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## **I. STATEMENT OF PHILOSOPHY AND PURPOSE**

Adult Care Home Case Management Services are directed at the goal of improving the overall quality of care for Special Assistance/Medicaid eligible heavy care residents of adult care homes. The service provides support to those residents who are seriously impaired and require more extensive assistance in order to have their needs adequately addressed. With additional personal care assistance, case management support, and other needed services residents and residents' families who want their relatives to be able to "age in place" can be allowed to do so.

The purpose of Adult Care Home Case Management Services is to provide a case manager to work in partnership with residents, residents' families, significant others, adult care homes, and community service providers to assure that the needs and preferences of heavy care residents are being met. Case managers have important and diverse roles with these residents. Their first responsibilities are to verify the residents' eligibility for Enhanced Adult Care Home Personal Care; to review adult care homes' care plans to be sure these plans correspond to the needs of the residents; and to review adult care homes' provision of services to assure changes in residents' conditions are being addressed.

Case managers are also responsible for conducting broader assessments which can identify the need for other health and social services which might benefit residents. Case managers develop service plans and monitor these plans. The service plans outline the primary problems and concerns as identified by residents, residents' families, significant others, adult care homes, and case managers. Service plans identify activities that are intended to address these problems, ultimately improving the quality of care for residents.

This manual contains the state policies and practice guidelines for providing Adult Care Home Case Management Services. The state policies must be followed by county departments of social services that claim Medicaid reimbursement for providing the service. The case management practice guidelines are intended to provide guidance in carrying out state policies and to offer additional information which may be helpful to case managers.

## **II. LEGAL BASE**

In the 1995 Session of the General Assembly a series of initiatives were enacted through the ratification of Chapter 449 of the 1995 Session Laws (Senate Bill 864) to improve the care provided to residents in adult care homes. One provision required the Social Services Commission to adopt rules for the provision of Adult Care Home Case Management Services to residents in adult care homes who are eligible for Medicaid funded Enhanced Adult Care Home Personal Care. These rules are filed in 10A NCAC 71D under the provisions of the Administrative Procedures Act.

### III. DEFINITION OF TERMS

The following definitions are provided to assist with understanding Adult Care Home Case Management Services.

- A. Adult Care Home Case Management Services (ACH/CMS)** is a group of interrelated activities conducted by a qualified ACH/CMS case manager which includes:
- verifying that a resident meets the Medicaid criteria for a heavy care resident;
  - reviewing the heavy care resident's care plan to assure that the resident's personal care needs are adequately addressed;
  - authorizing Enhanced Adult Care Home Personal Care (ACH/PC) payments to the adult care home;
  - monitoring the heavy care resident's condition and determining if the tasks in the adult care home's care plan are being performed in a manner appropriate to the needs of the resident;
  - providing consultation and assistance to the adult care home, when needed, for assessment and care planning;
  - assessing and reassessing the broader health care service needs of the heavy care resident;
  - preparing an Adult Care Home Case Management Service Plan to address the overall health care needs of the heavy care resident with Medicaid-covered services, whenever possible;
  - working with the adult care home, the heavy care resident, and the resident's family/responsible party to locate and arrange for other health and social services which support the provision of Medicaid-funded services;
  - coordinating services when multiple service providers are involved in the heavy care resident's care; and
  - determining that services received are appropriate and adequate for meeting the heavy care resident's needs and that the services are consistent with accepted standards for quality care.
- B. Adult Care Home Screening** is a group of interrelated activities conducted by a qualified ACH/CMS case manager which includes:
- assisting the adult care home to identify potential heavy care residents;
  - reviewing referral documents provided by the adult care home;
  - assessing the condition of residents relative to Medicaid criteria;
  - securing any additional information to verify a resident's status;
  - making the determination that the resident does or does not qualify for Enhanced ACH/PC;

- determining whether a resident who has died or was discharged from the adult care home was eligible for Enhanced ACH/PC while residing in the facility; and
  - carrying out administrative and other tasks required by the program which cannot reasonably be assigned to an individual resident (e.g., providing general program consultation to adult care homes and other similar activities that affect multiple residents).
- C. Ambulation/Locomotion** is how the resident moves, either walking or wheeling, inside or outside the home. It does not include any set-up help the resident may receive, such as handing the resident a cane, bringing the resident a walker or wheelchair, or locking the wheels on a wheelchair. It does not include transferring.
- D. Authorizing Enhanced ACH/PC coverage** means the process of evaluating and approving a referred potential heavy care resident's eligibility for Enhanced ACH/PC payments to the adult care home. If the potential heavy care resident is determined to be eligible, then the case manager "authorizes" Enhanced ACH/PC.
- E. Basic Adult Care Home Personal Care (ACH/PC)** is a fixed daily rate paid to a Medicaid-enrolled adult care home for the provision of routine personal care to Special Assistance/Medicaid eligible residents. The fixed rate for Basic ACH/PC is based on the estimated cost of providing the one hour per day of routine personal care required by the Adult Care Home Licensure Rules.
- F. Care Plan** identifies and documents the adult care home's responsibilities for meeting the personal care needs of a Medicaid eligible resident. The care plan is based on an assessment by the adult care home of the resident's abilities, functional limitations, and personal care needs. A physician must authorize the provision of the personal care services in the plan. The care plan is documented on the DMA-3050R or the home's own assessment and authorization/care plan form.
- G. Eating** is how the resident drinks and gets food from the plate to his mouth. It also includes receiving nourishment by tube feedings or intravenous means. It does not include any set-up help the resident may receive, such as opening containers and cartons, preparing food, or cutting up food. The skills used by the resident in eating, such as eating only finger food instead of using a fork, using only one implement, or being neat or messy, are not considered in assessing the resident's performance and need for assistance.
- H. Enhanced Adult Care Home Personal Care (ACH/PC)** is one of four fixed daily rates paid to a Medicaid-enrolled adult care home for the provision of personal care assistance to heavy care residents (see definition of heavy care resident below). The daily rate paid for a heavy care resident's Enhanced ACH/PC is based on the estimated cost of providing routine personal care plus the extra care required by the heavy care resident with eating, toileting, eating and toileting, and/or ambulation/locomotion.

- I. Extensive Assistance** means the resident can perform part of the activity for him/herself. The resident also requires either weight-bearing support from staff three or more times in a week, or a staff member to perform the task for him/her (three or more times) during part (but not all) of the week. The following are examples: (a) on three occasions in one week, the resident needed a staff member to lean against and steady him/her while transferring from standing with a walker into a bed or chair; (b) a resident who feeds himself/herself breakfast and lunch with staff supervision; however, due to fatigue late in the day, he/she must be fed dinner by a staff member daily; (c) resident can walk within a room but requires weight-bearing assistance to walk outside of the room; (d) resident is able to propel self in a wheelchair, however due to fatigue the resident requires a staff member to push the wheelchair three or more times a week; (e) resident is able to use an assistive device(s) (i.e. walker, cane, rollator walker), however he/she requires a staff member to provide weight-bearing assistance three or more times a week.
- J. Heavy Care Resident** means a Medicaid eligible resident of an adult care home who, according to Medicaid criteria, needs extensive assistance or is totally dependent on a staff member for eating, toileting, and/or ambulation/locomotion, and whose eligibility for Enhanced ACH/PC has been verified by a qualified case manager.
- K. Independent** means the resident performs the activity without help, or may require minimal supervision or assistance only once or twice during a week. For example, a resident who usually transfers on and off the toilet unassisted may need a staff member to stand by the toilet room door after an especially tiring day away from the adult care home.
- L. Limited Assistance** means the resident is highly involved in performing the activity for him/herself. The resident also requires help from staff in guided maneuvering of limbs or other non-weight-bearing assistance three or more times during a week, or limited assistance plus more physical assistance only once or twice during a week. For example, a resident may need a staff member to hold up his shirt and physically guide his hand to the sleeve opening, but the resident can push his arm through the sleeve. Another example would be a resident who walks independently throughout the facility during the daytime, but wants staff to hold her hand and guide her while walking to the toilet room during the night.

**M. Payment Rate** means the fixed daily rate paid by Medicaid to enrolled adult care homes providing ACH/PC. Rates apply statewide and remain in effect until changed by the Department of Health and Human Services. The current Medicaid payment rates for ACH/PC are:

Basic ACH/PC (Licensed Beds 1-30)	\$17.33
Basic ACH/PC (Licensed Beds 31 +)	\$18.98
Enhanced ACH/PC (extra assistance with Eating)	\$10.69
Enhanced ACH/PC (extra assistance with Toileting)	\$3.82
Enhanced ACH/PC (extra assistance with Eating and Toileting)	\$14.51
Enhanced ACH/PC (extra assistance with Ambulation/Locomotion)	\$2.73

**N. Service Plan** identifies and documents the mutual responsibilities of the heavy care resident, case manager, adult care home, family, and significant others for meeting the health care and social service needs of the heavy care resident. The service plan is based on a thorough assessment of the heavy care resident's level of functioning and allows all responsible parties to track progress toward meeting the heavy care resident's goals.

