Iowa Association of Community Providers
IHH/Provider Collaborative Meeting
January 20, 2015

The following is information discussed at the January 20, 2015 meeting of IHHs and Providers. If you have questions about the material, please email the IACP TA Team @ techassistance@iowaproviders.org

Kelley Pennington reviewed the Magellan annual report that came out 1.19.15. That report can be found here: http://www.magellanofiowa.com/media/970231/2014_ihh_report_to_the_community_final_1-19-15.pdf

A sample Person-Centered Plan and IHH Checklist was developed by Magellan. All IHHs have received it, though it can also be found here.

http://iowaproviders.org/iacp_resources/iacp_resources_docs/IHH%20%20Sample%20Treatment%20Plan%20and%20CCP%20Template.pdf
http://iowaproviders.org/iacp_resources/iacp_resources_docs/IHH%20SAMPLE%20TREATMENT%20PLAN%20CHECKLIST.pdf

Steve Johnson, Kelley Pennington and LeAnn Moskowitz were present to answer questions. The following reflects the discussion.

Question	Answer
1. Hab providers indicate there are many members who have not been assigned a tier for home-based habilitation. When do you think that will	The goal was to have finalized in 6 months. The domino that has to fall before tier assignment is the non-financial eligibility application renewal. We want to be more aggressive with that, but we cannot overstep that piece. It

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be completed?	will still be at least 6 months before totally transitioned. People will be moved to a tier when the home based habilitation services authorization is coming up for renewal or when an individual is new to hab services. This process will default to the non-financial eligibility date when the non-financial and financial eligibility dates are not the same.
2. If a member does not have a tier assignment, is the provider to continue billing as they have been?	Yes. You should still bill under the old codes. Most of the rates that were in higher and medium tiers are coming in on time. The larger services by number of members served (bottom two tiers) are coming in slower.
3. We are a brand new provider. Who determines and how do they determine what tier is assigned? We were not part of that process for the people we serve.	Use the person-centered planning process. This should inform the member, the Hab provider and the IHH care coordinator together about the member service needs and corresponding number of hours they need. Previously, it has been primarily a phone call with Magellan and Targeted Case Manager. Using the Person-Centered Plan should make the process more streamlined and keep all informed. Neither entity should be deciding on their own. If you as a provider are aware of a change that may necessitate a tier change, you should talk to the IHH and then you can call Magellan together if you like. Everyone needs to work together, though you may not always agree. When there are significant changes, people need to come back together so the Person-Centered Plan can be changed to reflect the member's service needs. Small events in the member's life may not suggest a need for a tier change however if there is a serious or prolonged change in member's situation, it is likely a tier change, whether to a higher intensity or a lower intensity, may be needed.
4. Only one of the people we serve is in a tier. I learned from another agency that one person can access hours within the dates of the NOD that they did not previously use. Last month	When assigned a tier, there is no hard stop for the units each month. If a person is approved 1,000 units in a year, they may use more in a month and fewer in another month.

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needed 40, this month 55…	
5. Is there any way to get the assessment date and the service plan date near the same time? I feel the person-centered plan is much more effective if they are near each other.	Yes. You can align the non-financial eligibility assessment and change the date, as long as it is done at least annually.
6. How can we align the dates when the tier authorization is for 3 or 6 months?	The funding authorization is based on need. Because of this, the timing of the financial authorizations may not align consistently with the other pieces mentioned previously.
7. Regarding funding: What should happen if a member's service units are fully utilized in 11 months of a 12-month authorization period? What do we, the provider organization, do?	This is something that should be able to be anticipated to an extent. Communicate ahead of time with the member and the team. Additional units may be authorized based on need.
8. What do we do if staff provide Hab services for an amount of time that is less than the authorized tier amount?	You have to work with a person for 8 minutes to bill at all. There may be times when that happens, though we would assume those instances would be pretty rare. There may be times staff needs to meet all day with a member in crisis. You can't submit a service claim for a day you did not provide the service.
9. Quality Oversight: How will the pieces be looked at when reviewed through quality oversight?	LeAnn Moskowitz (IME): From a QA standpoint, we are looking at the requirements as outlined in Iowa Admin Rule, Chapter 79.3. Does it meet those requirements and rules? Does it show date, start time, end time, intervention, location, etc…? When you are looking at billing (and we haven't audited under this new system and we've not talked about when we will start auditing HCBS records on this system) any audits in the foreseeable future will be in past billing types. If you get paid a day, is the documentation sufficient to support a day? With tiers, if you are being paid for a 17-24 hour tier, your documentation over a month needs to average 17 or more hour per day of documentation. Otherwise, you'll have a hard time

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	supporting that payment level. What Steve has said is that if the team is consistently providing additional services over the course of a week or two, the provider needs to get in touch with the IHH care coordinator and talk about how to respond to the change in member needs. Then the appropriate person needs to contact Magellan regarding the change. The bottom line is that it is a Medicaid funded service and we need to follow 79.3, and your documentation needs to support what you are billing.
10. What should we do if there are changes in the schedule that are rare, but regular (once a month/quarter)?	If it is once a quarter, we are looking at figuring that out into the whole total. That will allow for additional billing units. Let's say you are seeing someone two hours per day usually but once a month you are giving someone a ride to Iowa City. You serve them two hours per day. That year you will add in eight hours per quarter and figure that into the average daily "order" for service.
11. Ex: Approved every day for two hours per day. But one time per month, I go with you overnight for one day. How does that look?	The team discussion needs to be about how many hours the person needs. In the plan, there is a section to indicate the number of service hours the team recommends. Fill that out and make the justification. You take that total, including the overnight trips and divide it out into your billing. This may cause the average to go up.
12. Can we mix tier approval?	Magellan has not talked about doing that due to the difficulties with billing.
13. If it goes up to the next tier level of the billing, do we need to increase the daily level of service?	No. Average it over the number of days in the authorization period.
14. When the average is teetering at 2.25, what happens if it goes slightly lower?	If you are getting down to tenths of point, it is not an issue. If it is a dramatic issue and persists for a two-week period, then have some team communication and contact Magellan. People have flexible needs and you can be flexible. We don't want to force unnecessary specificity. If it is a couple of days in a month, that is situational. If it is for weeks, bring the team together and communicate, whether it is the person not wanting the

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	services or whether the person wants fewer services than what is approved.
15. Due to a crisis, we had to work with a person for a number of hours above and beyond her tiered amount. The IHH asked us to bill the immediate following day (in addition to the day in question) to make up for this time, even though we did not provide service on the day they suggested we bill.	No. Do not do this. You cannot submit a claim for a day during which a service was not provided. That is fraud. We are happy to clarify that with the IHH and we'd like to.
16. A person was hospitalized and released, went to a higher tier. They were refusing service. Some days, they locked us out. We ended up discharging for failure to be complaint. Regarding billing for those two weeks; Can we? Some days, staff talked to the person. Some days, staff knocked and there was no answer.	I think your efforts may be billable depending on the circumstances. We can look at that specifically. It depends on how much time staff were trying to engage. If a provider shows up and has verbal contact with the person, you can bill for that time with the member if it is 8 or more minutes. If the person did not communicate with the staff person at all, no service was actually provided to the member and thus there is nothing to substantiate a claim.
17. We serve a member who is on MEPD and "fell off" of it. No one on his team was aware this had occurred. He is still getting the services, but Medicaid has said they will not fund that. His services through Magellan are still pending. He now has a 1-hour per month job to re-qualify for MEPD. How can an agency prevent potential loss due to not being able to bill in these circumstances?	If the person was not Medicaid eligible, no funding. For the people with a gap between Iowa Plan and Medicaid eligible, they are billed to IME. Which means they need to have an ISIS service plan. Hab eligibility is tied to Medicaid as well as 150% poverty. It is possible to be Medicaid eligible and not Hab eligible. The best advice is to get on the ELVS website every month. Members with MEPD have to pay a monthly premium. If the IHH helps the member to do this monthly, the member will not lose eligibility.
18. Is there a diagram that explains?	The various scenarios of how people move in and out of Medicaid eligibility

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	are too numerous to document.
19. MEPD - What can you do if someone falls off it?	We know this is overwhelming and it is often a case-by-case basis. Members with MEPD have to pay a monthly premium. If the IHH helps the member to do this monthly, the member will not lose eligibility due to non-payment.
20. If you are emailing LeAnn M, what do we include?	Always include the member name, state ID, birthdate.
21. As a provider, I've never heard of the annual non-financial eligibility review date. How can we find it?	It is set for all members in habilitation. That began July 1. It is essentially a determination of the clinical issues of the member to determine if their member meets criteria for Hab services. It is performed by IHHs should complete an assessment annually and submit to IME Medical Services Unit, whom review and approve/deny based on criteria. The assessment is updated and hopefully you are using whatever clinical assessment you have available. That is sent into IME Medical Services and sent in. Once that assessment is approved, the person-centered plan should be completed. See the Hab workflow. The next domino is the authorization. It is the clinical eligibility. Do they meet the criteria for services?
22. Where is the a workflow for habilitation?	It is available from Magellan or on the IACP website.
23. Sometimes working with a new IHH or an IHH new to the member makes communication to Magellan difficult. We know we can contact Magellan together; is it possible and does it not make more sense to have the provider contact Magellan?	It happens in a pinch. We don't want to bypass the IHH. If we are a month into it and the provider isn't getting paid? Yes. Call. However, if there is something that has come up, the team should be communicating, perhaps writing an addendum and that can be uploaded to the IHH portal. That will be the strongest process. They also need to contact the IHH to notify that the contact with Magellan has been made. The purpose is to work as a team. This is an opportunity to come together and collectively come together and represent that person's needs to Magellan. Calling together is preferential if the provider has more information than the IHH. This can be

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	a quick call. It may not mean a new meeting, depending on the circumstance.
24. At some point with the IHH care coordinators have access to the authorizations?	Yes. Hopefully in the next week.
25. Placement for people sitting in jail? Obviously, I'm not in favor of the person going to MHI as an option, but we are struggling.	We do have habitation providers who have carved out a specialty in that area as well. You sometimes have to look statewide. Hopefully, we can eventually find a community placement. We've seen very challenging situations where people can be surveyed successfully in the community. Talk to Steve Johnson and we'll be sure to get logged in the system as a need. Sometimes getting everyone in the phone, it seems to go better. It can sometimes look bleak when you put it in writing.
26. As we implement, we are noticing there is a lot of additional administrative time and meetings. People who used to be authorized for one year of service are now served at two or three months. We are trying to find a balance between the 250 people we serve in Habilitation and the thousands we serve who are not in Hab. I don't know if we are the only IHH experiencing this. We really want to work on population management and databases, but we are feeling tied to the old case management world with 19 page assessments, etc. We understand the importance of this for our members, but are struggling with the time and the cost involved. Can you offer any comment on this?	As we look at that, we want to make sure there is a team process, PCP uploaded to the IHH portal, etc. If that is completely filled out, we think you'll see the time reduced on phone calls. We see Magellan being more on the technical assistance line. Then intent was that Hab would not be coordinated as it is now. At the end of the day, these folks have significant needs. Early on, some of that feels overwhelming and there is a ton of work and coordination. I think we can all be pretty sure that there won't be more funding with a $50 million hole in Medicaid. We need to continue to have conversations, though many things are federal regulations. We recognized that we seem to only focus on high end. Not what we want/wanted. This is much bigger than that. It is a conversation worth continuing. As we ALL find efficiencies (like not having to call all the time), there is a lot to it. This is all new. We can't throw it out and say it doesn't work because we aren't there yet. But we have more work to do.

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27. Relaxing the face-to-face requirement for IHH for members… Will it happen?	Magellan has not forgotten about this and we are working on it. We do not want unnecessary duplication. We are working on relaxing and will likely relax certain requirements once the IHH can demonstrate they have safeguards in place to manage the populations they are responsible for.
28. Regarding outcome measures for IHH - Within 7 days of hospitalization, a member needs to be seen by certain people within the IHH. We were told that an RN won't meet the measure. There are different parameters depending on the measure. Can you please speak to this?	Trying to adhere to a standard. They need to see a clinician. Master's level, psychiatric nurse, MD, DO. There are certain codes that may not be a licensed person and meet it, but it must adhere to the national standard. The clinician seen by the member within 7 days of hospital discharge has to be a licensed MD, DO or a masters prepared clinician. HEDIS has specific guidelines we are required to follow for this measure. Julie sander at Magellan can be contacted for specific questions about this.
29. ICM/Hab members – If a person qualifies is receiving Habilitation, do they qualify as ICM for the increased IHH reimbursement?	Yes. Members receiving habilitation qualify for the ICM rate. IHH may want to compare who is receiving hab and to the ICM list. This can be done through the portal. You may have opportunity there for increasing the ICM members.
30. Pleased that you recognize that we are spending a load of time on authorizations now. Initially, we were doing the same thing with the ICM nurses every time we were meeting with them. You mentioned using the Person-Centered Plan (PCP). I'm not sure that will meet all of the questions that come up there. We don't have any information showing	Magellan is adjusting processes so can use the PCP online. If we are all looking at it, I think we'll be in much smoothers spot and eliminate redundancy.

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that people at Magellan have access to anything we have submitted. In particular, the social history. We came up with a template for information...	
31. If working on a PCP and the IHH makes a recommendation that a member receives 8 hours a day and Magellan says that the member only needs 4 hours per day, there is a feeling that it is not honoring the person-centered planning process. Can you please speak to this?	If it is a good coordinated person centered plan, Magellan won't be challenging that. The PCP asks for a specific number of hours, and that number will be used to calculate the tier.
32. Will IHH be able to do funding authorizations at some point?	Yes. The IHH leading the PCP, they really already are. We are moving towards that as a possibility in the future, but there is not definite date set for transition of this type.
33. Supervision: How much of the service can be supervision? We were told that if we provide 40 prompts or two minutes of goal effort, we will be fine.	Each service is going to be different. Giving a standard isn't possible. It has to be part of the PCP process. There are no state or federal criteria for the specific amount of intervention on goals a person must receive for the provider to not risk recoupment. It goes back to the PCP and what are the member's skill-based training needs. The provider plan should crosswalk to the long-term goals the person has for their hab goals. The PCP will drive everything. The PCP is based on the assessment. What are the priority needs that the provider is going to work on? Why am I getting X service and what is going to be provided to me as part of that service and support. Maybe I will need in-sight supervision for 8 hours per day. Maybe I will have 24-hour supervision 1:1 with staff. It all goes back to the PCP.
34. Supports and supervision are acceptable for any tier as long as it is in the plan, correct?	Yes, but it cannot be the entirety of the service.
35. We are still being told that we cannot bill for	Tell whoever you are speaking with to look at the HCBS provider

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job development until the job is obtained.	manual. Magellan is willing to do additional training on this as well as needed.
36. Pre-Voc: Can it be dually approved with SE?	It is possible on an individualized basis. It has to be explicitly explained that it is being used as a wrap around support. Why is that support needed? Are there still work-related skills the person is working on so they can advance their hours or job placement? Habilitation webinar #3 presented in July went into this in depth. It also talks about IVRS and IME funding services and how they intertwine. These are on the Hab provider portal should you wish to reference them now.
37. Is it no longer possible to provide Habilitation service concurrently with community support services to a person?	There is no standard to preclude this, however it really has to be justified. They are very similar. We are able to use CSS when the member is over 150% of poverty, making them ineligible for Hab. There is not a categorical denial.
38. We have had a lot of interest about the amount of direct supervision is being evaluated, in particular technology. There is a feeling that remote monitoring is not available now that we are looking at how tiered funding works. How can members and providers access it?	We have some ability through integrated services and support dollars to assist with this in unique situations. However, it is largely a policy decision. Therefore, we can offer on a select basis, but it is not available for everyone. We agree it should be explored further.
39. We are currently doing more of a 24-hour model, serving folks out of the criminal justice system. Under ID or BI we can access environmental funding through the $1570 rule. Where is the line between what we should	If they are coming out of an institutional setting, they can access Money Follows the Person. If it is through criminal justice or otherwise, Medicaid doesn't pay for furnishings. We cannot pay for room and board in community-based services. The $1570 that providers claim on the cost reports is related to member-specific needs rather than room and board

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be providing? Some members have nothing to begin life in the community.	needs. From a Medicaid perspective, I don't see us ever paying for room and board things.
40. Before tiers, we worked with cost settled rates. The tiers make us nervous and they seem they should be 1:1	There is nothing that dictates a 1;1 ratio or change services due to tiers. The PCP should indicate what is necessary. This can maintain the staffing ratios used previously.
41. During a call with our IHH and Magellan, a tier had been agreed to for a member. When the NOD came, it was assigned incorrectly. We are having a very hard time getting corrected. Is there a particular process we should follow?	Go back to the person at Magellan you spoke to and they can help you correct it.
42. Is there any advice or information you can share as to where the paperwork is going to stand eventually? We know the PCP is changing. Is the 39-page assessment going to change? I don't know if anyone else has any advice on what can be changed? We are in the process of updating and we have to do manually.	The assessment: In most cases, that can be much shorter, though it has to be submitted to Magellan to approve first. Otherwise, you can use the old TCM assessment. If you have an assessment you used previously, take it, add information regarding IHH and submit to Magellan for approval. Regarding the PCP: it combines federal requirements and previously required care coordination plan into one document. Things will continue to evolve over time. We will continue to streamline to the extent we can while still meeting regulations.
43. One IHH pointed out the PCP feels redundant with some of the risk stuff. What can you share about that?	That isn't locked in stone. If you want to move information around to make it make more sense, you can do that. If there is a question being asked on the PCP several times, you don't have to repeat it. Just tweak it. Many elements of the person-centered plan are required, so removing sections is

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	not advisable.
44. Is there a requirement that the same care coordinator has to see an ICM level person at least quarterly?.	ICM level members must be seen monthly, but remember that anyone on the IHH team can do that meeting. It does not necessarily have to be the IHH care coordinator you have assigned.
45. What is the average caseload size for an IHH care coordinator?	The PMPM is based on a suggested ratio of 250 members to one care coordinator, 250 members to one peer and 400 to one nurse. There is a suggested 1:50 ratio for our ICM folks. We understand this feels overwhelming. It is the recommended number. You can hire more. The idea is that there is a certain level of high need people and more that are low need, all being served by the same IHH. Many members only need bird's-eye-level management and others need more intensive, on-the-ground, regular coordination assistance. Right now, that is upside down in some places. We still have 40,000 people to locate and get involved in IHHs. Once those other members are involved, some of this will feel more manageable. We are not used to using data and population management which will allow the IHHs to serve more people with appropriate interventions and monitoring based on need, not requirements. We have flexibility, but there is a model of staffing we want (peer, nurse, coordinator). It is not just like TCM where you have a caseload of 40 people. Though, we know we are not where we want to be to have the efficiency. The more IHH push out to work with community providers, the more manageable it will seem.
46. IHH nurses were listed by a DHS brochure as someone who can accompany members (and transport them) to their medical appointments. Really?	It is not prohibited, and it is also not the expectation.
47. The PCP copies – Who needs copies of the	The IHH should make sure everyone who is at the meeting signs off on the

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IHH person-centered plan?	plan. We need to make sure they are distributed to all who need it. This includes the providers who are providing services according to those IHH plans.
48. Do HAB providers need a copy of the care plan/treatment plan?	Yes. It is really important they have it. That is what will inform the service plan the provider will develop. It is critical that the individual service plan gets out to the provider in a timely manner. When they are reviewed, we want to be sure that the services in the treatment plan are delivered.
49. What about amendments to the service plan? We are struggling with getting amendments from the IHHs.	I think the first suggestion would be meeting with the IHH director and talk about that specifically. That may be a better work option than getting Magellan involved. If you need an addendum, there can be something you agree upon. If you have met and have the expectation up front, it may just be a new care coordinator who does not know the process. We've heard from many IHH and providers that coming together has made quite a bit of progress.
50. What is a timely manner when it comes to a provider getting the service plans?	It has to happen quickly. Regarding addendums, it doesn't involve redoing any specific form (assessments, authorization forms, etc). The addendum can be short in focus and explain the change. For example, you may need to take a member up to the highest tier. Add the information needed to the addendum. Don't re-do everything. We recommend the provider document your efforts and keep information on trying to obtain the service plan from the IHH. If you are not continually getting a service plan after asking for it, it needs to be addressed. If it is not a rare occasion, communicate with Kelley Pennington about it. We want to get it done correctly.