

Case Management – Administrative Issues Summary

1) PCP Document

- a. Too long and cumbersome
- b. Complicated format

2) Method of Payment and Billing

- a. Move to case rate stratified by level of intensity
- b. Move from a fee for service approach to an expenditure approach
- c. Direct billing
- d. Tiered reimbursement rate based on the consumer's level of need and/or case manager credentials required to serve the client.
- e. Tiered number of case manager units per consumer, based on objective measure of consumer need
- f. Allow DME to bill directly for regular and waiver supplies
- g. Consider capping the maximum case management billing time in proportion to the client's approved level of care.
- h. Move to monthly or daily rate instead of units

3) Documentation

- a. Reduce frequency, e.g. move from a service note per contact to a consolidated note weekly or monthly summary
- b. Too many forms require the same identifying information on each page and the need for multiple signatures every time a plan is updated
- c. Redundancy of signatures every 30 days
- d. Redundancy of paperwork
- e. Lack of standardization

4) Authorizations and Reauthorization

- a. Timelines need to be long enough to allow for planning
- b. Authorize an array of services for 6 months to a year instead of multiple re-auths for each service
- c. Eliminate authorizations from VO
- d. Frequency of requesting authorizations
- e. Delay in receiving authorizations
- f.

5) Face to Face

- a. Should be based on the needs of the consumer

6) Training

Responses Received

“What administrative tasks must be eliminated that do not add value?”

Frequency of audits

Frequency of reauthorizations

Other paperwork that does not add to value of the service (would need to be determined/evaluated per current case management entity).

When talking with CSC (Child Care Services Coordinators) the overwhelming response was the amount of paperwork required to meet Medicaid guidelines for passing their audits (form HS-3291)

Currently opening a new client to CSC if visit is 6 units (1 1/2 hr.) it takes an additional 1 1/2 hours to complete the paperwork. I will be sending you a link to see the amount of forms required. Will be either this afternoon or tomorrow morning. These forms were developed by Cheryl Lowe (State Consultant) to help meet all of the Medicaid requirements. Most of the CSC programs are using these forms.

Example:

Initial visit to open a client----1)DHHS T1516, 2) DHHS T1516-1, 3) DHHST1517 (age appropriate of next 11 forms), 4) HS-3502, 5) DHHS-2801, 6) DHHS-2811 7) HS-2991 then at least 3 care plans are started , more pending the needs- can be 6 plus easily.

Subsequent visits: care plans are updated every 3 mos.and the forms used are HS 3501 if referrals/additional phone calls then DHHS-2734. This usually takes as much time as the routine visit.

Every 6 mos: DHHST1516, one of DHHS T517-A to L, HS-3502

Closure: without a visit- 1) DHHS T1518, 2)update DHHS-2801, 3) DHHS-3750 4)DHHS-T1513

I have spoken with one of the MCC (Maternity Care Coordinator) she works with the Hispanic population. They can only bill 6 units but generally she spends much more time in the home and on her paperwork.

Initial visit: forms used are 62.312-7/2/07, 62.105-8/28/00, DHHS-T1513, billing HS-3005
subsequence visit 62313-1/22/08 billing HS-3005

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- 1) Getting an authorization - eliminate the bureaucracy of getting authorizations. Cap the units of allowable benefits and allow service providers to bill as required up to that limit.
 - 2) PCP document - the current document is too long and loses its value because of its cumbersome characteristics
 - 3) Notes - shift to a monthly status update on each of the status domains in the plan rather than a note for every contact with a consumer
 - 4) Billing - determine a 'case rate' possibly stratified by level of intensity, and have that bill monthly (pro-rated based on portion of a month a consumer is in service.)
 - 5) Accreditation - why require national accreditation for this service above the LME service definitions endorsement and monitoring?

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- 1) Revise the method of payment for Case Management, moving from a fee for service approach to an expenditure-based approach
 - 2) Reduce frequency of documentation, e.g., moving from a service note per contact to a consolidated note (e.g. weekly or monthly summary)

- 3) Reconsider requirement for TCM to have monthly face to face contact (allowing substitution of telephonic contact when appropriate.)

PCP has become a cumbersome lengthy and time consuming document that does not always convey useful relevant information.

The ones that look functional are the ones that keep the number of goals limited and the focus narrowed to measurable outcomes and show frequent reviews with meaningful progress or barriers to progress identified.