**O. Significant Change** in a resident's condition is one or more of the following:

- deterioration in two or more activities of daily living;
- change in ability to walk or transfer;
- change in the ability to use one's hands to grasp small objects;
- deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic;
- no response by the resident to the treatment for an identified problem;
- initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or ten percent weight loss or gain within a 6-month period;
- threat to life such as stroke, heart condition, or metastatic cancer;
- emergence of a pressure ulcer at Stage II or higher;
- a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time such as initial diagnosis of Alzheimer's disease or diabetes;
- improved behavior, mood, or functional health status to the extent that the established plan of care no longer matches what is needed;
- new onset of impaired decision-making;
- continence to incontinence or indwelling catheter; or
- the resident's condition indicates there may be a need to use a restraint and there is no current restraint for the resident.

**Significant Change** in a resident's condition is not any of the following:

- changes that suggest slight upward or downward movement in the resident's status;
- short-term changes that resolve with or without intervention;
- changes that arise from easily reversible causes;
- a short-term acute illness or episodic event;
- a well-established, predictive, cyclical pattern; or
- steady improvement under the current course of care.

**P. Special Assistance for Adults (SA)** is the financial assistance program which helps eligible individuals pay for the cost of care in licensed adult care homes. The Special Assistance payment rate can be revised annually by the General Assembly.

Special Assistance for the Aged (SAA) is for eligible individuals 65 years of age and older; Special Assistance for the Disabled (SAD) is for eligible individuals 18 to 64 years of age who are disabled according to Social Security standards; and Special Assistance for the Blind (SAB) is for eligible individuals who are legally blind.

A small number of SA recipients are known as “**disenfranchised recipients**”. The original category of disenfranchised recipients was created in August 1995 when the General Assembly reduced the payment level for SA and authorized use of Medicaid reimbursement for personal care services in adult care homes. The SA payment level was reduced effective August 1, 1995 from \$975 for ambulatory residents (group “A” of the original category of disenfranchised recipients, as indicated on the resident's Ambulation Capacity Code in EIS) and \$1,017 for semi-ambulatory residents (group “S” of the original disenfranchised recipients) to \$844 for all recipients. Those recipients who had incomes between \$844 and \$975 or \$1,017 would have no longer been eligible, if they had not been grandfathered by the General Assembly for continued coverage under SA. Only these grandfathered recipients are included in the groups A and S category of “disenfranchised recipients”.

**Group A and group S disenfranchised SA recipients are not eligible for ACH Personal Care Services (Basic, or Enhanced) and are not eligible for Adult Care Home Case Management Services.**

- Q. Supervision** means the resident can perform the activity when a staff member provides oversight, encouragement, and prompting, or with supervision plus some physical assistance only once or twice during a week. For example, an incontinent resident may be able to use the toilet room unassisted if regularly reminded to do so. Another example would be a resident who bathes daily with supervision and encouragement. He is able to wash himself completely with oversight from another person. Once or twice during the week, he may need staff to hold his hand and provide some support while he gets in and out of the tub.
- R. Toileting** is how the resident uses the toilet room, commode, bedpan, or urinal; transfers on and off the toilet; cleans perineum; changes pads; manages a catheter or ostomy; and adjusts clothing after toileting. It does not include any set-up help the resident may receive, such as how the resident gets to the toilet room or supplying toilet paper or incontinence pads.
- S. Totally Dependent** means a staff member must complete the task for the resident at all times. For example, a resident who cannot do any part of dressing for himself, and requires total assistance with dressing from staff. Another example is a resident who receives a tube feeding administered completely by staff. Another example would be a resident who is unable to walk, with or without, an assistive device(s), or a resident who is unable to propel self in a wheelchair and requires total assistance from staff.

#### IV. ELIGIBILITY FOR ENHANCED ADULT CARE HOME PERSONAL CARE

Items A. and B. of this section describe the actions taken by the adult care home to refer a potential heavy care resident for Enhanced ACH/PC. Referrals may come from other sources, i.e., physician, nurse, family member, or adult homes specialist. The remaining items in this section describe the responsibilities of the case manager after a referral is made.

##### A. Adult Care Home Identifies a Potential Heavy Care Resident

###### 1. State Policies

The target population eligible for Enhanced ACH/PC consists of individuals who are Medicaid eligible residents of Adult Care Homes who meet the Medicaid criteria for a heavy care resident and are authorized for Enhanced ACH/PC. Medicaid criteria for heavy care include residents who require extensive or total assistance with eating, toileting and/or ambulation/locomotion. **Group A and S “disenfranchised” SA residents are not included in the target population.**

The adult care home completes the Personal Care Physician Authorization and Care Plan (DMA-3050R) or the home’s own assessment and authorization/care plan to assess and document a Special Assistance/Medicaid eligible resident’s abilities, limitations, and personal care needs and to develop a care plan for meeting those needs. When the adult care home enters a performance code of “3” (extensive assistance) or “4” (totally dependent) for eating, toileting and/or ambulation/locomotion in item #17 of the DMA-3050R, this individual may be a heavy care resident. The DMA-3050R and the instructions for completing the form are contained in Appendix A. of this manual.

The adult care home may develop and use its own assessment and authorization/care plan form instead of the DMA-3050R. If the home uses another form it must be approved by DHHS and provide the same information as the DMA-3050R about the resident’s abilities and limitations, need for assistance with personal care tasks, and the plans for meeting those needs. The home must identify a potential heavy care resident by rating the individual’s degree of dependence on others for assistance with eating, toileting and/or ambulation/locomotion according to the same Medicaid criteria and performance coding system described above.

###### 2. Case Management Practice Guidelines

The identification of a potential heavy care resident will most likely occur when the adult care home assesses the resident’s personal care needs upon

admission. A heavy care resident may also be identified any time the home reassesses a resident's needs, i.e., when the resident's physical or mental condition changes, during monitoring and supervisory reviews, during an annual reassessment, or following a hospitalization.

B. Adult Care Home Makes Referral to Case Manager

1. State Policies

Once a potential heavy care resident is identified, the adult care home notifies the case manager and requests an evaluation to verify that the resident meets the Medicaid criteria for a heavy care resident. The adult care home documents in the resident's record the name of the staff person who made the referral, the name of the case manager at the department of social services (DSS) who was contacted, and the date of the referral.

The adult care home gives the case manager the following "referral documents." These referral documents must be maintained in the resident's DSS case record and are not to be returned to the adult care home.

- a. A copy of the DMA-3050R or the home's own assessment and authorization/care plan signed and dated by the administrator or the person designated by the administrator to assess residents' needs; and
- b. Copies of any other available documentation supporting the home's assessment findings, such as copies of the resident's FL-2 or notes made by facility staff who provide care.

The adult care home may bill the Basic ACH/PC rate while the case manager's authorization of Enhanced ACH/PC coverage is pending. The adult care home will not receive Enhanced ACH/PC payments prior to the case manager authorizing the coverage in EDS' claims processing data base. See item D. of this Section for information on the prior approval process.

The adult care home may bill the Basic ACH/PC rate and /or Enhanced ACH/PC rate for services provided by the adult care home to a recipient who is also receiving Hospice services. The adult care home referral procedures for Enhanced ACH/PC as found in section 9015, 'Eligibility For Enhanced Adult Care Home' will be followed.

2. Case Management Practice Guidelines

In most instances the DSS is the most appropriate agency to provide adult care home case management and is responsible for verifying eligibility, authorizing Enhanced ACH/PC, and providing case management for the resident. The Local Management Entity (LME) is the appropriate adult care home case management provider if the potential heavy care resident has been or is currently a CAP-MR/DD client and has been or is currently receiving treatment, case management, or other services through the LME or its contracted providers. The LME may be the appropriate agency to provide or arrange adult care home case management if the potential heavy care resident has a past history of mental illness or psychiatric hospitalization; or has mental illness and is in need of treatment and/or other services through the LME; resides in a facility operated by or under contract with the LME; or resides in a DDA group home. The county DSS and the LME should jointly determine the most appropriate adult care home case management provider where there is uncertainty about who is responsible.

The DMA-3050R or the home's own assessment and authorization/care plan does not have to be signed by the resident's physician before it is forwarded to the case manager or before Enhanced ACH/PC is authorized. The case manager should follow up and encourage the home to have the form signed by the physician once Enhanced ACH/PC is authorized. Ultimately the adult care home is responsible for assuring that the physician has signed the DMA-3050R or the home's own assessment and authorization/care plan.

