

State Plan under Title XIX of the Social Security Act
State/Territory: North Carolina

TARGETED CASE MANAGEMENT SERVICES
Adults and Children Over 5 Years of Age, or On the CAP-MR/DD Waiver, With Developmental
Disabilities Or Traumatic Brain Injury

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

This target group includes the individuals who meet the following criteria:

Adults and children five years of age and older, or children on the CAP-MR/DD HCBS waiver, who are diagnosed with a developmental disability or diagnosed with mental retardation manifested prior to the age of 22, , or who have mental or physical impairments similar to developmental disabilities as the result of a traumatic brain injury manifested after age 22.

Recipients included in the 1915 c Innovations waiver will be excluded. They will receive coordination of services under 42 CFR 438.208.

Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 60 consecutive days of a covered stay in a medical institution. Reimbursement is made to the Community Case Management Provider rather than the medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

Entire State

Only in the following geographic areas: Recipients with eligibility in the counties covered under Fee for Service Medicaid are eligible for this service.

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

Services are provided in accordance with §1902(a)(10)(B) of the Act.

Services are not comparable in amount duration and scope (§1915(g)(1)).

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State Plan under Title XIX of the Social Security Act
State/Territory: North Carolina

TARGETED CASE MANAGEMENT SERVICES

Adults and Children Over 5 Years of Age, or On the CAP-MR/DD Waiver, With Developmental Disabilities Or Traumatic Brain Injury

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

The TCM recipient is assessed on an ongoing basis to determine if additional services or different services might be needed and at least annually as a part of the review of the individualized services plan, referred to as the care plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual.
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including,
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

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- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Plans are monitored on at least an annual basis or at any time additional services are needed and requested by or for a recipient. The plan will be reviewed and agreed upon by the recipient, recipient parent or legal representative and case manager.

✕ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Qualifications for Individual Case Managers: Case Managers under this State Plan must meet one of the following qualifications:

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1. A Licensed clinical social worker; or
2. A Licensed psychologist; or
3. A Master's prepared individual with degree in a human service area with one year of experience in case management with the developmentally disabled; A Master's prepared individual with a degree in a human service field, employed by the agency at the time of enrollment, but who does not have one year of experience with public sector case management must meet this experience criteria within one year; or
4. A Bachelor's prepared individual with degree in a human service area with two years of experience in case management with the developmentally disabled; A college prepared individual with a Baccalaureate degree in a human service area that includes the above disciplines, employed by the agency at the time of enrollment, but does not have two years experience with public sector case management must meet this experience criteria within two years; or a Baccalaureate degree in an area other than human services with 4 years of experience in case management with the developmentally disabled.
5. Registered nurse currently licensed by the North Carolina Board of Nursing at the time of enrollment with two years experience with public sector case management; Registered nurse currently licensed by the North Carolina Board of Nursing employed at the time of enrollment but does not have two years experience with public sector case management must meet this experience criteria within two years.

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Qualifications for Agency Providers for adults and children five years of age and older or children in the CAP-MR/DD HCBS waiver, who are diagnosed with a developmental delay/disability manifested prior to the age of 22, or diagnosed with mental retardation, or who have mental or physical impairments similar to developmental disabilities as the result of a traumatic brain injury manifested after age 22 shall meet following qualifications.

Provider Agencies providing TCM for persons with Developmental disabilities will include both Local Management Entities (LMEs) and private providers through subcontracting arrangements with LMEs. If Local Management Entities serve as providers, they will be approved by the Division of Mental Health, Developmental Disabilities and Substance Abuse. These provider agencies must have the capacity to assure quality and provide services according to North Carolina laws, policies and regulations.

By August 1, 2010, private providers will be endorsed by the Local Management Entities. Upon provider endorsement, each provider must ensure that each case manager has 20 hours of training relating to case management functions within the first 90 days of hire.

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TN# 05-007

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TARGETED CASE MANAGEMENT SERVICES

Adults and Children Over 5 Years of Age, or On the CAP-MR/DD Waiver, With Developmental Disabilities Or Traumatic Brain Injury

EPSDT: The statewide vendor conducts reviews for consumers under the age of 21, when additional services may be requested even if they do not appear in the State Medicaid Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the service is medically necessary. Any denial, reduction, suspension or termination of a service requires notification to the recipient and/or legal guardian about their appeal rights.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

x Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

Targeted Case Management Provider Agencies providing services to this target group must be endorsed by the Local Management Entity by August 1, 2010, as meeting both business and service quality criteria.

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Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the

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direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

This service has a limit of one unit per week, with no upper limit on the number of hours per week.

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TARGETED CASE MANAGEMENT SERVICES
Children Less Than Three Years of Age Who Are At Risk For, or Have Been Diagnosed With,
Developmental Delay/Disability or Social Emotional Disorder

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

This target group includes the individuals who meet the requirements defined in the Children's Development Service Agencies policy: Children less than three years of age who are at risk for, or have been diagnosed with, developmental delay/disability or social emotional disorder.

Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 60 consecutive days of a covered stay in a medical institution or up to 180 days for infants in a neo-natal intensive care unit. Reimbursement is made to the Community Case Management Provider rather than the medical institution.

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- Entire State
 Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
 Services are not comparable in amount duration and scope (§1915(g)(1)).

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TARGETED CASE MANAGEMENT SERVICES
Children Less Than Three Years of Age Who Are At Risk For, or Have Been Diagnosed With,
Developmental Delay/Disability or Social Emotional Disorder

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

The TCM recipient is assessed on an ongoing basis to determine if additional services or different services might be needed and at least annually as a part of the review of the individualized services plan, referred to as the care plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual.
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including,
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

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Developmental Delay/Disability or Social Emotional Disorder

- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan.

Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Plans are monitored on at least an annual basis or at any time additional services are needed and requested by or for a recipient. The plan will be reviewed and agreed upon by the recipient, recipient parent or legal representative and case manager.

✕ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Provider agencies are certified by the North Carolina Division of Public Health, Early Intervention Branch as having in-depth knowledge, experience and understanding of the special populations of infants and children who are in this defined target population.

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Children Less Than Three Years of Age Who Are At Risk for, or Have Been Diagnosed With,
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Qualifications for case managers are established by the Division of Public Health, Early Intervention Branch. They are as follows:

1. Case managers for an infant or toddler, referred to or enrolled in the Early Intervention Program, shall meet *one* of the following qualifications regarding degree held:
 - Hold a master's degree from an accredited university in a health, education, early childhood, or human services field.
 - Hold a current North Carolina license in nursing, regardless of whether a two, three, or four-year educational program.
 - Be an infant or toddler's case manager who is working with children and families under the supervision of a Case Management Supervisor as defined below to conduct those case management activities that they have been approved to perform.
2. An infant or toddler's case manager must be approved through the certification process of the Division of Public Health Early Intervention Branch for the NC Infant-Toddler Program.
3. A Case Management Supervisor shall meet *one* of the following qualifications regarding degree held:
 - Hold a master's degree from an accredited university in a health, education, early childhood, or human services field; or
 - Hold a bachelor's degree from an accredited university in a health, education, early childhood, or human services field and have a minimum of two years of experience in providing services to infants or toddlers with or at risk for developmental delays.
4. A Case Management Supervisor must be approved through the certification process of the Division of Public Health Early Intervention Branch for the NC Infant-Toddler Program.
5. Certification Process. The Division of Medical Assistance has adopted the Division of Public Health, Infant Toddler Program standards and procedures for certification of each individual case manager. This certification process assures:
 - a. Their capacity to provide case management services.
 - b. Their experience with delivery and/or coordination of services for children and families.

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TARGETED CASE MANAGEMENT SERVICES

Children Less Than Three Years of Age Who Are At Risk for, or Have Been Diagnosed With,
Developmental Delay/Disability or Social Emotional Disorder

EPSDT: The statewide vendor conducts reviews for consumers under the age of 21, when additional services may be requested even if they do not appear in the State Medicaid Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the service is medically necessary. Any denial, reduction, suspension or termination of a service requires notification to the recipient and/or legal guardian about their appeal rights.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

3. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
4. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

X Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services.

TCM Provider Agencies must be certified by the Division of Public Health as meeting both business and service quality criteria.

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Children Less Than Three Years of Age Who Are At Risk For, or Have Been Diagnosed With,
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Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

This service is limited to 12 units or three hours per month.

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TARGETED CASE MANAGEMENT SERVICES
[Individuals with Mental Illness/Substance Use Disorders]

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

In order to receive services, the individual must meet the defined entrance criteria.

1. (For recipients age 3 through 20): Has a serious emotional disturbance or substance use disorder.
2. (For recipients 21 and older) Has a severe and persistent mental illness or a substance use disorder.

X Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 60 consecutive days of a covered stay in a medical institution. Reimbursement is made to community case management providers rather than the medical institution, for these activities. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- Entire State
- X Only in the following geographic areas: Recipients included in the 1915(b) North Carolina MH/DD/SA Health Plan will be excluded. They will receive coordination of services under 42 CFR 438.208.

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- Services are provided in accordance with §1902(a)(10)(B) of the Act.
- X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

The TCM recipient is assessed on an ongoing basis to determine if additional services or different services might be needed and at least annually as a part of the review of the individualized services plan, referred to as the Person Centered Plan.