And in reviewing records for CS reviews, DT reviews and now child residential reviews the PCP often looks canned and copied.

- Duplication of case management services (recent example where Health Dept. case manager and TCM working on same tasks for/with a family)
- Multiple meetings with different agencies involved with the child/family rather than TCM getting all agencies together
- For consumers in a residential setting that is all inclusive, many times the TCM rather than the residential provider takes the consumer to appts. (psychiatric, medical, annual Medicaid review, etc) and that is costly with no value.
- TCM should link consumer to services rather than duplicate functions of other services (for example we both were involved with: consumer had 10 hrs of personal assistance but the TCM was going to the consumer's house and assisting the consumer to pay bills. Another example: consumer has supported employment but the TCM accompanied the consumer to complete applications for employment.

Concerns related to many forms that require the same identifying information on each page and the need for signatures every time a plan is updated.

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- Authorization for an array of services for 6 months to a year instead of multiple re-auths for each service
 - Services need to include reimbursable transition planning from jail to community with case management in place to assist in plan development, linkage, and coordination.
 - Various levels of case management need to be based on the needs of the individual.
 - The current funding system results in individuals being put in silos based on their primary diagnosis, thus making it difficult for individuals with dual diagnosis to have access to best practices in integrated treatment approaches. Services and treatment should be consumer and family centered, not oriented to the requirements of bureaucracy. Care must focus on increasing consumer's ability to successfully cope with life's challenges, recovers, building resiliency and not on symptom management.
 - Peer Specialists need to have various roles in service delivery.
 - There are both local and state documentation requirements which negatively impact the services delivered. There needs to be a comprehensive vision for the system in which a plan is developed, implemented, and data/outcomes are gathered to determine effectiveness rather than modifying the plan and requirements frequently. The frequent changes require providers to switch gears and are not allowing for the tracking of outcomes. For example, establish standards and mating those standards rather than changing them.
 - Service definitions need to be clear and not open to interpretation. Providers need access to support to troubleshoot issues as they arise. There also needs to be comprehensive, consistent and quality trainings for the service definitions and be skill based, rather than philosophical.

- Requirements for face to face time, level of service, etc should be based on the needs of the consumer in accordance with the philosophy of person centered planning.

The following should be eliminated:

- PCP requirements - pared down to the minimum required to assure needs are identified and met
- Authorization timelines and requirements --need to be long enough to allow planning and meeting with parties, effectively engage the consumer in services, and allow time for assessing outcomes/ reassessing progress and needs. Reviewing too frequently won't present a comprehensive picture with this many elements included.
- Direct billing of this service would be more efficient than billing through LMEs
- Consideration of billing increments to capture the activity (per 15 minutes increments? Hourly? Per event? and all associated paperwork.
- Eliminate seeking authorizations from VO and any other vendor. Instead CM should have an established no prior authorization limit like outpatient treatment an authorization should only be sought for those rare situations that will exceed the unmanaged visits. Fro example, most consumers only use an average of 4 hrs a month of CM, which equals 48 units a year so set the limit at 48 units a year, once the consumer uses 48 units then the
- CM should have to request an authorization. ECBH has been doing this with The Arc of Nc for about 2 years it has worked very well for about 150 state funded clients. The ARC CMs have never exceeded the allowable units.
- Eliminate CM having to request initial authorization for any other services require the direct service provider to request its own authorization prior to service starting. Currently CM has to request initial services for CAP and most LME DD services.
- Consolidate consents that are signed into one document to reduce time in getting signatures and allow one consent for all time unless revoked instead of requiring annual signatures for such paperwork. These are redundant and expensive.
- Don't require any mandatory face to faceonly provide the service based on the consumer request.... Nota ll consumer require face to face from a CM
- Remove the requirement to monitor services also duplicative of LMEs. This provides no value bus is expensive. Most CM couldn't tell you what or why they conduct monitoring of services other than to be able to write a note and get productivity. Not sure who has this requirement but it has not ever made sense to me. The direct service agency who has authority over the staff should complete the monitoring of it's services. Instead maybe the CM should call to confirm services are still meeting the needs of the person. Or, consider implementing a triggered service monitoring based on complaints from the consumer or legally responsible person.
- CAP equipment and supplies should be able to be obtained by the recipient directly from the vendor just like other prescription medication. CM spends a great deal of time securing estimates, processing paperwork, processing billing not to mention the agency's financial burden as a middle man. Instead why not the vendor deal directly with the consumer using a prescription plan like is set up for medications.