C. Case Manager Assessment of Resident's Eligibility for Enhanced ACH/PC

1. State Policies

The case manager must conduct an assessment of the resident's eligibility for Enhanced ACH/PC. The following tasks must be carried out by the case manager as part of conducting the assessment.

- a. establish that the resident is Medicaid eligible and not a group A or S "disenfranchised" resident;
- b. review the assessment findings and any supporting documentation supplied by the adult care home as referral documents;
- c. obtain copies of any other relevant documents from other sources, such as nursing notes or hospital records;
- d. conduct an independent assessment of the resident's need for assistance with eating, toileting and/or ambulation/locomotion by personal observation as well as by asking the home's staff, the resident's family/responsible party, or others who are knowledgeable about the resident's needs;

- e. observe the resident going about his/her usual daily routine in order to assess abilities and limitations (it is not necessary for the case manager to directly observe the resident toileting); and
- f. determines whether the resident meets the Medicaid criteria for a heavy care resident.

If the resident dies or is discharged by the adult care home after the referral is made, the case manager must complete the assessment and, if possible, make a decision based on available information regarding the resident's eligibility for Enhanced ACH/PC during the time period prior to the date of death or discharge. The case manager is not required to set up a case record, but documentation regarding these decisions must be maintained by the agency.

## 2. Case Management Practice Guidelines

At times the case manager may not immediately be able to verify that a referred resident meets the Medicaid criteria for a heavy care resident. When this is the case, the case manager should work with the adult care home to reach a mutually agreeable conclusion about the resident's eligibility for Enhanced ACH/PC.

The case manager should ask the adult care home administrator or the person designated by the administrator to assess resident needs for any other available records which document the resident's need for assistance with eating, toileting and/or ambulation/locomotion. The case manager should be sure that he has been given copies of all the documents the home used to assess the resident's needs and identify that individual as a heavy care resident. The case manager and the home together should attempt to obtain any other pertinent documents to further clarify the resident's abilities, limitations, and need for assistance. These could include nursing notes from any recent hospital admissions, mental health treatment notes, or other physical or psychological evaluations.

The case manager and the adult care home administrator or designated staff should review the referral documents and any additional documentation together to determine the resident's abilities, limitations, and need for assistance with eating, toileting and/or ambulation/locomotion. The case manager and the administrator or designated staff should talk with the home's staff who care for the resident, the resident's physician, and family members or others who have knowledge of the resident's current abilities and limitations. A resident's functioning may improve or decline during the course of a day or because of a change in daily activities. For this reason, it may be helpful to reassess the resident at a different time of day or on a different day of the week than previous assessments. The case manager and the administrator or designated staff should note and attempt to resolve any discrepancies in the documentation or statements of caregivers or others which conflict with their assessment of the resident's abilities, limitations, and need for assistance.

D. Case Manager Initial Decision Regarding Resident's Eligibility for Enhanced ACH/PC

1. State Policies

Within 30 calendar days from the date of receiving the referral documents from the adult care home, the case manager must complete the assessment of the resident's eligibility and decide whether to authorize Enhanced ACH/PC.

a. Resident Meets Medicaid Criteria for Enhanced ACH/PC

When the case manager determines that the resident meets the Medicaid criteria for a heavy care resident, the case manager must complete an Individual Authorization Form (DMA-3019), contact EDS' Prior Approval Unit, and authorize the appropriate Enhanced ACH/PC payment rate for that resident. Once the authorization has been entered in EDS' claims processing data base, the case manager must send the heavy care resident and the adult care home a Decision Notice which authorizes the home to begin billing the Enhanced ACH/PC payment rate.

(1) Complete Individual Authorization Form (DMA-3019)

The case manager must complete a DMA-3019 to authorize Enhanced ACH/PC for the heavy care resident. The DMA-3019 includes the correct Enhanced ACH/PC rate to be paid for the heavy care resident's care, the effective date for authorization, and other necessary information. A sample Individual Authorization Form and the instructions for completing the form are contained in Appendix B. of this manual.

The effective date for an initial authorization of Enhanced ACH/PC is the date the resident's DMA-3050R or the home's own assessment and authorization/care plan, identifying the individual as a heavy care resident, was signed by the administrator or a person designated by the administrator. The effective date may be no more than 90 days prior to the date of the Decision Notice and can not precede the date the resident's DMA-3050R or the home's own assessment and authorization/care plan, identifying the individual as a heavy care resident, was signed by the

administrator or a person designated by the administrator. See item (3) below for information on the Decision Notice. See Appendix N for assistance in determining 90-day retroactive effective dates. The effective date for Enhanced ACH/PC is the first date of service the adult care home can bill at the Enhanced ACH/PC rate. The

effective date for Enhanced ACH/PC also starts the annual cycle for re-evaluating and re-authorizing Enhanced ACH/PC for the case manager.

(2) Contact EDS' Prior Approval Unit

The case manager must call in the information on the completed DMA-3019 to EDS' Prior Approval Unit (see Appendix C. for the telephone number of EDS' Prior Approval Unit). This applies to all initial authorizations of Enhanced ACH/PC and each time the case manager re-authorizes or discontinues an authorization of Enhanced ACH/PC. The EDS Prior Approval Analyst enters the information into the claims processing data base and gives the case manager a Confirmation Number for making inquiries about that authorization in the future. The case manager's authorization of Enhanced ACH/PC must be in EDS' claims processing data base before an adult care home can be paid an Enhanced ACH/PC rate for a heavy care resident's care.

(3) The Decision Notice

The case manager must prepare and send a Decision Notice to the resident and a copy to the adult care home each time a decision is made to authorize, deny, continue, change, or discontinue the resident's Enhanced ACH/PC. The Decision Notice provides information about the resident's and the adult care home's rights and notifies the home of the effective date to begin or discontinue billing for Enhanced ACH/PC. The resident's actions discussed throughout this section may be undertaken by the resident, their legal guardian or the resident's representative such as a family member, a friend, an attorney, or the Adult Care Home provider. Whenever this material states that the "resident" may act, this means their representative as well.

The Decision Notice must contain the following information.

- (a) The case manager's decision to authorize Enhanced ACH/PC; deny Enhanced ACH/PC; continue the current level of Enhanced ACH/PC payments; change the level of Enhanced ACH/PC authorized to a higher or lower payment; or discontinue the resident's Enhanced ACH/PC.
- (b) Reference(s) to specific state policies (including section and sub-section numbers) contained in this manual which support the decision.

- (c) The effective date of the initial authorization, denial, continuation, change, or discontinuation of Enhanced ACH/PC. See the remainder of item D. in this Section and Section VII. for additional information pertaining to the appropriate effective date to include on the Decision Notice.
- (d) A date 365 days after the date the resident's DMA-3050R or the home's own assessment and authorization/care plan, identifying the individual as a heavy care resident, was signed by the administrator or a person designated by the administrator indicating when the authorization of Enhanced ACH/PC coverage will end if the coverage is being authorized, continued, or changed. See Appendix N for assistance in determining the end date.
- (e) A statement that both the resident and the adult care home have the right to request a review of the case manager's decision. The resident and/or the adult care home may request a review of the case manager's decision through an informal local hearing; a state hearing; or a formal appeal hearing by the Office of Administrative Hearings (OAH). See Section X. of this manual for information on hearings.
- (f) The timeframe for requesting a hearing to review the decision. See Section X. of this manual.
- (g) The timeframe for holding local and state hearings. See Section X. of this manual.
- (h) A statement about the resident and adult care home's right to be represented by someone else and bring others to the hearing.
- (i) An explanation of the conditions for continuing to bill for services pending a local hearing decision.
- (j) The timeframes for mailing notices to the resident and adult care home, which contain the local and state hearing decisions. See Section X. of this manual.
- (k) The case manager's name, title, business address, and telephone number.

The date on the Decision Notice is the date it is mailed by the case manager. The effective date in the Decision Notice must be the

same effective date the case manager entered on the DMA-3019 and called in to EDS' Prior Approval Unit. A copy of the Decision Notice must be kept in the resident's DSS case record. A copy of the Decision Notice is in Appendix D. of this manual.

b. Resident Does Not Meet Medicaid Criteria for Enhanced ACH/PC

When the case manager does not agree with the adult care home's assessment findings and cannot resolve the differences with the home, the case manager must notify the resident and the adult care home in writing of the decision to deny Enhanced ACH/PC. The case manager must send a Decision Notice to the resident and a copy to the adult care home to officially notify them of the decision to deny Enhanced ACH/PC and of their right to request a review of the decision. The Decision Notice is described in item D.1.a.(3) of this Section.