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TARGETED CASE MANAGEMENT SERVICES
[Individuals with Mental Illness/Substance Use Disorders]

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Plans are monitored on at least an annual basis or at any time additional services are needed and requested by or for a recipient. The plan will be reviewed and agreed upon by the recipient, recipient parent or legal representative and case manager.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

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TARGETED CASE MANAGEMENT SERVICES
[Individuals with Mental Illness/Substance Use Disorders]

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

To provide TCM for persons with mental illness or substance use disorder, provider agencies must be certified as a Critical Access Behavioral Health Agency (CABHA). These provider agencies must have the capacity to assure quality and provide services according to North Carolina laws, policies and regulations. CABHAs will be certified by the DHHS and Local Management Entities (LMEs). Each provider must ensure that each case manager completes DHHS-approved targeted case management training within the first 90 days of hire.

Qualifications for Individual Case Managers: Case Managers under this State Plan must meet one of the following qualifications based on the target population being served:

1. currently licensed by the appropriate North Carolina licensure board as a Licensed Clinical Addiction Specialist, Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Psychiatrist, Licensed Psychologist or a Licensed Psychological Associate or;
2. a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, post-graduate degree accumulated MH/DD/SAS experience with the population served or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling or;
3. a graduate of a college or university with a bachelor's degree in a human service field or an RN currently licensed by the NC Board of Nursing and has four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has two years of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling or;

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4. a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, post-bachelor's degree accumulated MH/DD/SAS experience with the population served, or a substance abuse professional who has four years of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling.

*Degrees in a human service field include but are not limited to, the following degrees: psychology, social work, mental health counseling, rehabilitation counseling, addictions, psychiatric nursing, special education, and therapeutic recreation.

Freedom of choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

5. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
6. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

X Target group consists of eligible individuals with mental illness or substance use disorders. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with mental illness or substance use disorders receive needed services:

For this target population, Targeted Case Management Provider Agencies must be certified as Critical Access Behavioral Health Agencies (CABHAs) by DHHS and Local Management Entities (LMEs).

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM)) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Case management services may be provided by only a provider agency that is a certified Critical Access Behavioral Health Agency (CABHA). An individual may receive case management services from only one CABHA during any active authorization period for this service.

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In situations where more than one recipient within a family qualifies for MH/SA Targeted Case Management and the family has chosen the same CABHA, that CABHA shall assign the same case manager to serve each recipient in the family only as long as that case manager has the required qualifications to serve both populations and is clinically appropriate.

The following are not billable under this service:

- Transportation time
- Transportation services
- Any treatment interventions (for example, habilitation or rehabilitation activities)
- Any social or recreational activities (or the supervision thereof)
- Clinical and administrative supervision of staff, including team meetings
- Writing assessment reports, Person Centered Plans, or service notes
- Service record reviews

Service delivery to individuals other than the recipient(s) may be covered only when the activity is directed exclusively toward the benefit of the recipient(s).

Case Management services can be provided for two weeks during the same authorization period as the following services for transition purposes: Intensive In-Home Services, Community Support Team, Assertive Community Treatment Team, Multisystemic Therapy, Child and Adolescent Day Treatment, Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, or Substance Abuse Non-Medical Community Residential Treatment.

Medicaid recipients receiving MH/SA case management may not receive other Medicaid-reimbursable case management services during the same period, including but not limited to the following:

- Community Alternatives Program (CAP), including CAP for Disabled Adults (CAP/DA), CAP for Children (CAP/C), CAP for Individuals with Mental Retardation or Developmental Disabilities (CAP/MR-DD) or CAP Choice.
- Targeted Case Management for Individuals with Mental Retardation/Developmental Disabilities (MR/DD)

Service is limited to one unit per week.

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ADULTS AND CHILDREN AT-RISK OF ABUSE, NEGLECT, OR EXPLOITATION

Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

The target group includes Medicaid recipients who are assessed as at-risk of abuse, neglect, or exploitation as defined in North Carolina General Statutes 7B-101 and 108A-101 *and who meet requirements defined in the At Risk Case Management policy.*

The recipient cannot be institutionalized nor a recipient of other Medicaid-reimbursed case management services provided through the State's home and community-based services waivers or the State Plan. The at risk case manager assesses risk using a State prescribed format. The criteria for determining whether an adult or child is at risk of abuse, neglect, or exploitation is as follows:

1. At-Risk Adult: An at-risk adult is an individual who is at least 18 years old, or an emancipated minor, and meets one or more of the following criteria:
 - a. An individual with only one consistent identified caregiver, who needs personal assistance 24 hours per day with two or more of the activities of daily living (bathing, dressing, grooming, toileting, transferring, ambulating, eating, communicating); or
 - b. An individual with no consistent identified caregiver, who is unable to perform at least one of the activities of daily living (bathing, dressing, grooming, toileting, transferring, ambulating, eating, communicating); or
 - c. An individual with no consistent identified caregiver, who is unable to carry out instrumental activities of daily living (managing financial affairs, shopping, housekeeping, laundry, meal preparation, using transportation, using a telephone, reading, writing); or
 - d. An individual who was previously abused, neglected or exploited, and the conditions leading to the previous incident continue to exist; or
 - e. An individual who is being abused, neglected, or exploited and the need for protective services is substantiated.

2. At-Risk Child: An at-risk child is an individual under 18 years of age who meets one or more of the following criteria:
 - a. A child with a chronic or severe physical or mental condition whose parent(s) or caretaker(s) are unable or unwilling to meet the child's care needs or whose adoptive parents needs assistance in order to meet the child's care needs; or

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- b. A child whose parents are mentally or physically impaired to the extent that there is a need for assistance with maintaining family stability and preventing or remedying problems which may result in abuse or neglect of the child; or
- c. A child of adolescent (under age 18) parents or parents who has their first child when either parent was an adolescent and there is a need for assistance with maintaining family stability, strengthening individual support systems, and preventing or remedying problems which may result in abuse or neglect of the child; or
- d. A child who was previously abused or neglected, and the conditions leading to the previous incident continue to exist; or
- e. A child who is being abused or neglected and the need for protective services is substantiated.

___ The target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- Entire State
- ___ Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- ___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
- Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;

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- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

An initial assessment is conducted to determine the individual's need for medical, education, social, and other services. The continuing appropriateness of providing At Risk Case Management Services is assessed during quarterly reviews of the service plan. Reassessments are completed annually which include performing a new assessment and creating a new service plan.

- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
 - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
 - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
 - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

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- Follow up visits are conducted quarterly unless there is a change in the individual's condition. These contacts with the individual subsequent to the initial assessment must be one-on-one, face-to-face visits. It is necessary to contact the individual at least quarterly to ensure that there are not any new concerns or changes in the status of previously identified concerns. In addition, these contacts are necessary to ensure that the care plan is effectively implemented and is consistent with quality of care.

X At risk case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

1. Provider Qualifications

Providers must meet the following qualifications:

- Meet applicable State and Federal laws governing the participation of providers in the Medicaid Program.
- Be certified by the Division of Aging and Adult Services as a qualified At Risk Case Management Provider.

2. Certification Process

In the absence of State licensure laws governing the qualifications and standards of practice of providers of case management services for at-risk adults and children, the State Division of Medical Assistance and the State Division of Social Services and the State Division of Aging and Adult Services have a Memorandum of Understanding to provide a certification process. The State Division of Aging and Adult Services agrees to implement methods and procedures for certifying providers of At Risk Case Management services as qualified to render services according to professionally recognized standards for quality care. This will help assure that case management services are provided by qualified providers

To be certified as an At Risk Case Manager, a provider must:

- Have qualified case managers with supervision provided by a supervisor who meets State requirements for Social Work Supervisor I or Social Work Supervisor II classification.

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- Case Manager for At-Risk Adults: A case manager for at-risk adults must have a Master of Social Work degree or a Bachelor of Social Work degree, or be a social worker who meets State Requirements for Social Worker II classification. The individual must have training in recognizing risk factors related to abuse, neglect, or exploitation of elderly or disabled adults and in assessment of functional capacity and needs related to activities of daily living. The individual must have experience in providing case management for elderly and disabled adults.
- Case Manager for At-Risk Children: A case manager for at-risk children must have a Master of Social Work degree or a Bachelor of Social Work degree, or be a social worker who meets State requirements for Social Worker II classification. The individual must also have training in recognizing risk factors related to abuse or neglect of children and in assessing family functioning. The individual must have experience in providing case management for children and their families.
- Have the capability to access multi-disciplinary staff, when needed. For adults this includes, at a minimum, medical professionals as needed and an adult protective services social worker. For children, this includes, at a minimum, medical professionals as needed and a child protective services social worker.
- Have experience as a legal guardian of persons and property.

Freedom of choice (42 CFR 441.18(a)(1):

The State assures that the provision of at risk case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

7. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
8. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

____ This target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of targeted case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

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ADULTS AND CHILDREN AT-RISK OF ABUSE, NEGLECT, OR EXPLOITATION

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

EPSDT: Reviews are conducted for consumers under the age of 21, when additional services may be requested even if they do not appear in the State Medicaid Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the service is medically necessary. Any denial, reduction, suspension or termination of a service requires notification to the recipient and/or legal guardian about their appeal rights.

Payment (42 CFR 441.18(a)(4):

Payment for case management or at risk case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving at risk case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the at risk case management service; (iv) The nature, content, units of the at risk case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

At risk case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

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ADULTS AND CHILDREN AT-RISK OF ABUSE, NEGLECT, OR EXPLOITATION

At risk case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the at risk case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

FFP only is available for At risk case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

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Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):

The target group includes individuals below who meet the requirements defined in the HIV Case Management policy:

1. Have a medical diagnosis of HIV disease; or
2. Have a medical diagnosis of HIV seropositivity; and
3. Are eligible for regular Medicaid services; and
4. Are not institutionalized; and
5. Are not recipients of other Medicaid-reimbursed case management services, including those provided through the State's home and community-based services waivers or the State Plan.

___ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to _____ [insert a number; not to exceed 180] consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions). (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

- X Entire State
___ Only in the following geographic areas: [Specify areas]

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

- ___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

- ❖ Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include
 - taking client history;
 - identifying the individual's needs and completing related documentation; and
 - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

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HIV case managers shall conduct a comprehensive assessment and evaluate the individual's need for initial case management services. The reassessment shall be conducted on an annual basis. The assessment shall include observation of the recipient's physical appearance and behavior during the interview; and gathering the individual's history, obtaining information from other sources such as family members, medical providers, social workers and educators. The assessment shall address the following:

- coordination and follow-up of medical treatments;
 - provision of treatment adherence education;
 - physical needs to include activities of daily living and instrumental activities of daily living;
 - mental health/substance abuse/developmental disability needs;
 - housing and unmet needs related to physical environment;
 - financial needs; and
 - socialization and recreational needs.
- ❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - identifies a course of action to respond to the assessed needs of the eligible individual;
- ❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and
- ❖ Monitoring and follow-up activities:
- activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
 - services are being furnished in accordance with the individual's care plan;
 - services in the care plan are adequate; and
 - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

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Monitoring and follow-up are conducted quarterly and more frequently as necessary to determine whether:

- the individual is receiving medical treatment;
- services are being furnished in accordance with the individual's care plan;
- services in the care plan are needed;
- services in the care plan are adequate; and
- there are changes in the needs or status of the individual, and if so, whether
 - necessary adjustments have been made in the care plan and service arrangements with the providers; or
 - the individual's goals have been met and the individual has been discharged if appropriate.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

(42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

(PROVIDER)

Provider Qualifications

To qualify for certification as a provider of HIV Case Management services, a provider shall meet the following criteria:

- Have a documented record of three (3) years of providing or managing HIV Case management programs. Providers certified prior to 1/1/2010 shall have two years to be in compliance.
- Ensure the provision of HIV case management services by qualified case managers as described in Section 6.3.1 of the HIV Case Management policy. Providers shall have six months from 1/01/2010 to come into compliance with this requirement.
- Ensure supervision of HIV case managers by qualified supervisors as described in Section 6.3.2 of the HIV Case Management policy. Providers shall have six months from 1/01/2010 to come into compliance with this requirement.
- Enroll each physical site with DMA as a provider of HIV case management services in accordance with §1902(a)(23) of the Social Security Act.

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- Meet applicable state and federal laws governing the participation of providers in the Medicaid program.
- Maintain certification as a qualified provider HIV case management services and have a collaborative relationship with the physician record.
- Maintain certification as a qualified provider of HIV case management services.
- Demonstrate compliance with initial and ongoing certification processes.
- Demonstrate compliance with the monitoring and evaluation of case management records through a quality improvement plan.
- Allow DMA to review recipient records and inspect agency operation and financial records.
- Notify DMA of proposed changes such as business owner or name change, address or telephone number change, or plans for business dissolution within 30 calendar days of the proposed change and no later than five business days of the actual change.
- Achieve national accreditation with at least one of the designated accrediting agencies within one year of enrollment with Medicaid as a provider. (Providers, who were enrolled prior to 1/1/2010, shall achieve national accreditation within two years of this policy effective date). Designated accrediting agencies include the following: Utilization Review Accreditation Commission (URAC), Community Health Accreditation Program (CHAP) and Commission on Accreditation of Rehabilitation Facilities (CARF).

To qualify for reimbursement for HIV case management services, a provider shall meet all the criteria specified below:

- Be enrolled in accordance with section 1902(a)(23) of the Social Security Act; and
- Meet applicable State and Federal laws governing the participation of providers in the Medicaid program; and
- Meet applicable state and federal laws, including licensure and certification requirements; and
- Be certified by in accordance with standards established by the Division of Medical Assistance (DMA) and certified by DMA as a qualified HIV case management provider.
- Bill only for services that are within the scope of their clinical practice, as defined by HIV Case Management policy.
- Attest by signature that services billed were medically necessary and were actually delivered to the recipient.
- Secure a performance bond pursuant to S.L 2009-0451 Section 10.58(e)

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Provider Certification

In the absence of State licensure laws governing the qualifications and standards of practice for HIV case management providers, the State Division of Medical Assistance will be responsible for the certification process. DMA agrees to implement methods and procedures for certifying providers of HIV case management services as qualified to render services according to professionally recognized standards for quality care. This will ensure that HIV case management services are provided by qualified providers in accordance with section 1902(a)(23) of the Social Security Act. The initial certification is valid for one year.

To be certified and to qualify for reimbursement a provider shall submit a complete and signed application to DMA to include documentation of requirements indicated in the application. The application shall include the following information as identified under *Administrative, Case Management and Human Resource Requirements*:

Administrative Requirements

- A list of counties to be served;
- Hours of operation, the agency shall maintain regularly scheduled hours of operation;
- Emergency after hours response plan;
- A list of potential community resources for the entire service area;
- A copy of Articles of Incorporation, unless the agency is a local government unit;

The agency shall meet the following requirements:

- Have a physical business site at the time of application. The business site shall be verified by a site visit. This site cannot be in a private residence or vehicle.
- Submit a copy of the agency's organizational chart
- Submit a list of person who have five percent or more ownership in all or any one agency
- Submit a business plan that provides specific information for development costs and projected monthly revenue and expense statement for the 12 months subsequent to the approval of the application and actual revenue and expense statement for the 12 months preceding the application date. This plan must:
 - Include assumed consumer base, services, revenues and expenses;
 - Outline management of initial expenses;
 - Identify the individuals responsible for the operation of the agency and shall include their respective resumes;
 - Show a program development enhancement timetable; and include existing financial resources

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- Have computer capability to meet the following criteria:
 - Comply with Information Technology standards required by DMA, inclusive of maintenance of electronic records
 - Meet HIPAA requirements for safety and security of all data
 - Perform data analysis, inclusive of tracking and trending of outcome metrics
 - Comply with electronic billing requirements
 - Comply with requirements for Electronic Funds Transfer (EFT)
 - Communicate with Community Care of North Carolina (CCNC) or the primary care provider on a monthly basis as defined in Subsection 5.3 of the HIV Case Management policy.
- Comply with the completion of a precertification onsite visit in accordance with the Pre certification Site Visit checklist in the Records and Documentation Manual.
- Meet all applicable state and federal licensure and certification requirements to include the following written policies that are unique to the organization:
 - Confidentiality policy, to include a copy of the informed consent form;
 - Recipient grievance policy;
 - Recipient rights policy;
 - Non-discrimination policy;
 - Code of ethics policy;
 - Conflict of interest policy;
 - Electronic records policy;
 - Medical records policy to include record retention, safeguard of records against loss, tampering, defacement or use of and secure transportation of records;
 - Policy to assure the recipient's freedom of choice among providers;
 - Transfer and discharge policy and ;
 - Identification of abuse, neglect, and exploitation policy.

Case Management Requirements

- A description of the core components described in Section 5.0 of the HIV Case Management policy, including the title and position of the individuals who will perform those functions. Applicable FTEs or functions must be documented to meet requirements;
- A quality improvement plan pursuant to Subsection 6.2.1 (2) in the HIV Case Management policy, including but not limited to plans for:
 - Measuring recipient health outcomes;
 - The monitoring and evaluation of case management records (refer to Subsection 7.5 of the HIV Case Management policy);
 - Tracking and reporting complaints and how they are resolved;

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- Conducting statistical studies including cost and utilization studies ;
- Assuring accuracy with claims and service records; and
- Assuring that the provider and staff meet the qualifications set forth in the HIV Case Management policy.

Human Resource Requirements:

- Human resource policies unique to the organization to include process for validation of credentials, continuing education requirements, and criminal background check on all employees;
- Plan for providing case management if the agency has insufficient case management staff to cover caseload. plan for delegation of management authority for the operation of the agency and services;
- Plan for utilizing the services of volunteers, including supervision requirements for maintaining recipient confidentiality
- The agency shall submit the following
 - Supervision and training plan;
 - Case manager orientation plan and an annual in service education plan for the case managers;
 - Agency's plan for networking with CCNC or the primary care provider;
 - Agency's plan for tracking the case manager's demonstrated skill, abilities, competencies and knowledge
- The agency shall meet the following requirements
 - Be owned and operated by individual(s) that have not been convicted of a felony charge related to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.
 - Be owned and operated by individual(s) that have not been convicted of a felony charge related to the neglect or abuse of a recipient in connection with the delivery of health care services.
 - Employ qualified and trained case managers and supervisors, or contract with an agency or individual to provide case management or supervision who meets the qualifications as described in Subsections 6.3 and 6.4.

Note: If any elements of this section are non-compliant, the application is considered incomplete and handled pursuant to Section 6.2.1 of the HIV Case Management policy.

Quality Assurance Monitoring

A newly certified agency will be provided with four quality assurance (QA) site visits, to be completed within the first year following certification. The QA site visits are initiated by DMA after the agency is certified.

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The purpose of the site visits include technical assistance and consultation, review of staff qualifications and training, review of case management services, investigation of complaints and ensure implementation of policy requirements which include quality improvement activities.

