble, definition of care coordination (Rule 90.1), determination of need for targeted case management (Subrule 90.2(2)c, and application for targeted care management (Subrule 90.2(3)c(5). In the latter two instances, it is used to exclude IHH care coordination from targeted case management services. In addition, while the term IHH is defined to mean a provider of IHH services, this definition also includes substantive provisions that reference IHH covered services and member eligibility and states that "IHH provides case management services for enrolled IHH members."

Comment: **As written, it is unclear how IHHs fit within the revised Chapter 90.**

Definition of Care Coordination: The introduction of the term "care coordination" is confusing in the context of this Chapter. Under the IHH program (IAC 441-78.53(1)c), care coordination has a specific meaning and is defined as one of six covered services provided to IHH members. Its use in this Chapter is not analogous to the IHH covered service, and instead care coordination is defined as case management services (set forth but not defined in Rule 90.4) delivered to a subset of the IHH member population. To add to the confusion, in this Chapter the term "care coordination" is always prefaced by IHH despite the fact that the definition itself is limited to IHHs. **We would recommend that DHS remove the term "care coordination" from this Chapter and instead simply specific the segment of the IHH population being excluded from targeted care management services**. This could be accomplished by:

- Eliminate the definition of care coordination (Rule 90.1) and replace with the same definition attributed to "intensive case management or (ICM)" to reflect IHH practices. Intensive case management means "the case management services provided by an integrated health home to members who are also receiving home- and community-based habilitation services pursuant to rule 441—78.27(249A) or HCBS children's mental health waiver services pursuant to rules 441—83.121(249A) through 441—83.129(249A).";
- Revise the *Preamble* as follows: "The term 'case management' encompasses targeted case management, case management provided to members enrolled in a 1915(c) waiver,

community-based case management provided through managed care, and intensive case management (ICM) provided to members enrolled in an integrated health home (IHH).";

- Revise *Determination of need for targeted case management* (Subrule 90.2(2)c) as follows: "The member is not receiving, under the medical assistance program or under a Medicaid managed health care plan, other paid benefits that serve the same purpose as targeted case management or intensive case management.";
- Revise *Application for targeted care management* (Subrule 90.2(3)c(5)) as follows: "The applicant is receiving duplicative targeted case management or intensive case management from another Medicaid provider;".

Definition of IHH: **This definition is confusing, and we recommend it be revised to reflect how IHH case management services are to be treated in this Chapter**. Although defined to mean the provider or entity providing IHH services, the definition also includes language referencing IHH covered services, IHH member eligibility, and that "IHH provides case management services for enrolled IHH members." Given our uncertainty about the scope of this Chapter in relation to IHHs, we offer some observations as to how this definition may be improved. First, if the definition is intended to apply to IHHs providers, the definition should be limited to the first sentence. Second, unless the definition is intended to reference covered services or members, we do not believe that the second sentence adds value or needs inclusion within this Chapter. Next, we do not understand the rationale for including the last sentence within the IHH definition – "The IHH provides case management services for enrolled IHH members." Case management services are not formally defined in this Chapter and the definition of "case manager" would seem to apply agnostically across entities providing case management services as described in the Preamble.

TARGETED CASE MANAGEMENT

Under current law, the entirety of Chapter 90 addressed targeted case management. Under the proposal, only two rules have targeted case management within their titles – Rule 90.2 Targeted case management (formerly Eligibility) and Rule 90.3 Termination of targeted case management services (formerly Terminating services).

Comment: Currently, IHH members receiving intensive case management (ICM) services (e.g. IHH services provided to IHH members in HCBS habilitation services and children's mental health waiver services) are not eligible for targeted case management services. It is viewed as duplicative. However, currently IHH members may be eligible and receive targeted case management services if they are not receiving ICM services. **We do not believe that this interpretation is intended to change under the proposed rule.** We would request that DHS confirm this understanding and specify in each rule when / if it applies to community-based case managers or IHH case managers. Specifically:

- Subrule 90.2(1): In subpart f, it appears that an IHH members receiving ICM services are not eligible for targeted management. **If this is correct, we support this language, which retains the IHH status quo**.
- Subrule 90.2(2): In subpart c, it appears that documentation of IHH ICM services would negate the need for targeted case management**. We support the reference to IHH services as recommended above under *INTEGRATED HEALTH HOME (IHH) CARE COORDINATION,* which retains the IHH status quo**.