(1) Effective Date for Denial of Enhanced ACH/PC

The effective date for denying Enhanced ACH/PC is the date the resident's DMA-3050R or the home's own assessment and authorization/care plan, identifying the individual as a potential heavy care resident, was completed and signed by the administrator or designated staff. The adult care home is not entitled to Enhanced ACH/PC payments on or after this effective date unless the case manager's decision to deny coverage is reversed by a hearing decision. See Section X. of this manual for information on hearings.

2. Case Management Practice Guidelines

Referrals for residents who meet the Medicaid criteria for heavy care residents can come from a variety of sources, i.e., a physician, nurse, family member, responsible party, adult homes specialist, other individuals, or the case manager. When this occurs, the case manager should work with the adult care home to secure the appropriate referral documents to verify that the resident meets the Medicaid criteria for a heavy care resident, and if appropriate, authorize Enhanced ACH/PC. If an adult care home is unwilling to make a referral for a resident who meets the Medicaid criteria for a heavy care resident, the case manager may independently determine that the resident meets the Medicaid criteria for Enhanced ACH/PC. In order to make this determination, the case manager should review the adult care home's assessment of the resident. The case manager should document his own assessment of the resident and the basis upon which the Medicaid criteria was met. The case manager then follows the policies described in item D.1.a. of this Section to approve and authorize the resident for Enhanced ACH/PC.

Note: The adult care home is not required to bill for Enhanced ACH/PC, but this action does not affect the resident's eligibility for either ACH/PC or Adult Care Home Case Management Services.

There are justifiable situations where the initial effective date for Enhanced ACH/PC exceeds 90 days from the date of the Decision Notice. For example, a private pay resident who applies for Medicaid and Special Assistance and is determined to meet the Supplemental Security Income (SSI) eligibility criteria may have a retroactive period of eligibility that exceeds 90 days. A resident may enter an adult care home on a private-pay basis, spend his financial resources on the cost of care, and then apply for SSI/Medicaid and Special Assistance. The adult care home completed the required DMA-3050R or the home's own assessment and plan of care upon admission showing that the resident needed extensive assistance. If the SSI eligibility determination process takes more than 90 days, that also delays the Medicaid eligibility decision. Once the SSI/Medicaid eligibility is determined, it may be retroactive to the date of application, as might Special Assistance. The case manager should review the DMA-3050R done by the home as well as the home's subsequent documentation of personal care services and if he agrees that the assessment findings and plan of care continue to be a current and accurate reflection of the resident's needs, the initial effective date for Enhanced ACH/PC in this case will be the date of Medicaid eligibility, which is more than 90 days earlier than the date of the Decision Notice. If the case manager feels there is a justifiable cause such as this for not meeting the 90 day standard, he should call the Adult Care Home Case Management Program Manager to make this determination prior to contacting EDS' Prior Approval Unit.

When the case manager denies coverage for Enhanced ACH/PC or authorizes a lower level of Enhanced ACH/PC than indicated on the adult care home's assessment, the case manager should document his own assessment of the resident and the basis upon which the Medicaid criteria was not met. The case manager should make efforts to determine the basis for the difference in findings; and, before denying coverage, observe the resident on different occasions in the facility.

E. Application Process for Adult Care Home Case Management Services

1. State Policies

a. Eligibility Criteria

If an individual meets the criteria in the target population below, he is determined to be eligible for Adult Care Home Case Management Services. Adult Care Home Case Management Services must be

provided by every county department of social services where it is determined that residents of adult care homes fall within the target population for the service.

b. Target Population for Adult Care Home Case Management Services

The target population consists of individuals who are Medicaid eligible residents of adult care homes who meet the Medicaid criteria for a heavy care resident and are authorized for Enhanced ACH/PC. Group A and S “disenfranchised” SA residents are not included in the target population.

Once the case manager determines that the resident meets the Medicaid criteria for a heavy care resident and authorizes Enhanced ACH/PC, i.e., falls within the target population, an application (DSS-5027) for Adult Care Home Case Management Services must be taken. The application must be made in accordance with policies in the Family Services Manual, Volume VI, Chapter II, Section 8065. The specific location of the documentation in the case record (page number, date, or other location) that the resident meets the criteria for the service must be referenced on the DSS-5027.

2. Case Management Practice Guidelines

The case manager conducts a series of activities in order to determine whether or not to authorize a potential heavy care resident for Enhanced ACH/PC. These activities include assisting the adult care home to identify potential heavy care residents, reviewing referral documents provided by the home, assessing the condition of residents relative to Medicaid criteria, securing additional information about residents to verify their status, and making a determination that a resident does or does not qualify for Enhanced ACH/PC. These activities are considered Adult Care Home Screening and do not require a DSS-5027 to be signed. At the point that the case manager verifies that a resident meets the Medicaid criteria for a heavy care resident and authorizes Enhanced ACH/PC, the DSS-5027 should be signed.

The date of application (DSS-5027) should usually be the date the case manager issues a Decision Notice. If a resident dies or is discharged by the adult care home after a referral is made to verify that a resident meets the Medicaid criteria for a heavy care resident, the DSS-5027 is not required.

It is preferable for the heavy care resident to sign his own application, but since many individuals are unable to sign, another responsible person may apply on the resident's behalf. In order of preference, those other persons are a legal guardian (if applicable), attorney-in-fact appointed in a power of attorney or health care agent appointed in a health care power of attorney (if applicable and depending on responsibilities granted), a relative, other responsible person, the administrator or designated staff of the adult care home, or the case manager. See Volume VI, Chapter II of the Family Services Manual for additional information about the DSS-5027. When another person applies on behalf of a resident, that person should be encouraged to make the resident aware of the application, if this has not been done already.

## V. PROVISION OF CASE MANAGEMENT SERVICES

### A. Assessment of Residents

#### 1. State Policies

Once a resident's eligibility for Enhanced ACH/PC is authorized and the DSS-5027 is signed, the case manager must conduct a thorough assessment of the heavy care resident's abilities and health care needs. The purpose of the assessment is to determine the heavy care resident's level of functioning, including strengths and limitations in the areas listed below.

- a. physical health;
- b. mental health;
- c. social support system;
- d. activities of daily living(ADLs) and instrumental activities of daily living (IADLs);
- e. economic and financial circumstances; and
- f. environment.

The resident must be seen personally by the case manager as many times as necessary to conduct a thorough assessment in the six areas. The case manager must involve the resident, the adult care home, family members, and/or other responsible parties, as appropriate, in order to complete the assessment.

#### 2. Case Management Practice Guidelines

##### a. Assessment of the Six Functional Areas

The following points should be taken into consideration in assessing the six functional areas for Adult Care Home Case Management Services.

##### (1) Physical Health

An assessment of the resident's physical health is critical, since physical health is a strong factor in determining the health care service needs of the resident. The FL-2 and the DMA-3050R or the home's own assessment and authorization/care plan are an important part of the physical health assessment. The information on these forms should be compared to the information gathered by the case manager to see if it is consistent.

Often residents are seeing more than one physician, taking medications prescribed by more than one physician, and taking over-the-counter medications. It is important for any discrepancies in this information to be noted and brought to the attention of the adult care home administrator or designated staff and to the resident's physician, where appropriate. It is important to observe the resident directly and talk with adult care home staff and other health care professionals (i.e., RN, LPN, OT, PT) involved in the care of the resident. Illness and the progression of illness may impact various goals and service options.

When a resident is authorized for Enhanced ACH/PC based on the need for additional assistance with eating, the case manager should assess past weight, current weight, ability to perform ADLs with regard to use of arms and hands, swallowing difficulty, dentures and other dental appliances, dietary orders and food supplements, medications, and the need for adaptive eating equipment. The case manager should use the Eating Assessment Tool and Tips to facilitate the collection of information relating specifically to eating difficulties. A copy of this assessment tool is in Appendix I. of this manual.

When a resident is authorized for Enhanced ACH/PC based on the need for additional assistance with toileting, the case manager should assess ADLs in regard to getting on/off the toilet, the ability to adjust clothing, and the ability to perform personal hygiene. If the resident is incontinent, the case manager should use the Adult Incontinent Assessment Tool. A copy of this assessment tool is in Appendix J. of this manual.

When a resident is being assessed for authorization for Enhanced ACH/PC based on the need for additional assistance with ambulation/locomotion, the case manager should assess ADLs in regard to the ability to walk safely without weight bearing support from a staff member or the ability to locomote in a wheelchair without staff assistance. The resident's gross motor skills, range of motion, strength in arms and legs, steadiness when walking with or without an assistive device (cane, walker, or rollator walker), and history of falls should be considered. The resident's need for transferring assistance is not a consideration when assessing the need for assistance with ambulation/locomotion. Blindness or disorientation does not equate to extensive assistance for ambulation/locomotion; what

must be considered is whether the resident needs weight bearing support versus gentle guidance to safely ambulate or locomote inside or outside the home. Guidance in the absence of weight bearing assistance is not extensive assistance.