If deficiencies are identified, the provider shall submit a written plan of correction within 30 calendar days, upon written request from DMA. Upon review of the plan of action, QA visits will be scheduled as necessary to determine if corrective action has taken place and if the service is compliant with all of the program's requirements.

Failure to adhere to policy requirements will result in decertification or a provisional recertification or a referral to DMA's Program Integrity unit.

Recertification

The recertification is valid for two years, unless otherwise specified. To be recertified a provider shall:

- Submit a complete signed renewal application to DMA no later than 60 calendar days prior to certification expiration date.
- Submit copies of all items in Subsection 6.2.1 of the HIV Case Management Policy that have changed since the initial certification.
- Submit copies of all HIV CM and supervisor credentials.
- Submit an annual summary of quality improvement activities to include outcome metrics.
- Submit documentation that verifies the provider's National Accreditation is current and in good standing.
- Submit to recertification on site visits, including a review of recipient records or other clinical and business documentation, as needed.

DMA shall provide a provisional recertification for a period of six months if site visits show evidence of noncompliance with policy requirements.

Decertification Process

If any one of the following conditions is substantiated, the provider may be decertified by DMA and disenrolled by DMA. This list is not all inclusive.

- Failure to provide core service components;
- Fraudulent billing practices;
- Owner(s) being convicted of a felony charge;
- Failure to develop, submit, and implement a written plan of correction to resolve unmet program requirements cited by DMA ; to make recommended corrections; or both within 30 calendar days;

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- Falsification of records;
- Violation of a recipient's confidentiality;
- Employment of staff who do not meet the criteria stated in Subsection 6.3;
- Failure of staff to attend the DMA mandatory basic training within 90 days of their employment date;
- Failure of staff to obtain required continuing educational units (CEU), as specified in Subsection 6.4;
- Failure to provide case management staff with supervision to meet the recipients' needs;
- Failure to submit any required documentation within the time frame designated by the HIV Case Management policy or upon request from DMA;
- Failure to provide documentation as specified in Subsection 7.4.2 that is sufficient to support the agency's billing;
- Failure to implement and enforce a quality improvement program;
- Failure to notify DMA, within 30 calendar days of proposed changes or five business days of actual changes, of any changes in agency name, director/ownership, mailing address, and telephone number(s), resulting in the DMA's inability to contact the agency;
- Failure to comply with all applicable federal and state laws, regulations, state reimbursement plan, and policies governing the services authorized under the Medicaid program;
- Failure of an agency to enroll any recipients within four months of certification;
- Failure of an agency to achieve and or maintain the requirements for certification as defined in Section 6.0 of the HIV Case Management policy.

When a provider agency is decertified by DMA, due process/appeal rights shall be issued to the provider agency, in accordance with NCGS 150B-23(a) and 130A-24.

(STAFF)

Staff Qualifications

It is the responsibility of the provider agency to verify staff qualifications and credentials prior to hiring and assure during the course of employment that the staff member continues to meet the requirements set forth in the HIV Case Management policy. Verification of staff credentials shall be maintained by the provider agency.

HIV Case Manager

An HIV case manager shall meet *one* of the following *qualifications*:

- Hold a master's degree from an accredited college or university in a human services field, including, but not limited to, social work, sociology, child development, maternal and child health, counseling, psychology, or nursing.

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- Hold a bachelor's degree from an accredited school of social work.
- Hold a bachelor's degree from an accredited college or university in a human services field or related curriculum, including at least 15 semester hours in courses related to social work, counseling, or public health; and have six months of social work or counseling experience.
- Hold a bachelor's degree from an accredited college or university and have one year of experience in counseling or in a related human services field that provides experience in techniques of counseling, casework, group work, social work, public health, or human services.
- Be licensed, if applicable, by the appropriate licensure board in North Carolina as a registered nurse, nurse practitioner, physician, physician assistant, or certified substance abuse counselor and have two years of experience working in human services.
 - In addition, the case manager must possess two years case management experience. Twelve months of those two years must include experience with HIV+ persons. All case managers must possess or acquire through cross training a clinical understanding of HIV, as evidenced by documentation in their personnel file.
 - Case management experience encompasses the functions of intake, assessment, reassessment, service planning, case coordination, case conferencing, service plan implementation, crisis intervention, monitoring, follow-up of services provided and case closure.

An HIV case manager shall meet the following *core competencies*:

- Able to perform the assessment
- Able to provide recipient centered goals for meeting desired outcomes developed in the care plan.
- Able to provide referral and linkage to recipients serviced
- Able to provide monitoring of care and service rendered to recipients
- Able to provide documentation and attestation as to accuracy of the entry by a personal signature

The case manager must possess and demonstrate the following *Knowledge, Skills and Abilities*.

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- Basic knowledge of HIV disease, prevention and treatment techniques. The knowledge should be based on current clinical practice, defined as standards of practice prevalent within one year from the date of hire. The basic knowledge shall include: methods of transmission and treatment, common definitions, general knowledge of medications used to treat HIV and barriers to medication and treatment compliance.
- Communication skills including listening, written, verbal and non-verbal skills
- Ability to gather information and data, and accurately synthesize into written form
- Ability to identify resources, both formal and informal
- Ability to initiate professional/clinical assessments
- Ability to evaluate environmental stressors
- Observation skills inclusive of human behavior, family dynamics, mood changes, etc
- Ability to assess the cultural environment and to interact in a culturally sensitive manner
- Ability to determine if identified services meet the intensity of needs of the recipient and are accomplishing the desired outcomes
- Prioritization skills including time management skills, planning; organizational skills and professional judgment skills
- Ability to review data and draw appropriate conclusions to address the needs of individuals served
- Ability to accurately document case management activities and attesting to its accuracy by personal signature

HIV Case Manager Supervisor

An HIV case management supervisor shall meet *one* of the following *qualifications*:

- Hold a master's degree from an accredited college or university in a human services field, including, but not limited to, social work, sociology, child development, maternal and child health, counseling, psychology, or nursing; and one year of human services experience.
- Hold a bachelor's degree from an accredited school of social work and have two years of human services experience.
- Hold a bachelor's degree from an accredited college or university in a human services field or related curriculum, including at least 15 semester hours in courses related to social work or counseling and have two years of experience in human services or public health.
- Hold a bachelor's degree from an accredited college or university and have either three years of human services experience or two years of human services experience plus one year of supervisory experience.

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- Be licensed, if applicable, by the appropriate licensure board in North Carolina as a registered nurse, nurse practitioner, physician, physician assistant, or certified substance abuse counselor; and have either three years of human services experience or two years of human services experience plus one year of supervisory experience.
 - In addition, the HIV case manager supervisor must possess three years case management experience. Twelve months of those three years must include experience with HIV+ persons.
 - Case management experience must encompass the functions of intake, assessment, reassessment, service planning, case coordination, case conferencing, service plan implementation, crisis intervention, monitoring and follow-up of services provided and case closure.

In addition to those listed for the case manager, the case manager supervisor must possess and demonstrate the following *knowledge, skills and abilities*:

- Ability to direct and evaluate the scope and quality of case management services
- Knowledgeable in case management principals, procedures and practices
- Ability to conduct detailed analytical evaluations and studies and prepare related reports and recommendations
- Apply professional level of knowledge of federal and state assistance programs for HIV positive population

The agency shall identify the HIV case manager program supervisor within the organization. The supervisor is to provide “clinical/professional supervision”. This is defined as providing regularly scheduled assistance by a qualified professional to a staff member who is working directly with recipients. The purpose of clinical supervision is to ensure that each recipient receives case management services which are consistent with accepted standards of practice, the needs of the recipient and care plan.

Documentation of supervisory review of case manager’s caseload and proper utilization of case management services is required. The supervisor shall attest to the accuracy of the documentation by a personal signature to include credentials and title. Each recipient record should reflect supervisory review every 4 weeks at a minimum. The frequency of the review should be increased if the findings warrant such action. The review must include the following: The recipient record to assure that all required paperwork as defined by the HIV Case Management policy is in the record. Progress notes should be reviewed for compliance with the requirements in Subsections 7.4.2 and 7.4.3 (c) of the HIV Case Management policy. The billing should be checked for accuracy to assure it corresponds to the progress notes. This is not billable case management time.

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Contract Staff

Providers may elect to contract with qualified case managers and supervisors. The same qualifications described in Subsections 6.3.1 and 6.3.2 of the HIV Case Management policy is required of both employees and contractors.

Training Requirements

All HIV case managers and case manager supervisors shall complete North Carolina state-sponsored, basic policy training within ninety days of their employment date and must be completed prior to any billed case management units. It is the responsibility of providers to retain copies of certificates of completion issued by DMA.

Upon successful completion of the basic training, the case manager or supervisor will be able to perform all of the following:

- Describe basic HIV information and prevention techniques;
- Describe the scope of work for case managers;
- Identify and explain the core components of HIV case management;
- Demonstrate an understanding of basic ethical issues relating to case management;
- Demonstrate an understanding of the responsibilities and functions of the HIV case manager system of care; and
- Demonstrate an understanding of the documentation requirements of this program as defined in Subsections 7.4.2 and 7.4.3 of the HIV Case Management policy.

Annual Training

All HIV case managers and supervisors are required to attend 20 hours annually of continuing education related to HIV case management. It is the responsibility of providers to retain copies of certificates of completion.