The major hurdle for a QP or CM is paperwork. If there's anyway to streamline functions i.e. merging the PCP in order to eliminate redundancies, it would be helpful. Also, NC TOPPS is a valuable system, but cumbersome and time consuming and needs to be re-designed.

Transportation of client needs to be included as reimbursable in the Service Definition. It would GREATLY improve treatment adherence.

Tiered reimbursement rate. Based on consumer's level of need and/or case manager credentials required to appropriately serve the client.

Tiered number of case manager units per consumer, based on objective measure of consumer need, and approved by LME.

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- Duplication about a requirement to be assigned a mh case mgt. prior to being able to access mh services. Example, a DSS At-Risk case mgt. needed to access placement for a mh client. Before the client could access those mh services, the client had to have a mh case mgr. assigned.
 - When an individual has a public agency guardian, (DSS, LME, public health dept or dept on aging) that entity will have to be the assigned case mgt. due to the legal responsibility for the person.
 - Considerable concern about the education requirements for case mgrs. and concern about using non degree people. Also, concerns about case load size especially if the case mgr. has to know how to access wide range of resources for the people they are working with.
 - Concern about doing a thorough assessment as a case mgr. if the person is not an expert based on the needs of the client. Example, a case mgr. who is an expert in working with older adults who then has to do an assessment of a severely impaired child.
 - There have been issues when mental health is working with the client also and we can not get an answer to what they are charging to Medicaid. That affects the client's CAP/DA budget and the at risk case management especially if they are billing case management or like services. There needs to be more cooperation between mental health and us. Case management signature requirements are different from CAP/DA and At-Risk. It makes it hard to remember which is right. At-Risk requires a signature on each entry with name, position. CAP requires a signature at the bottom of each page.

The Adult Services Committee had a discussion about the recommended goals and outcomes and there was some discussion about several topics that need further attention.

Person Centered case management- This makes sense in theory and I support this; however, much planning will be needed in determining staff qualifications and caseload size as well as ensuring consumers will receive needed services. It will take a case manager skilled in assessment to correctly identify needs and time to build relationships with providers to successfully advocate for services. Having worked in the DD , CPS and APS fields and drawing on my experience, each discipline has different resources and it takes time to build these relationships and specific knowledge. I would love to see the plan for how someone with a high school degree and no social work experience fits into the tiered plan. Please advocate for experienced case workers to have these positions. (either SW II or III level. The DD and adult services functional assessments are very similar and DD has better goal training. There are some overlaps and strengths from the different disciplines to pull from.

SINGLE PORTAL OF ENTRY- Please consider the lessons learned from DD case management. This was not family friendly and actually delayed services and required additional contacts for families. It was not a natural entry point. I prefer the no entry is wrong system.

What barriers exist regarding administrative duties that are could be eliminated and don't improve quality of care for consumers?

Lack of standardization

FREQUENT CHANGES that occur once we begin to understand how to effectively implement a practice

Retro changes or changes that becomes effective "today", which leaves no time to assess how to implement

What barriers exist regarding providing quality CM work (ex: QP qualifications, authorization limitations, etc.)

Frequency of requesting authorizations

Duplicative paperwork – including STR process (whether it is at the LME, and then sometimes providers need to redo the process if not done thoroughly)

NO WRONG DOOR – is NOT a reality, since referrals need to be brought through the LME, and that often delays entry into service

Delay in receiving authorization

Lack of consistency in what gets authorized

Clinical home confusion with some providers

Six Respondents State/Division – 1

LME – 1

Provider – 3

Advocacy – 0

Unknown – 0

1 – List administrative functions required in the delivery of Case Management services, but that do not add value.