(2) Mental Health

The resident's mental health status helps determine whether counseling, medications, and/or behavior management may be needed. Mental health status may be a strong factor in the precipitation or exacerbation of adjustment problems. The mental health assessment should include cognitive as well as emotional functioning. It should determine how well oriented the resident is to person, time, and place. It should determine whether the resident is depressed, agitated, or demented. Any progressive dementing illness is especially noteworthy since this will affect long-term planning with the resident. See Appendix K. of this manual for tips on communicating with residents with dementia and non-verbal residents. Judgment

and the ability to learn new things and solve problems are also important areas which affect how planning is done and the appropriateness of services. The mental health assessment should help determine whether guardianship or another surrogate decision-maker will be needed to facilitate services.

The case manager may want to administer some screening tests for mental status such as The 6-Item Short Blessed Test (SBT) or the Geriatric Depression Scale. Copies of these tools are in Appendices F. and G. of this manual.

The case manager may want to spread the assessment over several visits to obtain an accurate picture of mental status. It is also important to analyze the effects of time of day, nutrition, and medications on the resident's mental state. If there is any question about the resident's mental state, or whether there is a mental illness present, a mental health professional should be consulted and/or a mental health evaluation obtained. The FL-2 and the DMA-3050R or the home's own assessment and authorization/care plan also contain some information on mental status which should be compared to the case manager's assessment.

### (3) Social Support System

The social support system should be viewed broadly to include family, friends, adult care home staff, roommates, other informal caregivers, as well as any other person or activity which is of significance to the resident. The social support system often can make the difference in a resident's adjustment to the adult care home. The frequency and quality of the resident's interactions with others are important indicators of the adequacy of the resident's social support system.

The social support system should be assessed not only for assistance given to the resident, but also for the dynamics of the relationship between the resident and family members, adult care home staff, roommates, and others. Gaps in social support, social stressors, and significant recent changes in social support should all be noted. The case manager should be aware of social supports which could be strengthened or new supports which could be developed either in or outside the adult care home to improve the resident's functioning. There may be indications that problems in family functioning will need to be addressed for the resident to benefit from services. Assessing

social support will also help to determine how much the family and others can help with meeting the resident's needs. The case manager should talk with the resident's family, adult care home staff, and significant others as well as observe the resident's interactions with these individuals. The Resident Register (in the resident's adult care home file) may also be a source of information about the resident's like and dislikes and interest in activities.

The case manager may want to use an ecomap to depict the resident's relationships to others and to other systems. A copy of an ecomap is in Appendix H. of this manual.

Another important area to address is the resident's lifestyle prior to placement and what types of activities were and continue to be important to him. Observing and noting the type and frequency of participation by the resident in the adult care home's activities is also an effective way to assess social support.

(4) Activities of Daily Living (ADLs) and or Instrumental Activities of Daily Living (IADLs)

The FL-2 and the DMA-3050R or the home's own assessment and authorization/care plan are an important part of the ADL and IADL assessment. The information on these forms should be compared to the information gathered by the case manager to see if it is consistent. Any discrepancies in the information should be noted and brought to the attention of the adult care home administrator or designated staff and to the resident's physician, where appropriate. Completion of the ADL and IADL assessment by the case manager will help to determine how independently the resident can function and whether his functional capacity is likely to increase or decrease in the future. It will help to determine if rehabilitation is possible, or if functional capacity will remain stable or decline over time.

(5) Economic/Financial Circumstances

The economic status of the resident has already been determined to a large degree since he must be Special Assistance/Medicaid eligible in order to be authorized for Enhanced ACH/PC. However, the economic assessment is still important in helping to determine whether adequate personal funds are available to the resident. Lack of adequate personal funds can contribute to fewer options for outside activities and resources, which affects service planning for the resident. The

economic assessment coupled with the social support assessment should help determine whether other types of non-cash assistance may be available from family, friends, or others in the community to help meet the needs of the resident.

The economic status may also help to determine whether a representative payee or other surrogate decision-maker may be needed to help facilitate services for the resident.

(6) Environment

Environment includes the adult care home in which the resident is living as well as the outside grounds and neighborhood. The environment should be assessed for access to rooms; privacy; lighting; distance to bathroom facilities and the presence of grab bars and other safety enhancing equipment; and general cleanliness of the home. Fire safety and other potential hazards should be addressed, particularly if the resident is confused or disoriented. The case manager should evaluate problems in the environment and whether they can be corrected or not. Many aspects of the environment cannot be easily changed by the home. The case manager should discuss the findings of the environmental assessment with the home's administrator and/or the adult homes specialist to determine the feasibility of making any significant changes to the resident's environment.

The case manager should observe and note the resident's compatibility with roommates, other residents, and staff in the home. Information obtained during the environmental assessment is often closely linked to the resident's social support system.

These six functional areas overlap, and assessment in one area usually yields information pertinent to another area. The purpose of assessing all six areas is to get a well-rounded perspective of the resident and his situation so appropriate holistic goal-setting and service planning can be done. It is important for assessment to include the resident's perspective, as well as that of his caregiver(s) and significant others, and to incorporate observation as well as written materials and discussion. Case managers should use the Adult Services Functional Assessment (DSS-6220) to document assessment information. Additional assessment tools should be completed as needed and included in the case record.

b. Supportive Counseling

Supportive counseling is inherent in the assessment process and continues throughout service planning. As the case manager gathers information during the assessment process, the resident's and family's problems are uncovered, creating opportunities for the case manager to provide counseling or refer the resident and family to another professional for counseling. The case manager should not allow the information-gathering process to shortcut opportunities for dealing with the resident's and family's emotional issues, which are sometimes presented in subtle or non-verbal ways. Because the assessment process includes counseling, it may take more than one contact with the resident to complete the assessment and develop a relationship which is conducive to service planning. It is important for the case manager to conduct the assessment in a way that does not feel intrusive to the resident, family, and adult care home, and that supports and enables them to share information.

B. Setting Goals and Developing a Service Plan

1. State Policies

A service plan must be developed which addresses the health and social service needs identified during the assessment process. The resident, family members, adult care home, and other responsible parties and significant others must be involved in developing a service plan to meet those needs, where possible, through Medicaid-funded programs and services.

The resident's service plan must include the following information.

- a. any health care service needs noted by the adult care home during its assessment for ACH/PC;
- b. other health care and social service needs of the resident identified by the family, responsible party, significant others or the case manager;
- c. strategies for locating and contacting other service providers who may be able to meet the resident's health and social service needs;
- d. the names of the person(s) responsible for accomplishing these activities (i.e., the case manager, resident, adult care home administrator, family member, or other responsible party);
- e. resident goals and intended outcomes; and
- f. target date(s) for accomplishing goals.

2. Case Management Practice Guidelines

a. Goals and Service Options

The discussion of service options should take into account the resident's goals. Goals should not be confused with services. Services help to accomplish goals. Often there are a number of different ways goals can be accomplished. There may be short-term and long-term goals leading to short and long-term service planning. The identification of goals gives the case manager, family, significant others, and adult care home a clearer picture of which services are appropriate, what the services are meant to accomplish, and a framework for identifying when they are successfully achieved.

It is likely that the assessment process may uncover other problems and needs in addition to those identified in the health care area. While the focus of Adult Care Home Case Management is on addressing the overall health care needs of the heavy care resident, the case manager, in conjunction with the resident, family, significant others, and adult care home, should incorporate these other needs into the service planning process.

b. Resident Involvement in Service Planning

The resident should be involved as much as possible in the service planning process. If the client is involved in service planning and believes the plan will help him achieve personal goals, he is more likely to successfully adjust to the home. The case manager should look for opportunities to create choices for the resident, even where choices seem limited. It is important for the service plan to build on resident strengths and help him maintain a sense of self-esteem and as much independence as possible.

c. Family Involvement in Service Planning

The family is often instrumental in service planning, sometimes acting as surrogate decision-maker for the resident, and sometimes facilitating service provision for him. However, family dynamics sometimes interfere with the facilitation of service planning. Family members may disagree on an appropriate service plan for the resident, and if the resident is somewhat confused or not able to separate his needs and goals from those of family members, the service planning process becomes difficult. The case manager may need to counsel with the family to resolve the disagreement before service planning with the resident can proceed.