Annual training topics must include, but are not limited, to the following:

- Confidentiality;
- Cultural competency;
- Current trends in HIV disease management;
- Ethics;
- Refresher core components of case management; and
- Medical management/care of individuals who are HIV positive. Ten hours of the 20 hour annual requirement shall include clinically oriented training

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Suggested resources include but are not limited to the following:

- Partners in Information Access for the Public Health Workforce <http://phpartners.org/index.html>
- Regional HIV/AIDS Consortium
- North Carolina AIDS Education Training Center
- North Carolina Area Health Education Centers

Freedom of choice (42 CFR 441.18(a)(1):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

9. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
10. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b):

_____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

The State has limited the amount of HIV Case Management service that may be billed to Medicaid to 16 units per recipient per month. One unit equals 15 minutes, therefore 16 units equals four hours.

Physician Orders

- The case manager shall obtain a physician's written order that details the need for the initiation of HIV case management services.
- Ongoing HIV Case management services beyond two calendar months require a written physician's order attesting to the medical necessity of the additional case management.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: North Carolina

CASE MANAGEMENT SERVICES

A. Target Group: All Children to Age 21 Who Are Eligible for EPSDT

B. Areas of State in which services will be provided:

Entire State

Only in the following geographic areas (authority of section 1915(g)(1) of the Act is involved to provide services less than Statewide:

C. Comparability of Services:

Services are provided in accordance with section 1902 (a) (10)(B) of the Act.

Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) of the Act is involved to provide services without regard to the requirements of section 1901 (a) (10) (B) of the Act.

D. Definition of Services:

Case management is a set of interrelated activities under which responsibility for locating, coordinating and monitoring appropriate services for an individual rests with a specific person or organization. The purpose of case management services for children to age 21 is to assist those eligible for Medicaid in gaining access to needed medical, social, educational and other services, to encourage the use of cost-effective medical care by referrals to appropriate providers, and to discourage overutilization of costly services. Case management services will provide necessary coordination with providers of non-medical services such as nutrition programs like WIC or educational agencies, when services provided by these entities are needed to enable the individual to benefit from programs for which she is eligible.

The set of interrelated activities are as follows:

1. Evaluation of the clients' individual situation to determine the extent of or need for initial or continuing case management services.
2. Needs Assessment and reassessment to identify the service needs of the client.
3. Development and implementation of an individualized plan of care to meet the service needs of the client.
4. Providing assistance to the client in locating and referring her to providers and/or programs that can meet the service needs.

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5. Coordinating delivery of services when multiple providers or programs are involved in care provision.
6. Monitoring and follow-up to ensure services are received; are adequate to meet the clients' needs; and are consistent with good quality of care.

These activities are structured to be in conformance with 1902 (a)(23) and not to duplicate any other service reimbursed in the Medicaid program.

E. Qualification of Providers:

Enrollment will be accomplished in accordance with Section 1902(a)(23) of the Act.

1. Case Manager Qualifications:

- a. RN licensed in North Carolina with experience in community health nursing or experience in working children and families or
- b. MSW, BSW, or SW meeting State SW, Community Health Assistant qualifications with experience in health and human service or experience in working with children and families or individuals with comparable experience certified by the Department of Environment, Health and Natural Resources as being eligible to provide case management services.

2. Provider Qualifications:

- a. Must have qualified case manager(s)
- b. Must meet applicable state and federal law governing the participation of providers in the Medicaid program.
- c. Must be certified by the Department of Environment, Health and Natural Resources, Maternal and Child Health as a qualified case management provider.

Enrollment is open to all providers who can meet these requirements. In the absence of State licensing laws governing the qualifications and standards of practice for case management services to children, an agreement will be made with the State agency, Department of Environment, Health and Natural Resources, Maternal and Child Health, which has the recognized professional expertise and authority to establish standards that govern case management services for children. As part of the interagency agreement the Department of Environment, Health and Natural Resources, Maternal and Child Health will certify that providers are qualified to render case

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management services in accordance with professionally recognized standards for good care. the purpose of this activity is to help assure that case management services are provided by professionally qualified providers in accordance with section 1902(a)(23) of the Act.

3. Certification Process:

The Section through an MOU with the Division of Medical Assistance will implement methods and procedures to certify all providers for case management to children who can demonstrate:

- a. Their capacity to provide case management services.
- b. Their experience with delivery and/or coordination of services for children.
- c. Their capacity to assure quality.
- d. Their experience in sound financial management and record keeping.

Certification is open to all providers who can meet these requirements.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Only activities associated with direct services to clients will be considered targeted case management services.

LEVEL OF CARE CRITERIA

4600. General Information

The following criteria are not intended to be the only determinant of the recipient's need for skilled or intermediate care. Professional judgement and a thorough evaluation of the recipient's medical condition and psychosocial needs as well as an understanding of and the ability to differentiate between the need for skilled or intermediate care. Also, the assessment of other health care alternatives should be made as applicable.

4601. Skilled Level of Care Criteria

4601.1 Skilled Nursing Care

Skilled nursing services, as ordered by a physician, must be required and provided on a 24-hour basis, 7 days a week.

Skilled nursing care is that level of care which provides continuously available professional skilled nursing care, but does not require the degree of medical consultation and support services which are available in the acute care hospital. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care.

Skilled nursing services include observation and assessment of the total needs of a patient on a 24-hour basis, planning and management of a recorded treatment plan according to that which is established and approved by a physician, and rendering direct services to the patient.

4601.2 Factors Frequently Indicating Need for Skilled Care

1. Twenty-four hour observation and assessment of patient needs by a registered nurse or licensed practical nurse.
2. Intensive rehabilitative services as ordered by a physician, and provided by a physical, occupational, respiratory or speech therapist five times per week or as indicated by therapist.
3. Administration and/or control of medication as required by State law to be the exclusive responsibility of registered or licensed nurses and other specific services subject to such limitation.
4. Twenty-four hour performance of direct services that by physician judgement requires:
 - a. a registered nurse
 - b. a licensed practical nurse, or
 - c. other personnel working under the direct supervision of a registered nurse or licensed practical nurse.
5. Medications: Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration. The use of drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgement on a continuous basis, frequent injections requiring nursing skills or professional judgement.
6. Colostomy-ileostomy: In the stabilization period following surgery and allowing for instruction in self-care.
7. Gastrostomy: Feeding or other tube feedings requiring supervision and observation by licensed nurses.
8. Oxygen therapy: When monitoring need or careful regulation of flow rate is required.
9. Tracheostomy: When twenty-four hour tracheostomy care may be indicated.
10. Radiation Therapy or Cancer Chemotherapy: When case observation for side effects during course of treatment is required.

10. Isolation: When medically necessary as a limited measure because of contagious or infectious disease.
11. Sterile Dressings: Requiring prescription medications and aseptic technique by qualified staff.
13. Decubitus Ulcer(s): When infected or extensive.
14. Uncontrolled Diabetes
15. Conditions which may require SNF care until maximum rehabilitation potential has been reached (time frames may be adjusted according to rehabilitation progress, complications or other pertinent factors):
 - New CVA – within three months
 - New fractured hip - within three months
 - New amputation – within two months or less, adjusted for fitting with prostheses and necessary teaching
 - Comatose
 - Inoperable brain tumor
 - Terminal CA – last stages
 - New myocardial infarction – within two months or less
 - Congestive heart failure – degree of compensation
 - New cholecystectomy – within one month and healing
 - New mastectomy – within 2-3 weeks
 - New pacemaker – within one month
 - New paraplegic/quadriplegic condition
 - Surgical patients – within one month

4601.3 Less Serious Conditions Which Alone May Not Justify Placement at the Skilled Level

Although any one of these conditions alone may not justify placement at the skilled level, presence of several of these factors may justify skilled care. This determination will require careful judgement.

1. Diagnostic Procedures: Frequent laboratory procedures when intimately related to medication administration (such as monitoring anticoagulants, arterial blood gas analysis, blood sugars in unstable diabetics)
2. Medications: Frequent intramuscular injections, routine or PRN medications requiring daily administration and/or judgement by a licensed nurse.
3. Treatments: Required observation, evaluation and assistance by skilled personnel for proper use or patient's safety (e.g., oxygen, hot packs, hot soaks, whirlpool, diathermy, IPPB, etc.).
Skilled procedures including the related teaching and adaptive aspects of skilled nursing are part of the active treatment and the presence of licensed nurses at the time when they are performed is required.
4. Dietary: Special therapeutic diets ordered by a physician and requiring close dietary supervision for treatment or control of an illness, such as chronic renal failure, 0.5 grams or less sodium restrictions, etc.
5. Incontinency: Intense bowel and bladder retraining programs if deemed necessary in accordance with facility procedures.
6. Mental and Behavioral Problems: Mental and behavioral problems requiring treatment or observation by skilled professional personnel, to the extent deemed appropriate for the nursing home.
7. Psychosocial Conditions: The psychosocial conditions of each patient will be evaluated in relation to his/her medical condition when determining a change in level of care. Factors taken into consideration along with the patient's medical needs include age, length of stay in current placement, location and condition of spouse, proximity of social support and the effect of transfer on the patient. It is understood that there can always be, to a greater or lesser degree, some trauma with transfer; even sometimes from one room or hall to

another within the same facility. Whenever a patient/resident exhibits acute psychological symptoms, these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes, and/or by nursing or therapy notes. Proper and timely discharge planning will help alleviate the fear and worry of transfer.

4602. Intermediate Level of Care Criteria

Intermediate care, as ordered by a physician, must be provided on a 24-hour basis, with a minimum of eight hours of licensed nurse coverage daily. Intermediate care is that level of care which provides daily licensed nursing care, but does not require the 24-hour skilled nursing services required in a skilled nursing facility. ICF services must be furnished under the direction of a physician in order to promote and maintain the highest level of functioning of the patient, and to assure quality patient care.