Item	# citing item	Comments
Authorization	3	<ul style="list-style-type: none"> • period needs to be extended over a longer period of time, similar to CAPMR annual plan updates. require quarterly reviews to justify medical necessity • requests should be eliminated. The Plan should serve as a request for the authorization of services in the plan. It is redundant to then turn around and put that on another piece of paper • and the more often, the more problematic
PCP	1	<ul style="list-style-type: none"> • complicated format
Tracking minimum/maximum contact hours/events	1	
Travel	1	
Resolving barriers to communication	1	
Documentation/Paperwork	3	<ul style="list-style-type: none"> • Note in PIE format should be eliminated - a log of phone call or face to face with time spent could be kept and then a monthly or quarterly summary could address outcomes achieved • Redundancy of required signatures every 30 days • Financial determination paperwork
Lack of standard application for various services re: referral purposes	1	
NC-TOPPS	1	

Having to call 6 hospitals for denials in order to get into a State Hospital, even though it is clear that acceptance to the other hospitals will not be successful	1	
State data base vs. local data base	1	

We strongly concur with the first bullet under the Care Manger Goals/Outcomes: In order for there to be a reduction in Case Management billing, it is imperative that there be major revisions in the administrative regulations governing the programs. We can only speak to CAP since we are unfamiliar with requirements in the other programs, but have the following recommendations on how some case management time could be reduced by revising CAP regulations:

- If client has a level of care change, a Change in Status Assessment is required. This may not always be needed, such as when a wound heals and client reverts from SN to IC level, or number of therapy visits decrease. The Change in Status completion requirement should be at discretion of the Lead Agency.
- Regulations require that Case Manager see the IHA in the home at least every 90 days. This should be the responsibility of the IHA Provider Agency, not the CAP case manager.
- Much time is spent on clerical related requirements. Revise and reduce the amount of notices needed at time of case approval, CNR completion, and revisions.
- Current system is inefficient when case managers have to make numerous calls to track down home health services, supplies. Consider eliminating requirement to confirm costs on non-Medicaid items.
- We must bill to complete pen/ink revisions every time the DME or Home Health fee schedules are changed. Set a fixed time frame for when schedules can be modified. Notify Lead Agencies when this happens, or better yet, find a way for cost increases to be fed into AQUIP and automatically integrated into clients' cost summaries.
- Expand CAP/Choice as soon as the statewide Financial Intermediary (FI) contract can be awarded. Although it costs more initially in case management time to put a client onto CAP/Choice, the CM average drops off after the initial months. If the State FI were operational, even more time could be reduced by having clients deal directly with the FI instead of Care Advisor having to be the intermediary. (Average time of case management for CAP/DA client was 2.92 hours and average time for CAP/Choice was 3.3 hrs; however, of this at least .75 hours could be eliminated monthly if CAP Choice Care Advisors were not involved in the Financial Intermediary issues, resulting in average monthly CM time being less than for CAP/DA than for CAP/Choice.)
- Allow DME companies to bill Medicaid directly for regular and waiver medical supplies, eliminating the need for case managers to check bills and HCFA 1500s for supplies.
- Give case managers access to Medicaid Claims histories. We could identify items billed that were non-reported by clients or providers and prevent duplication of services.
- Consider capping the maximum case management billing time in proportion to the client's approved level of care. There also needs to be further delineation in the levels of care other than just IC and SN.

What could be adjusted to improve administrative efficiencies and reduce overhead?

Utilize the principals put forward by the NC Providers Council:

- A unified system of MH/DD/SA that assures consistent and statewide implementation of policies and procedures for Medicaid and state funded services (Policies and procedures interpreted and implemented consistently statewide could be trained, implemented and monitored more efficiently.)
- Clear accountability for the divisions of DHHS, local systems and providers through segregation of duties and the unduplicated delegation of responsibility and authority (If more than one person (entity) is responsible, no one (entity) is responsible. In the absence of established responsibility, there is no accountability. Increased accountability throughout DHHS and local systems would substantially increase effectiveness and efficiency.)
- Assurance of effective and efficient (identical/uniform/statewide) processes for authorizations and payment including uniform billing and payment procedures for Medicaid and State funded services. (Having more efficient authorization, billing and payment protocols would lower costs and increase cash flow. Increase in case flow would result in increased service capacity and access to services.)