The case manager may also have to help the family set limits about what kind and how much assistance they can provide to the resident. The case manager may need to help the family know how to

communicate their limits to the resident, so the resident is more fully informed about the possible consequences of his decisions and actions.

d. Adult Care Home Involvement in Service Planning

The adult care home is also instrumental in service planning, given its responsibility for providing twenty-four hour care for the resident. Adult care home staff are knowledgeable about the resident's strengths and limitations and the impact this will have on setting realistic goals and service plans. In many instances the home's staff will be responsible for helping the resident to accomplish his goals. Where family or other responsible parties are not available, adult care home staff will play a key role in facilitating service provision for the resident. Service planning should be viewed as a partnership with the adult care home and family to assist the resident in meeting his needs.

e. Involvement of Surrogate Decision-Makers in Service Planning

When the resident has a legal surrogate decision-maker, such as a legal guardian or attorney-in-fact appointed in a Power of Attorney, that person is crucial to service planning and service delivery. Depending on the responsibilities granted to the surrogate, a service plan may not be implemented without that person's involvement. Therefore, it is important to involve the surrogate early on in the assessment and service planning process. Even when there is a legal surrogate decision-maker, the resident still may be in a position to express his wishes and have input into some aspects of the service plan. If the surrogate decision-maker is not a family member, the case manager should try to be sensitive to the family's feelings, while assisting the surrogate decision-maker to fulfill his responsibilities to the resident.

f. Identifying Activities to be Undertaken and Responsible Parties

When the overall direction of the service plan has been decided, activities are assigned to responsible parties to be implemented and time frames can be established. The parties involved should be allowed to negotiate what they are able to do and what they need help in doing. Case managers should use the Adult and Family Service Plan (DSS-6221) for goal setting and service planning.

C. Monthly Contact

1. State Policies

The case manager must contact the adult care home staff and the resident, family members, or another responsible party at least monthly to assure that services are being received which are appropriate and adequate to meet the resident's needs and consistent with quality care.

2. Case Management Practice Guidelines

It is important for the case manager to maintain monthly contact with the adult care home and the resident, family or other responsible party to assure that adequate care and services are being provided to the resident. The monthly contacts may be made by telephone or through visits to the adult care home. The type of monthly contact may be dictated by the needs identified in the service plan and the extent to which family or other responsible parties are involved with the resident. Case managers should use the Contact/Activity Log (DSS-6222) to document monthly contacts.

D. Quarterly Reviews

1. State Policies

The case manager must meet in person with the adult care home and resident at least quarterly to review the resident's service plan. The case manager must also review the current DMA-3050R or the home's own assessment and authorization/care plan for the resident at least quarterly. The case manager together with the resident and adult care home staff must determine whether the resident's needs are being adequately met and make any needed changes in the service plan. If the resident's needs are not adequately being met, the case manager must assist the adult care home to correct the situation. If the case manager determines that the resident is no longer eligible for Enhanced ACH/PC or is eligible for a different level of coverage, the case manager must follow the policies in Sections VII. and VIII. of this manual.

2. Case Management Practice Guidelines

Quarterly reviews help determine at regular intervals whether the service plan is being carried out as specified, how well goals are being met, and whether changes are necessary. It is important for the case manager to capture both qualitative and quantitative data about the success of the plan during the quarterly review. Case managers should use the Interim or Quarterly Review (DSS-6223) to document the quarterly review.

E. Reassessment of Residents

1. State Policies

a. Adult Care Home Responsibilities

The adult care home must assure that a heavy care resident continues to need ACH/PC at least every twelve months. The adult care home administrator, or a person designated by the administrator, must assess the resident and complete a new DMA-3050R or the home's own assessment and authorization/care plan and obtain a physician's signature on the assessment and care plan to certify the continuing need for ACH/PC. The home must provide a copy of the new DMA-3050R or its own assessment and authorization/care plan to the resident's case manager.

b. Case Manager Responsibilities

(1) Continuing Eligibility for Enhanced ACH/PC

The case manager must verify that the resident continues to meet the Medicaid criteria for a heavy care resident and authorize the continuation of Enhanced ACH/PC at least every twelve months. The case manager must follow all the policies described in Section IV. A.-D. of this manual to determine the continuing eligibility for Enhanced ACH/PC including: verifying that the resident is Medicaid eligible and is not a group A or S "disenfranchised" resident; an independent assessment of heavy care status; documenting the authorization on the Individual Authorization Form (DMA-3019); contacting EDS; and issuing a Decision Notice to the resident and ACH Home. See Section VII. of this manual if the heavy care resident's needs have changed.

(2) Continuing Eligibility for Adult Care Home Case Management Services

The case manager must also conduct a reassessment of the heavy care resident's need for Adult Care Home Case Management Services at least every twelve months or earlier if the resident's needs have increased or decreased significantly. The purpose of the reassessment is to measure the effect of the resident's, family's, adult care home's, and case manager's actions in relation to the resident's initial circumstances, and, depending on the results, reinitiate the process of identifying problems and needs, specifying goals, and developing and implementing the service plan.

2. Case Management Practice Guidelines

As with the initial eligibility decision, the DMA-3050R or the home's own assessment and authorization/care plan does not have to be signed by the resident's physician before it is forwarded to the case manager. The case manager should follow up and encourage the home to have the form signed and returned by the physician.

The case manager should remind the home when a reassessment is due when making monthly and quarterly contacts. If the home does not complete an assessment and authorization/care plan within a twelve-month period, the case manager should also bring this to the attention of the home. The case manager should use procedures outlined in Section IV. D. 2. to document the resident's continuing eligibility for Adult Care Home Case Management Services and continue to provide ACH/CMS if the resident continues to be eligible.

If an adult care home is unwilling to make a referral for a resident who meets the Medicaid criteria for a heavy care resident, the case manager may independently determine that the resident continues to meet the Medicaid criteria for Enhanced ACH/PC. In order to make this determination, the case manager should review the adult care home's assessment of the resident. The case manager should document his own reassessment of the resident and the basis upon which the Medicaid criteria was met. The case manager then follows the policies described in item D.1.a. of Section IV. to approve and authorize the resident for Enhanced ACH/PC.

Note: The adult care home is not required to bill for Enhanced ACH/PC, but this action does not affect the resident's continuing eligibility for either ACH/PC or Adult Care Home Case Management Services.

The case manager's own reassessment is a more extensive review process than either the monthly contact or the quarterly review. Note: the case manager's reassessment is not the process to redetermine the resident's continuing eligibility for Enhanced ACH/PC or Adult Care Home Case Management Services; it is a process where the resident, family, significant others, adult care home, and case manager together evaluate the success of all current plans and determine whether there are new problems and needs to be

addressed. The reassessment typically completes a twelve-month cycle by measuring progress against the resident's initial circumstances and then reinitiates, as appropriate, problem identification, goal specification, and service plan development. However, the case manager should complete a reassessment more frequently than annually, if the resident's circumstances change dramatically.

The reassessment, which replaces the quarterly review every fourth quarter, should be done in person with the resident, the family, significant others, and the adult care home. The reassessment process has many elements in common with the initial assessment conducted by the case manager in that it examines the six functional areas. The reassessment provides an opportunity to focus on the resident's status now and what it was before, and what happened to produce the change. It also provides an opportunity to look at the resident's situation with "new eyes" in order to identify changes in functioning that may not have been apparent during the initial assessment and/or quarterly reviews. Case managers should use the Adult Services Annual Reassessment (DSS-6224) to document reassessment information.

It is important for the case manager to keep track of the reassessment deadlines for Enhanced ACH/PC (the adult care home's annual reassessment of the resident's personal care needs) and Adult Care Home Case Management Services (Adult Services Annual Reassessment - DSS-6224). Ideally these reassessments would occur at the same time, allowing the resident, family, significant others, adult care home, and case manager to review these services at the same time and to make any needed changes. It is also a more efficient use of the adult care home's staff time and case manager's time to complete the entire reassessment process. Significant changes in the resident's functioning or hospitalization periods of 30 or more consecutive days during the course of a year may, however, require that the adult care home produce a new plan of care and assessment (see Sections VII and VIII). This will result in different annual deadlines being established for the assessment of the resident's need for Enhanced ACH/PC (the adult care home's annual reassessment of the resident's personal care needs) and the Adult Care Home Case Management Services reassessment (Adult Services Annual Reassessment - DSS-6224). The Adult Care Home Case Management Services reassessment (Adult Services Annual Reassessment - DSS-6224) is required only once every twelve months, even if a significant change or prolonged hospitalization results in the adult care home producing a new plan of care and assessment within that same twelve month period.

## **VI. DOCUMENTATION AND PROGRAM REPORTING**

### **A. Resident Records**

#### **1. State Policies**

A separate record must be kept by the case manager for each heavy care resident receiving Adult Care Home Case Management Services. Each record must include the following information and be maintained for a period of five (5) years from the date of service.

