Iowa | Medicaid

CBCM and IHH roles and responsibilities

A guide for CBCMs and IHHs when a member is enrolled in both waiver and IHH

The purpose of this document is to assist in the non-duplication of case management and care coordination services between the Community-Based Case Manager and Integrated Health Home when a member is enrolled in a waiver (excluding Children's Mental Health waiver) and IHH. If a member receives case management through a waiver and also qualifies for the IHH, the Integrated Health Home and CBCM must collaborate to ensure the care plan is complete and not duplicative between the two entities at a minimum of at least quarterly.

Definitions

Case management services are designed to ensure the health, safety and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational and other services.

The term **case management** includes the following categories: 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 provided to the Habilitation and Children's Mental Health Waiver populations (**441 IAC Chapter 90**).

Community-based case managers (CBCMs) for both Wellpoint. and for Iowa Total Care, Inc. are responsible for providing case management services to members on the following waivers: Elderly, Health and Disability, AIDS/HIV, Brain Injury, Intellectual and Physical Disability. When a member is accessing waiver and habilitation, the CBCM will manage all services.

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in medical institutions. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved (**441 IAC Chapter 83**).

HCBS Habilitation services are intended to provide state plan Home and Community Based Services (HCBS) to Iowans with functional limitations typically associated with chronic mental illness. HCBS Habilitation services are provided to members in integrated, community-based settings that support full access of members receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. (**441 IAC Chapter 78**)

Integrated Health Homes (IHH) integrate medical, social and behavioral health care needs for individuals with serious mental illness or emotional disturbance **(State Plan Amendment)**. They offer

person-centered, team-based care coordination with a strong focus on behavioral health care and social supports and services. The goal is to promote access to and coordination of care. Team members include a nurse case manager, care coordinator and peer or family support worker. The **six core health home services** include: comprehensive care management, care coordination, health promotion, comprehensive transitional care from inpatient to other settings including appropriate follow-up, individual and family support; and referral to community and social support services.*

Defining Roles

Task	Long-Term Services & Supports (LTSS) Community Based Case Manager (CBCM)	Integrated Health Home (IHH)
Referral	To complete a member referral to an IHH: Obtain member consent for referral. See IHH Map and contact information **here**. Contact the IHH and provide referral information for the member. The member can also contact the IHH directly to be enrolled. To be eligible for an IHH, the member must meet the following criteria as determined by a mental health professional within the last 365 days: Adults diagnosed with a serious mental illness (SMI) Children diagnosed with serious emotional disturbance (SED). Have at least one functional impairment	To complete a member referral for HCBS Waiver, IHH's: **1.** Obtain member consent for referral. 2. Contact the Department of Human Services (DHS) income maintenance worker for information on waitlists and how to apply. The member can also contact the DHS income maintenance worker directly to apply for a waiver. **Visit the DHS website for more information regarding waivers and waitlist status: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs.**
Level of Care (LOC) Eligibility Process	CBCM completes all required waiver and habilitation assessments, social histories and other information that may be needed for LOC (waiver) and needs based (habilitation) determination.	If the member has habilitation and is approved for waiver, the IHH will transfer habilitation case management responsibilities to the CBCM which includes a "warm hand-off" with necessary documents, of the member to the CBCM. If the member has waiver with habilitation and IHH, the IHH team will support access to or completion of required documentation for LOC determination

		(waiver) and needs based (habilitation) as needed. In this scenario, the member will be enrolled with the IHH as non-ICM.
Care Plan Development	CBCM schedules, facilitates and writes the person-centered service plan (PCSP). CBCM assists member in leading and participating in the person-centered service plan process.	IHH participates in the person-centered planning process with the CBCM, the member and other key participants. IHH signs the PCSP as a participant/provider. IHH develops a non-intensive person-centered care plan (PCCP) and incorporates the waiver/habilitation into the PCCP.
Care Plan Implementation	CBCM provides monitoring and follow-up actions including: making contacts that are necessary to ensure the health, safety and welfare of the member, ensures that the PCSP is effectively implemented, and ensures PCSP adequately addresses the needs of the member. At a minimum, monitoring includes assessing the member, the places of service (including the member's home when applicable) and all services. Monitoring also includes a review of the service provider documentation. CBCM will take action if care gaps are identified.	IHH implements and monitors the IHH PCCP. IHH will initiate contact with the member and CBCM if gaps in the member's care are identified.
HCBS and Habilitation Service Authorizations	CBCM completes all waiver and habilitation service authorization requests.	If member is enrolling into an IHH after member is accessing waiver services, the IHH will submit the Health Home Notification Form with supporting documentation for review, as a non-ICM member.
Care Coordination	CBCM completes referrals and related activities that include: activities to help the member obtain needed services such as scheduling appointments for the member, linking member with medical, social, educational, housing, transportation, vocational or other service providers.	IHH implements the IHH PCCP. IHH will maintain regular communication with the CBCM and initiate contact if gaps in the member's care are identified. In collaboration with the CBCM, the IHH will provide the member education about health prevention, managing chronic

	CBCM will take action if care gaps are identified. CBCM provides health education regarding chronic conditions including prevention and self-management support (i.e. flu shots, wellness visits, disease management, support groups, and other preventative care). CBCM providers transitional care support to a member from an inpatient setting (i.e. nursing facility, hospitalization, PMIC, etc.) to other settings. CBCM is responsible for ensuring HEDIS® measures are met (i.e. 7-day follow up after inpatient mental health stay). CBCM closely monitors members who are discharged from the hospital including ongoing follow up and medication reconciliation. CBCM assists with coordinating peer support activities and ensures that a goal is in place for this service within the PCSP as appropriate.	conditions and self-management support as needed. IHH will communicate with CBCM when they are aware of a transitional care situation. IHH will support the CBCM in comprehensive, transitional care when a member transitions from an inpatient stay to another setting. IHH will support the CBCM in meeting HEDIS measures (i.e. 7 day follow up after inpatient mental health stay), assisting with medication reconciliation, and planning for potential crisis as needed. The IHH supports the member's crisis plan and can provide 24/7 access to mental health services as needed. IHH in collaboration with the CBCM assist members in accessing self-help and peer/family support services, advocate for support services for members and families, help members identify and develop social support networks, assist with medication and treatment management and adherence, identify community resources and connect to peer advocacy groups.
Contacts	CBCM completes (at a minimum): Monthly contact with the member by face-to-face or by telephone. Quarterly face-to-face at the member's residence or location of service. IHH and CBCM should have communication, at least quarterly.	IHH will provide contact with the member as based on the member's needs. For non-ICM members there is not a specific face-to-face or telephone contact requirement. IHH and CBCM should have communication, at least quarterly.

* IHHs will be reimbursed at the non-ICM tiers for providing health home services to members on waivers excluding Children's Mental Health (CMH) waiver. Minimum service requirement to bill for the monthly PMPM is care management monitoring for treatment gaps defined as health home services. The IHH must document health home services that were provided for the member.

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