- Subrule 90.2(3): In subpart c(5), it appears that targeted case management applications will be denied for IHH members receiving IHH ICM services. **We support the reference to IHH services as recommended above under *INTEGRATED HEALTH HOME (IHH) CARE COORDINATION,* which retains the IHH status quo**.
- Subrule 90.2(4): In subpart a, it appears that "other HCBS programs or populations" would include IHH ICM services and therefore exclude these as allowable transitional case management services for purposes of fee-for-service (FFS) targeted case management. Managed Care Organizations (MCOs) are directed to provide transition services for all enrolled members. **We support these changes, which retains the IHH status quo**.
- Rule 90.3: No language was added referencing IHHs or HCBS programs or populations. Based on this, it appears that this would not apply to IHH case managers. **We support as written, which retains the IHH status quo.**

CASE MANAGEMENT SERVICES

Rule 90.4 provides detail regarding covered services, including assessments, person-centered service plans, referral and related activities, monitoring and follow-up, and contacts, as well as exclusions. The terms "IHH" or "care coordination" are not referenced in this Rule nor is the term "case management services" defined.

Comment: The Preamble indicates that this Chapter applies to case management services which encompass targeted case management, case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination. **We would request that this Rule contain an affirmative statement related to what case management services as listed in the Preamble are applicable.** Specifically, we are interested in whether IHH case management services are covered.

In addition, should this apply to IHHs, we seek clarity on several operational items:

- Assessment tool (Subrule 90.4(1)a): This Subrule states that "The assessment and reassessment will be done using the core standardized assessment or another tool as designated in 441—Chapter 83 for each population. . . . Reassessments may be either face to face or telephonic dependent upon the assessment tool and population as designated in 441—Chapter 83." While this language seems to provide flexibility in that assessment or reassessment shall use a CSA or other Chapter 83 tool, **the mode by which the reassessments are conducted is limited to the Chapter 83 tool and does not mention the CSA**. If this was an oversight, we encourage its correction. In addition, 441—Chapter 83 governs waiver programs. **In relation to IHH services, we are uncertain whether the CSA would apply, whether tools designated in 441—Chapter 78** (HCBS habilitation services) **were intentionally excluded, or if there is some other application** for IHH assessments and reassessments. The same issue may also be raised for HCBS elderly waiver services and HCBS brain injury waiver services, which also are administered pursuant to 441—Chapter 78. Further clarification would be helpful.
- Case manager participation (Subrule 90.4(1)a): The last sentence of this Subrule states "Case managers may participate during the assessment or reassessment process at the request of the member." In current practice, Telligen completes the standardized assessment; however, the lead-in language to this Subrule indicates its application to both FFS members and MCO-enrolled

members and the definition of "core standardized assessment" references both FFS and MCOs. **Is this request for participation applicable to MCO-enrolled members or solely targeted to FFS members?**

- Assessment vs. reassessment references (Subrule 90.4(1)a): It appears that this Subrule references "applicant" for individuals during an initial assessment and "member" for individuals during a reassessment. If so and for consistency, we would suggest that "applicant" occur in each sentence to correspond to "assessment" (last sentence) and that "reassessment" occur in each sentence with "member" (third sentence).
- Person-centered service plan choice (Subrule 90.4(1)b): In general, we are concerned with the significant detail contained within this Subrule relating to process and minimum plan content. In subpart b(2)(4), it states in part "The member should be able to choose the specific planning format or tool used for the planning process." While we support person-centric planning, this provision is broad. **We seek clarification on what this means and whether DHS will be providing different tools or mandating format options**.
- Monitoring and follow-up requirements (Subrule 90.4(1)d): This subpart revises language related to a case manager responsibility for monitoring. In particular, "The case manager shall perform, as needed, monitoring activities. . . . Monitoring shall also include review of service provider documentation." **With the addition of "as needed," the duty of the case manager shifted from a mandatory to a conditional duty, meaning that monitoring is required on an as needed, discretionary basis. We would request that DHS confirm this interpretation and provide guidance as to whether there are minimum frequency standards for monitoring outside a triggering event or reassessment timeframe**. Also language was revised so that when monitoring does occur, a review of service provider documentation is now mandated, instead of being optional. **We seek confirmation that this review is only mandated when monitoring occurs.**
- Contacts (Subrule 90.4(1)e): This Subrule states "The case manager shall have at least one face-to-face contact with the member in the member's residence at least quarterly." We seek clarity as to what case management services this requirement applies to, and specifically, whether IHHs must comply. This contradicts the current IHH State Plan Amendment for ICM services, which allows face-to-face contacts at a member's residence or place of service. From a policy perspective, we also question its alignment with person centeredness as the member should be able to choose where to meet the case manager. We have IHH members whose preference and desire is never to hold meetings in their home. The provision is also especially problematic for members experiencing homelessness. **We oppose this provision as written and would recommend inclusion of language to allow meetings at alternative sites, such as currently provided in the IHH State Plan Amendment**.
- Exclusions (Subrule 90.4(2)): This Subrule begins with the statement "For all case management services, fee-for-service payment shall not be made for activities otherwise within the definition of case management services when any of the following conditions exist:". This appears to be non-binding on MCOs and we would request that DHS confirm. This also reference the "definition of case management services." This Chapter does not contain a definition of this term in Rule 90.1 or within this Subrule. **We would encourage DHS to include a formal definition of this term** as we believe that it would not only address this Subrule, but answer many of the questions