Intermediate care includes daily observation and assessment of the total needs of the patient by a licensed nurse, planning and management of a recorded treatment plan according to that which is established and approved by a physician, and rendering direct services to the patient. In summary, the philosophy of intermediate care is to maintain patients at their maximum level of self care and independence, prevent regression, and/or return them to a previous level of or new stage of independence.

4602.1 Factors Frequently Indicating Need For Intermediate Care (ICF)

1. Need for daily licensed nurse observation and assessment of patient needs.
2. Need for restorative nursing measures to maintain or restore maximum function, or to prevent the advancement of progressive disabilities as much as possible. Such measures may include, but are not limited to the following:
 - a. encouraging patients to achieve independence in activities of daily living by teaching self care, transfer and ambulation activities.
 - b. use of preventive measures/devices to prevent or retard the development of contractures, such as positioning and alignment, range of motion, use of handrolls and positioning pillows.
 - c. ambulation and gait training with or without assistive devices.
 - d. assistance with or supervision of transfers.
3. Need for administration and/or control of medications which, according to State law, are to be the exclusive responsibility of licensed nurses and any other specific services which are subject to such limitations.
4. Performance of services that by physician judgement require either:
 - a. a licensed nurse a minimum of 8 hours daily; or
 - b. other personnel working under the supervision of a licensed nurse.
5. Medications: The use of drugs for routine and/or maintenance therapy requiring daily observation for drug effectiveness and side effects.
6. Assistance with activities of daily living (i.e., bathing, eating, toileting, dressing, transfer/ambulation), including maintenance of foley catheters and ostomies, supervision of special diets, and proper skin care of incontinent patients.
7. Colostomy – Ileostomy: Maintenance of ostomy patients, including daily monitoring and nursing intervention to assure adequate elimination and proper skin care.
8. Oxygen Therapy: Oxygen as a temporary or intermittent therapy.
9. Radiation Therapy or Cancer Chemotherapy: When a physician determines that daily observation by a licensed nurse is required and adequate.

10. Isolation: When medically necessary on a limited basis because of non-complicated contagious or infectious disease requiring daily observation by licensed personnel, not complicated by other factors requiring skilled care.
11. Dressings: Requiring prescription medications and/or aseptic or sterile technique no more than once daily by licensed staff.
12. Skin Condition:
 - a. decubitus ulcer(c) when not infected or extensive
 - b. minor skin tears, abrasions or chronic skin condition requiring daily observation and/or intervention by licensed personnel.
13. Diabetes: When daily observation of dietary intake and/or medication administration is required for proper physiological control.

4602.2 Illustrative Requirements Which, When Present in Combination, Can Justify Intermediate Level Placement

1. Tracheostomy: When minimal assistance or observation of self care technique is required.
2. Need for teaching and counseling related to a disease process and/or disabilities, diet or medications.
3. Ancillary Therapies: Supervision of patient performance of procedures taught by physical, occupational or speech therapists. This may include care of braces or prostheses and general care of plaster casts.
4. Injections: Given during the hours a nurse is on duty requiring administration and/or professional judgement by a licensed nurse.
5. Treatments: Temporary cast, braces, splint, hot or cold applications, or other appliances requiring nursing care and direction.
6. Psychosocial Considerations: The psychosocial condition of each patient will be evaluated in relation to his/her medical condition when determining a change in level of care. Factors taken into consideration along with the patient's medical needs include age, length of stay in current placement, location and condition of spouse, proximity of social support and the effect of transfer on the patient. It is understood that there can always be, to a greater or lesser degree, some trauma with transfer, even sometimes from one room or hall to another within the same facility. Whenever a patient/resident exhibits acute psychological symptoms, these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes, and/or by nursing or therapy notes. Proper and timely discharge planning will help alleviate the fear and worry of transfer.
7. Use of protective devices or restraints to assure that each patient is restrained in accordance with the physician's order and that the restrained patient is appropriately evaluated and released at a minimum of every two hours.
8. Other conditions which may require ICF care:
 - Blindness
 - Behavioral problems such as wandering, verbal disruptiveness, combativeness, verbal or physical abusiveness, inappropriate behavior when these can be properly managed in an intermediate care facility.
 - Frequent falls.
 - Chronic recurrent medical problems which require daily observation by licensed personnel for prevention and/or treatment.

Inpatient psychiatric facility services for individuals under 21 years of age.

DEFINITION:

Inpatient psychiatric services for recipients under age 21 must be provided by a psychiatric facility or an inpatient program in a psychiatric facility that meets the following requirements:

- (a) For private owned facilities:
 - (1) A psychiatric hospital or an inpatient psychiatric program in a hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, or
 - (2) A psychiatric residential treatment facility which is accredited by the Joint Commission on Accreditation of Healthcare Organizations, or the Council on Accreditation of Services for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities.
- (b) For state owned facilities:
 - (1) A psychiatric residential treatment facility accredited by any other accrediting organization with comparable standards that is recognized by the State DHHS.
 - (2) A psychiatric hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations.

These services are provided before the recipient reaches age 21 or, if the recipient was receiving the services immediately before he or she reached age 21, before the earlier of the following:

- (a) The date he or she no longer requires the services; or
- (b) The date he or she reaches age 22.

CRITERIA FOR MEDICAID COVERAGE OF SERVICES IN A NON ACUTE INTENSIVE
REHABILITATION PROGRAM FOR HEAD INJURY CARE

13. D. Diagnostic, Screening, Treatment, Preventive and Rehabilitative Services

Description of Services

Non-acute intensive rehabilitation services for head injury care

The state provides head injury care in the most appropriate setting based on medical necessity. This service is for persons who meet medical necessity for skilled nursing care. It is provided in a 24 hour separate setting in a licensed nursing facility for brain injury caused by external trauma.

Description of Service

This service provides intensive rehabilitative services for head injured persons. Services must be under the direction of a qualified physician and include nursing services, as well as a minimum of 15 hours per week of at least two types of the following therapies: Physical Therapy, Occupational Therapy, Cognitive Therapy and Speech Therapy. Recreational therapy must be available that provides activities, selected by the recipient, as a means to furthering individualized rehabilitation goals. Services are designed to effect a measurable and timely improvement in functional status. Recipients must be approved for this level of care by the Division of Medicaid or designated agency and must have specific functional goals and the potential to benefit from rehabilitative services. Continued stay reviews occur every 30 days.

Services include 24 hour care and medical supervision in addition to rehabilitative services that address the specific functional deficits of the individual, such as loss of speech, mobility, cognitive abilities and the abilities to carry out activities of daily living.

Provider Qualifications

Professional staff must meet all state licensure and certification requirements for their area of practice including licensed physicians, nurses, physical therapists, occupational therapists, psychologists and speech therapists. Direct care staff, social workers, dietary, and ancillary staff must meet requirements commensurate with those for skilled nursing facilities.

There is a need for a separate rate to be established commensurate with the level of rehabilitative care required to treat this type of patients. Other non-rehabilitative brain injury care is available in existing NF's.

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Geropsychiatric Care Units in Nursing Facilities

I. Definition

Geropsychiatric care is a separate or distinct part setting for nursing facility level of care individuals with long-term psychiatric and behavioral health needs and who exhibit challenging and difficult behaviors that are beyond the management capacity of traditional skilled nursing home facilities in community-based facilities.

II. Services Definition

Geropsychiatric units must provide a therapeutic environment using the least restrictive alternatives that promote the maintenance and enhancement of the recipient's quality of life. (10A NCAC 27E .0101) These therapeutic elements are provided through:

- a. Enhanced nursing services to meet both the nursing care and behavioral care needs of the recipients
- b. Psychiatric services to address the recipients' needs related to the management of symptoms and medications for severe and persistent mental illness (i.e. Psychiatrist will be part of the on-going treatment assessment and treatment planning of the patient)
- c. Psychological services to develop and implement behavior management plans, including training nursing staff in ongoing implementation of the plan (i.e. Psychologist will be part of the on-going treatment assessment and treatment planning of the patient)
- d. Social work services to coordinate the enhanced behavioral health care services provided to the recipients
- e. Licensed psychiatric nursing services to supervise and coordinate the nursing and medical services being provided to the recipients
- f. Programming that is focused on maintaining previously learned psychosocial and recreational skills

III. Eligibility Criteria for recipients

- A. The recipient must meet nursing facility level of care criteria.
- B. The recipient must meet the definition of severely persistent mental illness or severe behavioral issues as defined by the following:
 1. A major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, schizophrenia, bipolar disorder major depression, schizoaffective disorder, schizophreniform disorders, and psychotic disorder NOS (Not Otherwise Specified).
 2. Upon admission, the recipient's Global Assessment of Functioning score is 40 or lower.

Geropsychiatric Care Units in Nursing Facilities - Continued

- C. The level of the recipient's impairment is confirmed by a level II Pre-admission Screening and Annual Resident Review evaluation.
- D. The recipient is currently in a psychiatric hospital; or has had one or more past hospitalizations; or is exhibiting behaviors that place him or her at risk of psychiatric hospitalization in a State, public, or private psychiatric hospital in the State of North Carolina.
- E. The recipient exhibits chronic, unsafe behaviors that cannot be managed in a traditional nursing facility, including one of the following:
 - 1. Elopement or wandering,
 - 2. Combative and assaulting behaviors (physical or verbal abuse toward staff, or self-abuse),
 - 3. Sexually aggressive behaviors (touching or grabbing others, for example)
 - 4. Self-endangering behaviors, including suicidal ideation and medicine noncompliance, or
 - 5. Other challenging and difficult behaviors related to the individual's psychiatric illness.
- F. Alternative services to meet the person's behavioral health needs are not available.
- G. Prior approval is required.