Administrative functions specific to Case Management (CM) needing increase efficiencies

- PCP template too cumbersome
- Concurrent review by LME and VO
- Inefficiencies resulting from administrative requirements, i.e. running around collecting signatures
- Authorizations – too many – too often
- No discernable outcomes for CM
- Higher costs by frequent face-to-face visits requirement when CM separate from service (integrated w/direct service lowers costs)
- CM managing the Payee Representative process
- CM agency managing the durable medical equipment and supply process
- Frequency of documentation
- MD signature required for all service orders
- Redundancy of paperwork, i.e. PCP, PCP Admission Form, CTCM Form, ITR Form, STR Form, ORF Form are all repetitive
- VO, CareLink, etc... not using efficiencies of a web-based system
- Variable electronic systems
- Endorsement/Accreditation/Licensure/ Monitoring have duplicative, overlapping and often repetitive functions. Increased role clarification, responsibilities and accountability would increase efficiency and effectiveness. Current inefficiency increases costs and detracts from the quality of services

Case Finding and Outreach

- Limitations on available mechanisms to identify potentially eligible clients
- No longer receive referrals from DSS on pregnant women receiving Medicaid to assist with case finding

Policy

- DMA Policy revision has been in process since 2004, with lengthy inactive periods, resulting in delays and postponement of proposed program improvements.
- Forms have not been updated to reflect changes in practice and service standards.
- Cannot bill on same date of service as separate case management services for a different Medicaid recipient in the same family (Child Service Coordination), which can result in increased staffing costs

and inconvenience for the family, to conduct a separate contact on a different day to meet both program requirements.

- Minimum monthly contact required, which may not be indicated by client needs.

Service Limitations and Billing Procedures

- Unit Cap limits services and the claims adjustment process is overly burdensome to providers. Thus, women who need more intensive services may not receive them or the services may be provided by not billed, therefore skewing service utilization data.

Training

A moratorium on providing Basic Training for MCC and MOW services has resulted in challenges for providing comprehensive ongoing training for line staff and has increased consultant time required to provide one-on-one orientations, in lieu of group training. This model has also resulted in increased isolation of local staff, due to fewer opportunities to network and share resources

Constant changes in the world of CAP/MR/DD require collaboration with others of this specialty knowledge. Having a clear support network is key to the implementation and understanding of the rules and regulations. Often it is through the network you gain understanding of the requirements and how to assist your providers within your catchment area. If we are all cross trained it becomes impossible to have smooth application of resources if you only complete any given approach once in a while or never. One can educate themselves on everything there is to know, but cannot perfect without repetitive application.

The current public system doesn't foster cooperation or smooth transition from one discipline, specialty, or department. You can overhaul Case Management, but can you overhaul systems by September 1.

Having a case management "generalist" means we lose the expertise and experience that comes from having a qualified professional providing the service for a population that they know and are knowledgeable in.

Families may end up with someone who has virtually no or just a brief intro into DD trying to work with their family member. Difficult to do true person centered planning when you do not have a good grasp of the disability and issue that come with it. There will be no "experts" in the field any longer which is crucial to doing a good assessment, determining a person's needs, writing an effective plan, monitoring provision of services, etc. The time spent investigating the nuances or technicalities of funding, resources, and programs don't speak to efficiency of resources or personnel. How will the lack of knowledge and lag time needed to educate one's self on the fly help consumer's access resources? Or will the lack of knowledge add to consumer frustration.

Currently there is constant turnover and lack of experience in the field. Will this new process add to that or eliminate? Who will be qualified on September 1 to provide Case Management which will require them to navigate numerous systems and funding streams, all with different rules, timelines, and requirements. No one could possibly retain all of the information needed in order to effectively coordinate care across primary health, early intervention, DSS, juvenile justice, MH, DD, SA, etc. Let alone the very specific training requirements needed to know how to navigate the various CAP waiver programs, cost summaries, etc.

The logistics of trying to provide a service across all these disciplines would be very difficult from a provider agency standpoint and administratively as well. Staff training, core competencies, billing, authorizations, etc. would be extremely challenging.

Even if consolidating case management into a more general service saves some money in the short-term, the sign cant loss in the quality and satisfaction of the service is likely to lead to the demand for more specialization in the future, which in the end costs the system more

money to try and recreate.

How will the success or failure of the changes be measured?

Recommended Changes for TCM Service Definition and Requirements

State Plan to CMS

1. Ensure there are no requirements for Case Managers to be Masters level.
2. Move to billing TCM at a monthly rate, or daily rate, rather than a rate per 15-minute unit of service. (If not monthly and 15 minute units remain, omit any limits on number of units billed by each Case Manager/Practitioner. If units remain limited, then measure by weekly averages and not daily caps. Any such limits or guidelines should be person-specific, and not practitioner-specific.)
3. Ensure no limits on number of people supported by each Case Manager.
4. Simplify requirements for progress note documentation. Suggest a monthly summary instead of a daily note, or a checklist similar to CAP-MR/DD discrete service documentation.
5. If TCM service provision is restricted to QPs, ensure a sunset clause (for staffing requirements) in TCM definition to be changed with a date that coincides within one year of TCM definition implementation (e.g. implementation 1/1/09, sunset clause to meet staffing qualifications 12/31/09). This allows a window in which APs currently providing Case Management can gain enough experience to become QPs.