- a. Referral documents from the adult care home identifying a potential heavy care resident;
- b. A copy of the Individual Authorization Form (DMA-3019);
- c. Copies of all Decision Notices sent to the resident and adult care home;
- d. Documentation of resident eligibility for Special Assistance and Medicaid;
- e. A copy of the completed initial assessment;
- f. Copies of all service plans;
- g. Documentation of monthly contacts with the resident/family/significant others/adult care home regarding the resident's care;
- h. Documentation of referrals to service providers;
- i. Documentation of quarterly reviews;
- j. Copies of all completed reassessments;
- k. Documentation of the resident's or adult care home's request(s) for a local hearing;
- l. Copies of any documents filed at the local hearing;
- m. Copy of the notice of the local hearing decision;
- n. Copy of the local hearing summary provided for the state hearing, if applicable; and
- o. Copy of the notice of the state hearing decision.

#### **2. Case Management Practice Guidelines**

It is important for the case manager to maintain up-to-date and complete records on each heavy care resident. Sound recordkeeping supports the delivery of good case management practice. The case manager should use the Adult Services Recordkeeping Tools to document the provision of Adult Care Home Case Management Services. Copies of these tools may be ordered from the Division of Social Service's Forms and Supply Catalogue.

B. Program Reporting

1. State Policies

Time spent carrying out activities associated with Adult Care Home Case Management Services must be reported according to the instructions outlined in the Service Information System User's Manual (SIS) using program code 2 and service code 396 or 397. The SIS User's Manual describes the appropriate activities to be reported under code 396 (Adult Care Home Case Management) and code 397 (Adult Care Home Screening). All case management activities that can be reasonably assigned to one of these service codes must be coded this way.

2. Case Management Practice Guidelines

Service code 396 should be used to code any case management activity that is directed to support a particular client. Service code 396 can include activities in addition to direct client contact, such as working with family members, contacting collaterals, providing consultation and assistance to the adult care home about the client. Service code 397 should be used to address those activities conducted by the case manager prior to determining that the resident qualifies for Enhanced ACH/PC, and those administrative activities required by the program which cannot be reasonably assigned to an individual client.

## **VII. CHANGES IN HEAVY CARE RESIDENTS' NEEDS**

Item A. of this Section describes the responsibilities of the adult care home when a heavy care resident's needs change. Item B. describes the responsibilities of the case manager when a heavy care resident's needs change.

### **A. Adult Care Home Responsibilities**

#### **1. State Policies**

The adult care home must conduct a reassessment within 10 calendar days of a significant change (see Section III. for definition of significant change) in a resident's condition. The adult care home must report any significant change in a heavy care resident's condition to the resident's physician and the case manager within 10 calendar days from the date the significant change occurred. The resident's care plan must be reviewed with the physician to determine if it needs to be revised or if the resident needs a different level of care. If necessary, the adult care home changes the resident's care plan and obtains the physician's authorization for the change. This starts a new annual reassessment cycle for ACH/PC for the home. The adult care home documents in the heavy care resident's record the name of the staff person who contacted the physician and the case manager, the date of the contact(s), and the outcome of the review of the care plan.

### **B. Case Manager Responsibilities**

#### **1. State Policies**

Whenever there is a significant change in the resident's condition and care needs, the case manager must re-evaluate the resident's needs, determine if he continues to meet the Medicaid criteria for a heavy care resident, and verify continuing eligibility for an Enhanced ACH/PC payment to the adult care home. The three decisions which may result from a re-evaluation and applicable effective dates for these decisions are described below. The new effective date for the resident's Enhanced ACH/PC starts a new annual cycle for the case manager for re-evaluating and re-authorizing Enhanced ACH/PC coverage. As soon as the decision is made to continue, change, or discontinue an authorization of Enhanced ACH/PC, the case manager must update the resident's Individual Authorization Form (DMA-3019) and call EDS' Prior Approval Unit to update the information in the claims processing data base. The case manager must inform the resident and the adult care home of the results of the re-evaluation by sending them a Decision Notice within 30 calendar days from the date the adult care home notified the case manager about a significant change in the resident's condition. In addition, the case manager must determine whether the change in the resident's

condition warrants any revisions to the resident's service plan and make the appropriate changes. See Section 9015, items C. and D. for policies and guidance on evaluating eligibility for Enhanced ACH/PC.

- a. Resident Continues to Meet Coverage Criteria and Qualifies for the Same Level of Enhanced ACH/PC

The case manager determines that the resident continues to meet the Medicaid criteria for a heavy care resident and needs the same level of assistance with eating, toileting and/or ambulation/locomotion. As a result of this decision, the case manager will authorize the adult care home to continue to bill the same Enhanced ACH/PC daily payment rate. The effective date for the new authorization continuing Enhanced ACH/PC at the same payment rate is the date the home's assessment, indicating a change in the resident's care needs, was signed by the administrator or other person designated to conduct assessments. Adult Care Home Case Management continues unchanged.

- b. Resident Continues to Meet Coverage Criteria, But Qualifies for a Different Enhanced ACH/PC Payment Rate

The case manager determines that the resident continues to meet the Medicaid criteria for a heavy care resident, but due to a change in the need for assistance with eating, toileting and/or ambulation/locomotion, the resident qualifies for a higher or lower Enhanced ACH/PC payment. As a result of this decision, the case manager will authorize a change in the Enhanced ACH/PC daily rate paid to the adult care home for dates of service on or after the effective date in the Decision Notice. If the Enhanced ACH/PC payment rate now authorized is a higher rate, the effective date is the date the home's assessment, indicating a change in the resident's needs, was signed by the administrator or other person designated to conduct assessments. If the Enhanced ACH/PC payment rate now authorized is a lower rate, the effective date for the new authorization is 14 calendar days from the date of the Decision Notice. Adult Care Home Case Management continues unchanged.

- c. Resident No Longer Meets Coverage Criteria and Enhanced ACH/PC and Adult Care Home Case Management are Being Discontinued

The case manager determines that the resident no longer meets the Medicaid criteria for a heavy care resident. As a result of this decision, the adult care home cannot be paid for Enhanced ACH/PC for dates of service on or after the effective date in the Decision Notice. Adult Care Home Case Management is also discontinued on the effective date in the Decision Notice. The effective date for discontinuing Enhanced ACH/PC and Adult Care Home Case Management is 14 calendar days from the date of the Decision Notice, unless Enhanced ACH/PC and Adult Care Home Case Management are being discontinued due to the resident no longer being Medicaid eligible.

In instances of discontinuation due to the resident no longer being Medicaid eligible, the effective date of discontinuing Enhanced ACH/PC and Adult Care Home Case Management is the last date of Medicaid eligibility. The case manager conveys the decision by memorandum or letter to the resident, with a copy to the adult care home, but does not send a Decision Notice as no appeal rights are given for this decision. Note in the memorandum or letter the date that the resident's Medicaid eligibility ended, and therefore Enhanced ACH/PC and Adult Care Home Case Management ends on the same date. Medicaid eligibility staff informed the resident of rights to appeal the discontinuation of Medicaid eligibility when the resident was advised of the change in eligibility status and unless that decision is subsequently appealed and overturned, Enhanced ACH/PC and Adult Care Home Case Management remains discontinued.

## VIII. OTHER CHANGES AFFECTING HEAVY CARE RESIDENTS

### A. Notifying the Case Manager of Death, Discharge, or Hospitalization of a Heavy Care Resident

#### 1. State Policies

Adult Care Home Personal Care and Adult Care Home Case Management are only covered when the resident is living in a licensed adult care home enrolled with the Division of Medical Assistance as an adult care home provider. The adult care home will be reimbursed for providing Basic or Enhanced ACH/PC on the date of a resident's death. Adult Care Home Case Management can also be reimbursed for services provided on the date of a resident's death. The adult care home will not be reimbursed for providing Basic or Enhanced ACH/PC for dates of service on or after a resident's discharge from the home. Adult Care Home Case Management cannot be provided for dates of service on or after a resident's discharge from an adult care home.

#### a. Adult Care Home Responsibilities

The case manager will be notified orally or in writing by the adult care home when any of the following situations occur.

- (1) The heavy care resident dies;
- (2) The heavy care resident is discharged from the adult care home and admitted to a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or another adult care home; or
- (3) The heavy care resident is discharged from the adult care home and living in a private home or other non-institutional setting.

#### b. Case Manager Responsibilities

The case manager is not required to send a Decision Notice to the heavy care resident or the adult care home when Enhanced ACH/PC and Adult Care Home Case Management are discontinued due to the resident's death or discharge from the adult care home. The case manager must update the resident's DMA-3019 and call EDS' Prior Approval Unit, unless the resident was discharged to a hospital. If the resident was discharged to a hospital, the case manager does not update the resident's DMA-3019 and does not call EDS' Prior Approval Unit.