IV. Provider Qualifications

Nursing facilities that meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to establish geropsychiatric units and receive the special rate when they meet the additional staffing and certification requirements for geropsychiatric units and execute an agreement with DMA to provide the service.

V. Establishing Unit

The enhanced skilled nursing units must be an on-site geropsychiatric component of a licensed nursing facility and must be certified (42 CFR 483) to receive Medicaid and Medicare reimbursements.

The facility must meet nursing facility requirements as well as an enhanced level of nursing care to meet the special nursing and behavioral health needs of the residents. The facility must be certified and monitored by the Division of Health Service Regulation for compliance with nursing facility rules. This compliance is to ensure that the facility is designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.

The facility must also provide a therapeutic environment with enhanced and trained staff as identified below in (Staff Training Requirements).

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Geropsychiatric Care Units in Nursing Facilities Continued

(MH/DD/SAS) monitors all specialty training for the enhanced nursing staff in a therapeutic environment to ensure that it is timely maintained and documented. If training requirements are not met, the nursing facility does not qualify for the nursing specialty services, geropsychiatry. MH/DD/SAS Program Accountability will monitor all geropsychiatric units for the following through its annual program assessments/reviews:

- Therapeutic environment
- Staffing
- Staff training

All nursing facilities must provide a separate or distinct part and sufficient space on the geropsychiatric unit. They must also provide equipment in dining, medical health services, recreation, and program areas to enable staff to provide residents with needed behavioral health services.

A provider agreement between DMA and the facility is required.

There are two options for establishing a geropsychiatric unit in a nursing facility:

- A. A nursing facility may use no more than 20 currently certified nursing beds to create the geropsychiatric services unit. There must be clinical documentation to ensure that existing residents meet criteria for the geropsychiatric unit and that the geropsychiatric unit is the most appropriate placement for residents who would otherwise be displaced. The nursing facility must also provide a transition plan for any residents who will be displaced by the creation of the geropsychiatric unit.
- B. A nursing facility may expand its current number of certified beds by converting existing beds that are not currently certified beds or by developing new certified nursing beds. If this option is selected, the Certificate of Need (CON) requirements apply and the facility must meet and follow all CON requirements. The CON must be approved prior to the final approval of a proposal to develop a geropsychiatric unit in the nursing facility.

VI. Staff Training Requirements

All nursing staff (RNs, LPNs, and CNAs) must complete no fewer than 40 initial hours of staff training (20 hours annually thereafter) on behavioral health management issues for challenging and difficult behaviors, and additional training as professionally required (10A NCAC 27E .0107). The staff training calendar and schedule are planned by the Staff Development Coordinator with approval of MH/DD/SAS. All nurses and CNAs are required to participate in this training. The facility orientation will include additional training for all nursing facility staff assigned to the geropsychiatric unit.

Geropsychiatric Care Units in Nursing Facilities Continued

The additional training curriculum is defined by the MH/DD/SAS training guidelines. Training consists of at least 40 hours. Training includes, but is not limited to, the mental health, nursing, and medical guidelines for treating the geropsychiatric patient population to ensure employee skilled competencies in the following areas:

- A. Person-centered thinking and Person-centered care planning
- B. Assessment of mental status
- C. Documentation of behaviors
- D. Loss and grief
- E. Establishment of a therapeutic environment
- F. Effective communication with families
- G. Effective communication with persons with cognitive deficits
- H. Physical, social, and emotional self-awareness
- I. Recognition of symptoms of mental illness
- J. Sexuality and aging
- K. Mental illness and the aging population
- L. Crisis prevention and intervention
- M. Relocation trauma; psychological aspects of change
- N. Stress management and impact on caregivers
- O. Psychotropic medications and side effects and adverse reactions in the elderly
- P. Reality orientation
- Q. Problem solving: bathing
- R. Problem solving: incontinence
- S. Therapeutic approaches and interventions for problem behaviors
- T. Elopement precautions
- U. Working with aggressive, assaulting, and sexual behaviors
- V. Training for staff self-protection

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Geropsychiatric Care Units in Nursing Facilities Continued

VII. Continued Stay Criteria

Continued stay in a geropsychiatric unit is applicable when the geropsychiatric resident either:

1. exhibits unsafe behaviors in the specialty nursing unit (as outlined in paragraph III.E. Eligibility Criteria for recipients); or
2. exhibits the unsafe behaviors if moved from the enhanced services available in the geropsychiatric unit, as evidenced by exploratory visits in the regular nursing facility unit, during which unsafe behaviors are observed.

VIII. Discharge Criteria

A. Discharge from a geropsychiatric unit is contingent upon:

1. the consistent absence of unsafe behaviors (as outlined in paragraph III.E. Eligibility Criteria for recipients) in a consistently structured geropsychiatric specialty nursing unit; and
2. the anticipation that the individual will not exhibit unsafe behaviors if transitioned from the geropsychiatric unit, as evidenced by exploratory visits to a regular nursing unit, during which unsafe behaviors are not observed.

These criteria must be closely observed and monitored during a continuous period of at least three months.

B. Additional determining criteria for discharge include the following:

1. Monitoring of medication stability/consistency;
2. Treatment compliance;
3. Appropriate living arrangements upon discharge; or
4. Arrangement of aftercare for continued services in the community, with family/guardian support and involvement.

CRITERIA FOR VENTILATOR-DEPENDENT RECIPIENTS
(Hospital Based or Nursing Facility)

- I. Definition
 - A. Ventilator dependent is defined by the Division of Medical Assistance as requiring at least ten (10) hours/day of mechanical ventilation to maintain a stable respiratory status.
- II. Criteria
 - A. Recipient's condition must meet the definition of ventilator dependence.
 - B. The recipient's condition at time of placement must be stable without infections or extreme changes in ventilatory settings and/or duration (i.e. increase in respiratory rate by 5 breaths per minute, increase in FIO₂ of 25% or more, and/or increase in tidal volume of 200 mls or more).
 - C. The recipient must have prior approval for admission to a long term care facility. Prior approval requests for ventilator services must include the following:
 - a. The FL-2 or the North Carolina Medicaid designated screening form with the PASARR number, signed and dated by the attending physician.
 - b. Medical records documenting the criteria for ventilator level of care.
 - c. A ventilator addendum form, signed and dated by the attending physician within 45 days of the authorization for ventilator level of care.

Medical Care/Other Remedial Care

Services provided under this section are provided by individual practitioners who meet individual practitioner certification standards. Each provider must be certified as meeting program standards of the Department of Health and Human Services. The services are available to the categorically needy and medically needy and include the services described herein.

- A. Generally covered state plan services provided to outpatients by qualified health professional service entities to include prevention, diagnostic, therapeutic or palliative items or services when they are medically necessary.
- 1) Diagnostic services includes medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice that enable him to identify the existence, nature or extent of illness, injury or other health deviation.
 - 2) Screening services includes standardized tests performed under medical direction by qualified health care professionals to a designated population to detect the existence of one or more particular diseases.
 - 3) Preventive services includes services provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to a) prevent disease, disability and other health conditions or their progression b) prolong life and c) promote physical and mental health and efficiency.
 - 4) Therapeutic services means medical care and clinical services for a patient for the purpose of combating disease, injury or other physical/mental disorders by a physician or other qualified practitioner within the scope of practice under state law.
 - 5) Physical therapy occupational therapy and services for individuals with speech, hearing, and language disorders as defined in 42 CFR 440.110. Services are limited to EPSDT eligibles.

- 6) Psychosocial services include assessment, testing, clinical observation and treatment when provided by a psychologist licensed in accordance with state law or certified as a school psychologist by the North Carolina Department of Public Instruction or social worker when certified by the North Carolina Department of Health and Human Services. Services provided are limited to EPSDT eligibles.
- 7) Respiratory therapy services as defined in 1902(e)(9)(A) of the Act when provided by a respiratory therapist licensed under the provisions of the North Carolina Respiratory Care Practice Act. Services provided are limited to EPSDT eligibles.

For EPSDT eligibles, services covered under 1905(r)(5) and as required by 1905 (a) to correct, ameliorate defects and physical and mental illnesses and conditions discovered by screening services whether or not such services are included in the state plan.

Service providers will be offering a comprehensive array of health services to eligible individuals throughout the State of North Carolina and will be offering them in the most appropriate settings possible (for example, schools, homes). All services to an individual are provided as directed in an individualized treatment program by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law. The treatment plan also directs the duration and scope of services to be provided in order to achieve the goals and objectives of the plan.

Provision of services where the family is involved will be directed to meeting the identified client's treatment needs. Services provided to non-Medicaid eligible family members independent of meeting the identified client's treatment needs are not covered by Medicaid.

CRITERIA FOR MEDICAID COVERAGE OF CERTIFIED REGISTERED NURSE ANESTHETISTS SERVICES

Certified Registered Nurse Anesthetist Services

- 1) are provided in accordance with the scope of practice as defined by the Nursing Practice Act and rules promulgated by the Board of Nursing, and
- 2) are performed by Certified Registered Nurse Anesthetists who are duly licensed as registered nurses by the State Board of Nursing and are credentialled by the Council on Certification of Nurse Anesthetists as Certified Registered Nurse Anesthetists, and recertified through the Council on Recertification of Nurse Anesthetists, and
- 3) are performed in collaboration with a physician, dentist, podiatrist or other lawfully qualified health care provider and, when prescribing a medical treatment regimen or making a medical diagnosis, are performed under the supervision of a licensed physician.

COVERAGE LIMITATIONS

Medical services must be performed in accordance with the Certified Registered Nurse Anesthetists scope of practice.

1. By Certified Registered Nurse Anesthetists in any practice setting.
2. For DMA approved procedures developed for use by Certified Registered Nurse Anesthetists.
3. Subject to the same coverage limitations as those in effect for Physicians.

DEFINITION OF SERVICE

Anesthesiology is the practice of medicine dealing with, but not limited to, the following:

- a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and other diagnostic or therapeutic procedures
- b. The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations
- c. The clinical management of the patient unconscious from whatever cause
- d. The evaluation and management of acute or chronic pain
- e. The management of problems in cardiac and respiratory resuscitation
- f. The application of specific methods of respiratory therapy
- g. The clinical management of various fluid, electrolyte, and metabolic disturbances

Anesthesia services include the anesthesia care consisting of preanesthesia, intraoperative anesthesia, and postanesthesia components. Anesthesia services include all services associated with the administration and monitoring of the anesthetic/analgesic during various types/methods of anesthesia. Anesthesia services include, but are not limited to, general anesthesia, regional anesthesia, and monitored anesthesia care (MAC). These services entail a preoperative evaluation and the prescription of an anesthetic plan; anesthesia care during the procedure; interpretation of intra-operative laboratory tests; administration of intravenous fluids including blood and/or blood products; routine monitoring (such as electrocardiogram (ECG), temperature, blood pressure, pulse oximetry, capnography, end-tidal infrared gas analysis, mass spectrography, bispectral electroencephalography, and transcranial Doppler); immediate post-anesthesia care, and a postoperative visit when applicable.

Time-based anesthesia services include all care of the patient until the anesthesiologist, resident, anesthesiologist assistant AA₁, or certified registered nurse anesthetist (CRNA) is no longer in personal attendance.

QUALIFICATIONS FOR LICENSE

(a) Except as otherwise provided in this Subchapter, an individual shall obtain a license from the Board before practicing as an Anesthesiologist Assistant. The Board may grant an Anesthesiologist Assistant license to an applicant who has met all the following criteria:

(1) submits a completed license application on forms provided by the Board;

(2) pays the license fee established by Rule .0113 in this Subchapter;

(3) submits to the Board proof of completion of a training program for Anesthesiologist Assistants accredited by the Commission on Accreditation of Allied Health Education Programs or its preceding or successor organization;

(4) submits to the Board proof of current certification by the National Commission for Certification of Anesthesiologist Assistants (NCCAA) or its successor organization, including passage of the Certifying Examination for Anesthesiologist Assistants administered by the NCCAA within 12 months after completing training;

(5) certifies that he or she is mentally and physically able to safely practice as an Anesthesiologist Assistant;

(6) has no license, certificate, or registration as an Anesthesiologist Assistant currently under discipline, revocation, suspension, or probation;

(7) has good moral character; and

(8) submits to the Board any other information the Board deems necessary to determine if the applicant meets the requirements of the rules in this Subchapter.

(b) The Board may deny any application for licensure for any enumerated reason contained in G.S. 90-14 or for any violation of the Rules of this Subchapter.

(c) An applicant may be required to appear, in person, for an interview with the Board, or its representatives upon completion of all credentials.

COVERAGE LIMITATIONS

Medical services must be performed in accordance with the Anesthesiologist Assistants scope of practice.

4. By Anesthesiologist Assistants in any practice setting.
5. For DMA approved procedures developed for use by Anesthesiologist Assistants.
6. Subject to the same coverage limitations as those in effect for Anesthesiologists, Certified Registered Nurse Anesthetists and Physicians.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Program of All-Inclusive Care for the Elderly (PACE) services

State/Territory: North Carolina

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

- A. The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

- B. The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

- C. The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Program of All-Inclusive Care for the Elderly (PACE) services

State/Territory: North Carolina

Regular Post Eligibility

1. ____ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.
 - (a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.
 - (1.) Allowances for the needs of the:
 - (A.) Individual (check one)
 1. ____ The following standard included under the State plan (check one):
 - (a) ____ SSI
 - (b) ____ Medically Needy
 - (c) ____ The special income level for the institutionalized
 - (d) ____ Percent of the Federal Poverty Level: ____%
 - (e) ____ Other (specify): _____
 2. ____ The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
 3. ____ The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Program of All-Inclusive Care for the Elderly (PACE) services

State/Territory: North Carolina

(B.) Spouse only (check one):

1. ___ SSI Standard
2. ___ Optional State Supplement Standard
3. ___ Medically Needy Income Standard
4. ___ The following dollar amount: \$_____
- Note: If this amount changes, this item will be revised.
5. ___ The following percentage of the following standard
 that is not greater than the standards above: _____% of
 _____ standard.
6. ___ The amount is determined using the following formula:
 1924(d)(1)(B) of the Act
7. ___ Not applicable (N/A)

(C.) Family (check one):

1. ___ AFDC need standard
2. ___ Medically needy income standard

Note: The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ___ The following dollar amount: \$_____
- Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard
 that is not greater than the standards above: _____%
 of _____ standard.
5. ___ The amount is determined using the following formula:
 1924(d)(1)(C) of the Act
6. ___ Other
7. ___ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Program of All-Inclusive Care for the Elderly (PACE) services

State/Territory: North Carolina

Regular Post Eligibility

2. _____ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(A) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. _____ The following standard included under the State plan (check one):

(a) _____ SSI

(b) _____ Medically Needy

(c) _____ The special income level for the institutionalized

(d) _____ Percent of the Federal Poverty Level: _____%

(e) _____ Other (specify): _____

2. _____ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

3. _____ The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. _____ The following standard under 42 CFR 435.121:

2. _____ The Medically needy income standard

3. _____ The following dollar amount: \$ _____

Note: If this amount changes, this item will be revised.

4. _____ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.

5. _____ The amount is determined using the following formula:

6. _____ Not applicable (N/A)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Program of All-Inclusive Care for the Elderly (PACE) services

State/Territory: North Carolina

(C.) Family (check one):

1. AFDC need standard
2. Medically needy income standard

Note: The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. The following dollar amount: \$ _____
Note: If this amount changes, this item will be revised.
4. The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. The amount is determined using the following formula:

6. Other
7. Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
 Program of All-Inclusive Care for the Elderly (PACE) services

State/Territory: North Carolina

Spousal Post Eligibility

3. ___ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:

1. Individual (check one)

(A). ___ The following standard included under the State plan (check one):

- 1. ___ SSI
- 2. ___ Medically Needy
- 3. ___ The special income level for the institutionalized
- 4. ___ Percent of the Federal Poverty Level: ___
- 5. ___ Other (specify): _____

(B). ___ The following dollar amount: \$ _____
 Note: If this amount changes, this item will be revised.

(C). ___ The following formula is used to determine the needs allowance:

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

These individuals are living in the community and thus have greater needs for shelter, food and clothing. We provide optional coverage for Aged, Blind and Disabled in the community at 100% of the federal poverty level to meet these greater needs.

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 Supersedes
 TN No: 06-009

Approval Date: 12/18/08
 Effective Date: 07/01/08

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Program of All-Inclusive Care for the Elderly (PACE) Services

State/Territory: North Carolina

II. Rates and Payments

A. The State assures CMS that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. X Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

Mercer Government Human Services Consulting
3131 East Camelback Road
Suite 300
Phoenix, Arizona 850164536

Contact: Edward C. Fischer
602-522-6500

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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The description of the PACE payment methodology and actuarial certification of these rates is as follows:

1. To develop the UPL's, the state actuary used historical fee-for-service (FFS) data adjusted for the populations and services covered by the PACE program. This includes base information where the recipient is 55 years of age or older, who require a nursing home level of care, and live within a PACE service area. Only the costs of State Plan approved services from this data file were used for the development of UPL's. Separate UPL's were developed for dually eligible individuals (Medicare and Medicaid) and non-dually eligible individuals (Medicaid only) 55 years of age and older. The dual eligible categories QMB only, QDWI, SLMB, QI1, and QI2 are not entitled to Medicaid services and thus are not included in the UPL calculations. Recipients enrolled in managed care programs and services not covered under PACE were excluded.
2. Graduate and Indirect Medical Expenses (GME/IME) and Disproportionate Share Hospital (DSH) payment were not included in the Medicaid Management Information System (MMIS). MMIS data does not reflect rebates collected on pharmacy claims; thus it was appropriate to adjust the pharmacy data to reflect the impact of rebates.
3. Each of the dually eligible and non-dually eligible groups was analyzed separately with costs weighted between institutional and community populations to produce a UPL for each of the two eligibility categories.
4. Adjustments were applied to determine the UPL once the base data was analyzed and determined appropriate. The adjustments include program changes and trend. UPL methodology includes the impact of any programmatic changes.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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III. Enrollment and Disenrollment

There is a PACE administrative work group preparing for Pace implementation. The state assures that there will be a process in place to provide for dissemination of enrollment and disenrollment data between state and local agencies and will implement procedures for the enrollment and disenrollment of participants in the state's MMIS, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month before the PACE program is approved by the state.

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