contained within this comment letter. In subpart a, payment is prohibited for activities that are "an integral component of another covered Medicaid service". **We question whether this broad provision is intended to exclude IHHs from FFS payments under this Rule**.

DOCUMENTATION AND BILLING

*The proposed rule added significant details regarding documentation of contacts, rounding units of services, collateral contact documentation, and billable activities. For FFS case management services, billing is proposed to occur in 15-minute intervals and collateral contacts are included as billable activities (although Subrule 90.6(3) states a "case manager **may** bill for documented contacts", Subrule 90.6(4) related to billable activities states "any activity included in this list **must** be billed if the activity has occurred" – bold added for emphasis).*

Comment: It is uncertain whether Rule 90.6 and its new provisions apply to IHH case managers. These new provisions are contrary to documentation and billing requirements outlined in the IHH State Plan Amendment for billing the ICM level of fee. Two significant areas of conflict involve billing methodology – IHHs bill on a Per-Member-Per-Month (PMPM) rate for all six covered services and collateral contacts are not included as covered services activities for billing purposes for the ICM rate. In addition, while Rule 78.27(6)(b)(1) specifically excluded payments for "case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes," a similar exclusion is not contained within this Chapter. **We would recommend that this Rule call out which of the case management services are impacted as listed in the Preamble** (targeted case management, case management provided to members enrolled in a 1915(c) waiver, community-based case management provided through managed care, and integrated health home (IHH) care coordination). **Due to the IHH program parameters, we do not believe Rule 90.6 applies to IHHs; however, an affirmative statement to this effect within the Rule would be helpful**. For clarification, we would suggest that DHS consider including language in this Rule similar to that within Rule 78.27. In the alternative, if there are provisions that do apply to IHHs, we would recommend that the Rule be revised to state this.

We also believe that the new Subrule 90.6(4) adds confusion as to whether billing for collateral contacts are mandatory versus permissive. As written, Subrule 90.6(3) reflects current Subrule 90.5(1)e(3) and states that case managers may bill for contacts with non-eligible persons. In new Subrule 90.6(4), billable activities include collateral contacts and must be billed. Further guidance on this billing activity would be appreciated.

INCIDENT REPORTING

For purposes of incident reporting processes and requirements for case management services providers, the proposed rule revises the definition of "major incident" and includes a new definition of "minor incident." The substance of incident reporting is contained within Rule 90.7. Major incident reporting involves a more detailed process and requires an expedited timeframe.

Comment: First, Rule 90.7 does not specifically reference "IHH" or "care coordination" so it is unclear whether this Rule is applicable. **We would request that this Rule contain an affirmative statement related to what case management services as listed in the Preamble are applicable**. Second, these proposed incident reporting processes and requirements continue to deviate from requirements in

Chapter 24, *Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities*. In Chapter 24, the definition of "incident" remains general and does not distinguish between major and minor incidents. **We would request that standardized definitions be adopted. More importantly, we would request that Subrule 24.4(5) and Subrules 90.7(1) and 90.7(2) be streamlined, as their reporting timeframes, report content, attestations, and follow-up requirements differ.**

OTHER ITEMS

Upon our review, we offer some additional thoughts:

- Rights restrictions (Rule 90.5): We would reiterate that recommendation to clarify what case management services apply to each Rule within this Chapter.
- Definition of core standardized assessment (Rule 90.1): The last three sentences contain substantive provisions outside the definition of the instrument itself. We would recommend that these provisions relating to its intended use and its administration be appropriately located within Subrule 90.4(1)a – the portion of the Rule related to assessments.
- Item 1. Home- and community-based habilitation services (Subrule 78.27(6)): This Subrule was harmonized to cite to the portions of the new Chapter. A cross-reference to "rules 441—90.5(249A) and 441—90.8(249A)" was changed to "rules 441—90.4(249A) through 441—90.7(249A)." As discussed above, we question whether all four Rules are applicable to IHH case management services.

We appreciate this opportunity to provide feedback and its impact on our providers, Medicaid beneficiaries and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President of Government & External Affairs at Sabra.Rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs