MCO Documentation Expectations

Purpose: To provide guidance to the health homes for the proper documentation of activities related to needs-based eligibility / level of care (LOC), person-centered service plans (PCSP) and service follow-up. The following resources must also be referenced for further guidance: The Code of Federal Regulation, Iowa Administrative Code (IAC), State Plans, Managed Care (MCO) Provider Manuals and Iowa Health Link Contract. Information specifically required for the development of the PCSP is located in the PCSP template. Additional required PCSP planning elements can be documented in a progress note within the individual's record. In addition to the required information below, IHHs should also follow Iowa Administrative Code 441-79 and 441-24 for documentation and record requirements. The following documentation requirements will be requested from the Health Home by the MCOs as needed for auditing purposes.

Needs-Based Eligibility / Level of Care (LOC)

Pre-Needs-Based Eligibility/Level of Care Scheduling Contact Note/Template

Health Home will reach out to the individual/guardian to schedule the level of care and complete a progress note in their electronic medical record (EMR). The progress note should reflect a summary of the conversation that took place with the individual / guardian. Elements of the progress note must contain the following:

1. Identify that you are reaching out to schedule the needs-based eligibility / LOC assessment [3]
2. Identify type of assessment - initial, renewal or revised [3]
    a. ITC completes the initial assessments for CMH Waiver.
3. Identify type name of assessment to be completed - interRAI CMH or interRAI ChYMH [3]
4. Identify person to be completing the assessment [3]
5. Explain the purpose of the assessment and what topics you will cover [3]
6. Inform what information you will need at the assessment (i.e. diagnosis, medication list, etc.)
7. Inquire if individual has any questions regarding the assessment process [3]
8. Inquire who the individual would like to have present at their meeting [4]
9. Inquire what day, time & location individual would like to hold needs-based eligibility/ LOC meeting [4]
10. Inquire if the individual like to waive their 14 day notification and schedule the assessment sooner than 14 days? [5]

(ITC) Only – Iowa Total Care completes all initial Children's Mental Health Waiver assessments.

Completion of Needs-Based Eligibility/Level of Care Meeting Contact Note/Template

A progress note must be completed after each interaction with the individual/guardian. Health Home will complete a progress note upon completion of the needs-based eligibility / level of care in their EMR, the following elements must be included:

1. Type of assessment completed
2. Who was present at the LOC
3. Individual's participation during the assessment

MCO Documentation Expectations

4. Add any other notes that regarding the meeting that are important
5. Individual requests/declines a copy of LOC [4]
6. Other team members request/decline a copy of the LOC [4]
7. Date mailed/provided LOC to team members (must be within 3 business days of the assessment)[4]

(ITC only) The Health Home must complete the Member Reporting Assessment (MRA) in Iowa Total Care's Client Portal upon completion of the LOC as this will allow us to capture data for timeliness of assessments.

a. An electronic version of the assessment is available in the portal or the IHH can use the paper version and upload to ITC using the documents tab in the client portal.
b. Supporting documentation must be submitted along with the assessment such as: social history, diagnosis and medication list (attached or within assessment or social history).
c. Required sections to complete in the MRA are:
    i. Encounter Information
    ii. Contact Reasons
    iii. Assessment
    iv. General Note – when an assessment is not timely and must include the details including dates for outreach on why the assessment was not timely.

Sample Notes for Needs-Based Eligibility/Level of Care Situations:

Scheduling of Annual LOC: 7/1/2020 - I reached out to Jane, guardian, today to schedule the annual interRAI ChYMH assessment and explained that this needs to be completed by 8/20/20 for continuation of Children's Mental Health Services. Informed Jane of topics we will cover during the assessment. Inquired if individual had any questions regarding the LOC. Jane stated no. Informed Jane that this writer will be the one to complete the assessment and would like to get this scheduled. Inquired from Jane who she would like to attend the meeting and inquired what day, time and location she would like. Jane identified the following date, time and location, July 20th, 1pm at her home. CC will invite the following (list names). Informed guardian that we will need a recent diagnosis signed by the therapist and a current medication list at the time of the meeting. Guardian agreed to waive the 14 day notification to assessment to be complete.

Scheduling of Initial LOC: 7/1/2020 – I reached out to Joe today to schedule initial interRAI CMH assessment. I informed individual that this is to determine if he would be eligible to receive habilitation services. Joe stated he was still interested in this. Informed Joe that I would be the one to complete the assessment and inquired what day, time and location and who he would like to also attend. Joe stated he would like to have it on July 15, 2020 at 10 am at his home. He does not wish to have anyone else present during the meeting. Informed Joe that we will need a current medication list, so any medications he takes to have them listed or the pill bottles out, this includes over the counter medications. Joe agreed to waive the 14 day notification for the assessment to be completed.

Completion of LOC Meeting: 7/15/20 – Completed annual interRAI CMH assessment today with Jane, along with Jean -ABC provider, Joe- guardian, and care coordinator –Tori. Jane was very involved in answering the questions until we talked about mental health behaviors where she become quite and other individual of the team encouraged her to answer. The team provided extra documentation where needed. Individual declined a copy of

the assessment. Guardian requested a copy be mailed and this was mailed today. Provider requested copy by email and this was emailed today.

Person Centered Service Planning Process

Pre-Person Centered Planning Contact Note/Template [1,2,4]

Health Home will schedule the PCSP meeting with the individual and/or guardian and complete a progress note in their EMR. The following elements must be documented:

1) Who the individual wants at the person-centered planning meeting. This may include natural supports, current HCBS providers, other providers, Vocational Rehab counselor (if applicable), MHDS Region representative (if applicable), School representative / IEP (if applicable), etc.
2) Time they would like to have their meeting.
3) Day they would like to have their meeting.
4) Location they would like to have their meeting.
5) Individual's satisfaction with current providers
6) Special communication and cultural needs that were assessed and accommodations provided as required for the person-centered planning meeting and other phone / face-to-face contacts.
7) An agreed upon strategy for solving conflict or disagreement within the person-centered planning process, including clear conflict-of-interest guidelines for all planning participants.
8) Who the individual chooses to lead / facilitate the person-centered planning meeting. The individual will be encouraged to lead the process where possible.

Completion of Person-Centered Service Plan Meeting [1,2,4]

The Person-centered Service Plan meeting is a discussion among members of the Interdisciplinary Team (IDT). The Health Home will complete a progress note upon completing the PCSP meeting in their EMR. The progress note must contain the following elements:

1) Who attended the meeting
2) Individual's level of participation in the meeting
3) The individuals' priorities for next year
4) Changes the individual would like in their services for the next year
5) Individual's satisfaction with current providers
6) Special communication and cultural need accommodations provided as applicable
7) Strategy for solving conflict or disagreement
8) Individual was educated and offered choices on the available services, supports, and providers (including all available Medicaid and non-Medicaid services).
9) Individual and their IDT discussed options for meaningful day activities, employment, and educational opportunities.
10) Individuals who are under guardianship or other legal assignment of individual rights, or who are being considered as candidates for these arrangements, must have the opportunity in the planning process to address any concerns and are provided with the opportunity to give informed consent for any rights restrictions imposed.[3]

MCO Documentation Expectations

(ITC only) The Health Home will upload the PCSP and pre-PCSP meeting note via the Client Portal when PCSP is uploaded.

Sample Note for PCSP

7/31/20 – The following team members were in attendance: Individual guardian, CC (name), Provider X (name), etc. Individual participated in PCSP planning process the entire meeting and choose to have Care Coordinator lead the meeting. We discussed home-based habilitation providers in the area, including: XYC services, 123 Homecare, and 456 Independence. Jolie chose to stay with ABC Health Services. We discussed other services and supports including mental health therapy, day habilitation, employment services, volunteering, housing assistance, food pantry, and local support groups. Jolie said she would like to start therapy and attend local support groups. She would also like a list of food pantries in the area and more information on housing assistance. This care coordinator will bring this information to the person-centered planning meeting. We discussed what Jolie likes to do during the day. She enjoys drawing comics and watching tv. She would like to start working again, but feels she needs to be in therapy to address some things before she starts with that process. She would also like to get her AA degree in the future in graphic design. We talked about the supports she would need for this process and will come up with a more detailed plan at the person-centered planning meeting.

Within 5 Days of Initiation of Services [4]

The care coordinator must contact the individual within five business days of scheduled initiation of services to confirm that services are being provided and that the individual's needs are being met.

Ongoing Documentation[3]

The care coordinator will perform monitoring activities and make contacts that are necessary to ensure the health, safety, and welfare of the individual and to ensure the person-centered service plan is effectively implemented and adequately addresses the needs of theindividual.[3]

a. At minimum, monitoring should include
    i. Assessing the individual, assessing the places of service (including the individual's home, when applicable), and all services regardless of the service funding stream.[3]
b. Monitoring includes review of service provider documentation.[3]

Monitoring of the person-centered service plan includes contacting the individual and documenting the following:[3,6]

a. Documentation of whether the individual received the services identified in the person-centered service plan, including the amount of service provided and the individual's attendance and participation in the service.
b. Documentation of services authorized in the person-centered service plan that the individual has declined.
c. Has there been communication occurring among <u>all</u> providers to ensure coordination of services?
d. Documentation of the individual's progress towards goals and overcoming barriers to care.

   i. Documentation of whether or not the services in the person-centered service plan are adequate to achieve the goals in the plan.
   ii. If the individual does not demonstrate progress overtime, goals are re-evaluated and modified as appropriate.
e. Document changes in needs or status of the individual.
f. Document follow-up activities including making necessary adjustments in the person-centered service plan and service arrangements with providers.
g. The individuals' priorities
h. Changes the individual would like in their services
i. Individual's satisfaction with current providers
j. Special communication and cultural need accommodations provided as required for phone / face-to-face contacts
k. An agreed upon strategy for solving conflict or disagreement within the person-centered planning process, including clear conflict-of-interest guidelines for all planning participants.

Care coordinator will make contact with the individual, the individual's guardians or representatives, or service providers as frequently as necessary and no less frequently than necessary to meet the following requirements:[3,4,5]

a. The care coordinator must have at least one face-to-face contact with the individual in the individual's residence at least quarterly;[3,4,5]
b. The care coordinator should have at least one contact per month with the individual or the individual's guardians or representatives. This contact may be face to face or by telephone.[3,4,5]

MCO Documentation Expectations

References

1 Federal Code of Regulations. Chapter 441, Sub-part M- State Plan Home and Community-Based Services for the Elderly and Individuals with Disabilities, 79 FR 3033, Jan. 16, 2014, unless otherwise noted, 441.700 – 441.725(c)

2 Federal Code of Regulations. Chapter 441, Sub-part G- Home and Community-Based Services: Waiver Requirements, 46 FR 48541, Oct 1, 1981, unless otherwise noted, FCR current as of Aug 24, 2018, 441.300 – 441.310

3 Iowa Administrative Code, Human Services Department 441, Chapters 77, 78, 79, 83, 90. Accessed online: https://www.legis.iowa.gov/law/administrativeRules

4 Managed Care Contract and Amendments, Amerigroup Iowa, Inc., 3.2.11 and 4.4 Accessed online: https://dhs.iowa.gov/MED-16-009_Bidders-Library

5 State Plan Amendment – Health Home. Accessed online: https://dhs.iowa.gov/public-notices/health-homes

6 National Committee for Quality Assurance (NCQA), Long-term Services and Supports Distinction for Health Plans. Overview accessed online: https://www.ncqa.org/programs/health-plans/long-term-services-and-supports/ltss-distinction-for-health-plans/

1915(i) State Plan HCBS Habilitation Program. Accessed online: https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html

1915(c) HCBS Children's Mental Health Waiver Application. Accessed online: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html

Code of Iowa, 225C.28A Service quality standards. Accessed online: https://www.legis.iowa.gov/law/statutory

Additional Resources

HCBS Habilitation Provider Manual
http://dhs.iowa.gov/sites/default/files/Habilitation.pdf

HCBS Waiver Provider Manual – Includes the Children's Mental Health Waiver
https://dhs.iowa.gov/sites/default/files/HCBS.pdf

Provider and Case Management Tools – includes specific waiver information packets, information on CCO and CDAC, Employment matrix, Employment First Guidebook, Prevocational and Supported Employment FAQ
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers

HCBS Services – Programs, Services, News, Announcements, Waitlists
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs

HCBS Waiver Provider Contacts
https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/hcbs-contacts