State

6. Move to billing TCM at a monthly rate, with monthly summary progress note for state-funded TCM.
7. Postpone implementation of new PCP for CAP; continue use of current PoC. This is very costly. Experienced CMs are reporting 4 to 8 hours of work to transfer information to the new, and longer PCP – this is paid through Medicaid dollars that could be better applied toward helping people achieve outcomes.
8. Drop requirement for signatures on plans by MDs, PAs, Nurse Practitioners, and Licensed Psychologist. The plan (PoC or PCP format), signed by the QP, should serve as the service order. Medical necessity is determined by diagnosis, and QP should be able to complete the service order for people with MR/DD, as is the case with CAP-MR/DD. We continue to experience problems with doctors signing plans. Doctors do not feel comfortable signing a plan they know nothing about. Many refuse, seeing it as a liability for them. It is especially difficult with people who live in rural areas, and may not have a primary care physician that they maintain “regular” contact with, which impedes upon the doctor’s willingness to sign a plan for someone that they rarely see. The requirement to annually establish medical necessity for people with developmental disabilities through a doctor’s signature is ridiculous, redundant, time consuming, unnecessary, supportive of the old medical model, and it reflects very poorly on our system of services. It is also an added cost in the system for CMs to “chase” these signatures. Require a QP/Case Manager to sign all plans instead of an MD.

9. Drop the requirement that PCP reviews with no changes must have all required signatures. (RMDM page 6-7)
10. Not everyone needs a crisis plan. Most of them are going to sound silly, as the individual just doesn't have anything that we would call a crisis. In this requirement the system assumes that just because someone has a disability they are likely to experience crisis at a level which would require this amount of foresight, planning and coordination. This is a discriminatory practice at best. Remove the requirement for "crisis plans for all" or standardize a simple format for people who aren't crisis-prone.
11. Authorization requests for all TCM should be one time or annual at the most.
12. Drop requirement for monthly face-to-face visits for people receiving CAP. Suggest requirement for bi-monthly or quarterly face-to-face visits.
13. CAP supplies, equipment and modifications – either provide an administrative fee to cover the provider's administrative costs, or move this responsibility back to the LMEs. Also, consider giving participants who receive regular supplies (i.e. pull-ups or nutritional supplements) an annual stipend for these items. They can purchase most of these cheaper at Wal-Mart and save Medicaid dollars, including the costs of shipping by UPS!
Examples: Depends, Small/Medium Underwear Super
Medicaid allowable = .95 each, Wal-Mart = .67 each
Pampers Stage 6
Medicaid allowable = .95 each, Wal-Mart = .40 each
Boost
Medicaid allowable = \$1.69 each, Wal-Mart = .99 each
Ensure
Medicaid allowable = \$1.75 each, Wal-Mart = \$1.11 each
Glove N/S Latex (box of 100)
Medicaid allowable = \$11.16, Wal-Mart = \$9.68
Another alternative to consider – identify a statewide vendor/billing agent for all supplies and equipment.
14. Provider incident reports need to come to Case Managers and not just be reported to the LME. This disconnect has been happening for several years. As Case Management services were divested, providers were told they still had to send incident reports to the LME. This creates a real disconnect for Case Managers who are responsible for monitoring services provided, and health and safety, and many providers refuse to share these with Case Managers because it is not required. If Case Managers are expected to monitor for health and safety (and especially not making monthly face-to-face visits), we will need these.
15. Several LMEs still require Case Managers to submit authorization requests for all state-funded discrete services. Direct support providers should submit all authorization requests for all discrete services, consistent with methods of requesting authorization for CAP discrete services.

16. Ensure there is no requirement for Case Manager to be present during SIS. If the requirement stands, then postpone the full roll-out of the use of SIS, train Case Managers, and allow them to do the SIS as part of their assessment and plan development.
17. Drop requirement for target pop paperwork for all people NOT receiving state funded services. NC's target pop paperwork is not required by Medicaid or for Medicaid.
18. STR process - this is a function of the LME or provider QP supervised by a Licensed Professional. Some LME's require us to complete STR process. We are not supervised by LP, therefore, do not get reimbursed. We should not be mandated by LMEs to do this if we do not meet criteria and will not get paid for this service. Suggest all STR responsibilities stay with LMEs only. As a part of the STR process, LMEs should also hold responsibility for determining eligibility. This is not a CM function and it can be costly for providers with no revenue source to complete this process. Part of the Community Support failure was in not securing eligibility determinations for each person receiving services. Keep this with LMEs. In addition, LMEs should provide a very short eligibility determination and service order to jump start CM services for each person. (See attached for an old version used in Thomas S. services.)
19. All needed corrections/revisions of plans from the authorizing agent (VO or LME) should be provided in writing to the Case Manager. This does not currently happen. This used to happen in the system and it provided a mechanism for continual improvement in plan writing and development. Without it, providers will remain at the lowest common denominator in plan quality.
20. Waive or extend the 7-day rule for Medicaid billing.
21. Drop the requirement that the TCM provider must pay for translators for non-English speaking individuals/families receiving services. Reimburse these costs.
22. Get TCM endorsement procedures ready and distributed ASAP. This has to be completed before direct enrollment with DMA.
23. Ensure Case Management providers can bill services directly to EDS as soon as TCM definition is approved. This will save time and money for TCM providers.
24. Develop easier and shortened process to train trainers for PCPs. Providers can not afford long training processes.
25. Exempt CMs from unnecessary and redundant training requirements, such as NCI Part A or Communication and Interaction Strategies (this was a state response to people dying in facilities, not being harmed by CMs), CPR, First Aid.
26. Seek experienced providers to review and comment on new developments and processes like the revised PCP, CAP Manual, State Plan Amendment proposed to CMS. Providers are the experts on how proposals will work day in and day out on the ground.
27. Ensure VO sends CM authorization for services to the actual provider of the CM service. Today VO sends authorizations to LMEs and LMEs do not have staff to sort through and send appropriate

authorizations to appropriate CM providers. We often wait 2 months or more to receive the actual paper authorization. We incur a lot of extra costs, and have more mishaps with authorizations because we can not get these directly. CM providers need these NOW, whether we are directly enrolled yet or not.

28. Discharge planning – currently CMs can not bill for services provided while a person is hospitalized. Whether a psychiatric or a medical hospitalization, CMs often need to and continue to provide coordination of services for continuity of care and discharge planning. This needs to be provided for the individual/family to help optimize psychiatric or medical stabilization and ensure continuity of care after discharge. This is often a valuable service that we provide but can not bill and get paid for. CM providers should be paid for this – it will decrease overall costs and recidivism.
29. Require all LMEs to use the same standardized processes and forms for eligibility, documentation and reporting, authorizing, billing, etc. Customization per LME is very costly for a provider, and the state. Some LMEs still require purchase orders and others still provide their own version of a service authorization once VO has authorized – creating double work for everyone involved and further postponing our receipt of authorization information.
30. Establish ONE integrated data reporting and management system for providers, LME, state...
31. Reinstate the old “Case Support” service definition, to be paid at a lower rate, and provided by APs and PPs for people with fewer or less intense needs, or people entering the system for the first time. This would be similar to a lower tier of CM in a tiered system.
32. Providers must now complete HAIFA and CMGT forms just to get a denial from an insurance company for something we already know they will not cover, and we have to have this denial on paper before we can bill the LME. If it is already established that private insurances don't pay for certain things, it is a waste of time to get a denial on paper. Medicaid should be able to accept billing once it is established that the insurance company does not pay for the service.
33. Keep educational requirements at the current level and create a mechanism for people with degrees less than Bachelors to “grandfather” into the QP status with years of experience and proven competency. The current state plan and requirements places significantly too much emphasis on education and the attainment of a piece of paper representing very little if any real work or experience in the field and in our system. Families and individuals do not care about degrees. Experience is far more valuable, yet not given the recognition it deserves. Many of these people have made this work their life-long career choice and are our experts at doing it right.
34. Operationalize methods in the CAP waivers and with state funds to pay for more creative uses of assistive technology that can support and increase people's independence while decreasing their dependence and subsequent costs on system's services.