B. Resuming Services When a Heavy Care Resident is Re-Admitted to an Adult Care Home

1. State Policies

a. Adult Care Home Responsibilities

When a resident is re-admitted to an adult care home from a private home or another adult care home, the administrator or person designated by the administrator must conduct a new assessment, prepare a new care plan, and obtain a new physician authorization for the service. This starts a new annual reassessment cycle for ACH/PC for the home.

If a resident is re-admitted to an adult care home after being discharged from that home to a hospital, nursing facility or ICF/MR, the home must confirm that adult care home level of care continues to be appropriate for the resident according to the rules by which the home is licensed, and confirm that ACH/PC is still appropriate for meeting the resident's needs. The adult care home resumes the provision of ACH/PC for a re-admitted resident by one of the following two processes. The annual reassessment cycle for ACH/PC for the home is affected in the second process (resident is readmitted with a new assessment and care plan), but not the first.

(1) Resident Re-Admitted with Existing Care Plan

The adult care home may resume ACH/PC for a resident by documenting that the home's existing care plan continues to be appropriate for meeting the resident's needs. If the home does not conduct a formal reassessment and no changes are made in the existing care plan, the home's current annual reassessment cycle for ACH/PC continues as scheduled.

(2) Resident Re-Admitted with a New Assessment and Care Plan

The adult care home may also consider a re-admitted resident as a new admission by conducting an assessment, preparing a new care plan, and obtaining a new physician authorization. This starts a new annual reassessment cycle for ACH/PC for the home.

b. Case Manager Responsibilities

When a heavy care resident is re-admitted to an adult care home from a private home or another adult care home, Enhanced ACH/PC and Adult Care Home Case Management may not be resumed automatically. After being contacted by the adult care home, the case manager must evaluate the resident's eligibility for Enhanced ACH/PC and determine whether or not to authorize coverage. The policies in Section 9015 of this manual must be followed in making the determination and authorizing Enhanced ACH/PC.

When a heavy care resident is re-admitted to an adult care home after being discharged from that home to a hospital, nursing facility, or ICF/MR, the resident's eligibility for Enhanced ACH/PC must be re-evaluated or the current authorization for Enhanced ACH/PC payments continued, depending upon the circumstances of the re-admission and length of absence, as outlined below.

(1) Re-Establishing Eligibility for Enhanced ACH/PC

The case manager must follow the policies in Sections 9015 and 9030 of this manual for re-evaluating the resident's eligibility for Enhanced ACH/PC, re-authorizing or discontinuing the coverage, completing the DMA-3019, contacting EDS' Prior Approval Unit, and preparing a Decision Notice in any of the following situations.

- (a) The adult care home conducted an assessment and completed a new care plan; or
- (b) Thirty (30) calendar days or more have passed since the resident was discharged from that home to a hospital, nursing facility, or ICF/MR; or
- (c) Either the case manager or adult care home believes that a re-evaluation of the resident's eligibility for Enhanced ACH/PC is appropriate as a result of a change in his need for assistance.

The effective date for Enhanced ACH/PC is the date the resident's DMA-3050R or the home's own assessment and authorization/care plan was completed and signed by the administrator or person designated by the administrator; however, the effective date may be no more than 90 days prior to the date of the Decision Notice. This starts a new annual cycle for the case manager to re-evaluate and re-authorize the resident's Enhanced ACH/PC coverage.

(2) Continuing the Current Authorization for Enhanced ACH/PC

Currently authorized Enhanced ACH/PC payments may be continued without re-evaluating the resident's eligibility for Enhanced ACH/PC when the adult care home re-admitted the resident within 30 calendar days and resumed ACH/PC using the resident's existing care plan with no changes. If the resident is re-admitted from a nursing facility or ICF-MR, the case manager must update the resident's DMA-3019 and call EDS' Prior Approval Unit, but is not required to prepare a Decision Notice. If the resident is re-admitted from a hospital following a hospitalization period of less than 30 days duration with an existing assessment and care plan, the case manager is not required to call EDS' Prior Approval Unit and is not required to prepare a Decision Notice.

The effective date for Enhanced ACH/PC is the date the resident was re-admitted to the adult care home with an existing assessment and care plan. The case manager must also determine whether the services and goals in the case management service plan continue to be appropriate for meeting the resident's health and social service needs. The current annual cycle for the case manager to re-evaluate and re-authorize the resident's Enhanced ACH/PC coverage will continue on the same schedule as before.

C. Changes in Ownership

1. State Policies

a. Adult Care Home Responsibilities

The Medicaid provider participation agreement is not transferable. When an enrolled adult care home is sold, the new owner must apply for enrollment and be enrolled in order to continue to be paid by Medicaid. The new owner must notify DMA's Provider Services Unit

within 30 days of the change in ownership if he wishes to continue as a Medicaid provider. If this notification is received after 90 days, there may be a break in enrollment. A break in enrollment means that the provider may not receive reimbursement for ACH/PC between the date of the change in ownership and the effective date of the new enrollment as a Medicaid provider.

b. Case Manager Responsibilities

If there is no break in enrollment associated with the sale of a facility, the case manager contacts EDS' Prior Approval Unit and updates the DMA-3019 with the new provider number provided all other eligibility factors continue to be met. If the new owner of the adult care home chooses not to do a new DMA-3050R or the home's own assessment and authorization/care plan form, the case manager must assure that there is a current care plan and assessment in the home. If the new owner of the adult care home does choose to do a new DMA-3050R or the home's own assessment and authorization/care plan form, the case manager follows policies in Section IV. A.-D. of this manual (identification of potential heavy care resident, referral to case manager, case manager assessment of eligibility, case manager decision) to determine eligibility for Enhanced ACH/PC for the residents now being served by the new provider.

## **IX. METHODS OF SERVICE PROVISION**

Adult Care Home Case Management is an administrative component of the Medicaid Program. This service is to be provided by the department of social services (or Local Management Entity if appropriate) in the county where the facility, in which the resident requiring ACHCM lives, is located. County departments of social services can provide and be reimbursed for this case management through the following options.

### **A. Direct Service Provision**

#### **1. State Policies**

County departments of social services may employ case managers to provide Adult Care Home Case Management Services. The case managers must adhere to the following requirements.

- a. Have training in assessment and care planning of long term care services in residential and community care settings;
- b. Meet Office of State Personnel requirements for a Social Worker II or Public Health Nurse I;
- c. Perform all case management duties and activities in accordance with this policy;
- d. Obtain an application for services (DSS-5027) from the resident or other responsible party; and
- e. Follow program reporting instructions in the SIS User's Manual for this service.

Reimbursement of costs associated with this service must be claimed in accordance with the reporting instructions in the Social Services Fiscal Manual.

#### **2. Case Management Practice Guidelines**

In order to assure that a case manager has sufficient time available to provide Adult Care Home Case Management Services and to adequately address heavy care residents' needs, a full-time case manager should maintain a caseload of no more than 40 heavy care residents. Staff in Adult Homes Specialist positions should not provide Adult Care Home Case Management Services. A different type of relationship needs to be established between the case manager and the adult care home administrator. The focus of this relationship is service delivery to heavy care residents rather than monitoring and regulatory activities. When adult care home case management duties need to be assigned on a part-time basis to another social work position, they should be assigned to a social worker carrying out client case management in community based settings.

B. Contract with a Qualified Individual

1. State Policies

County departments of social services may contract with a qualified individual to provide Adult Care Home Case Management Services. Individual case managers under contract with the county DSS to provide this service must adhere to the following requirements.

- a. Have training in assessment and care planning of long term care services in residential or community care settings;
- b. Meet Office of State Personnel requirements for a Social Worker II or Public Health Nurse I;
- c. Perform all case management duties and activities in accordance with this policy;
- d. Obtain an application for services (DSS-5027) from the resident or other responsible party;
- e. Provide any data needed for SIS;
- f. Provide the service in accordance with the provisions included in a contract that meets the contracting requirements as described in the Contract Manual located on the Division of Social Services web site. Counties may negotiate a rate that is reasonable and necessary; and
- g. Have no agreement, financial or otherwise, with a licensed adult care home or any relationship with the adult care home industry that could give rise to a conflict of interest.

Reimbursement for this method is limited to individuals. The county DSS may not contract with a private agency to provide this service. The DSS must direct the work of the individual and assure that the provisions in items a. through g. above are met. Reimbursement of costs associated with this method must be claimed in accordance with the reporting instructions in the Social Services Fiscal Manual.

C. Contract with Another Public Agency

1. State Policies

County departments of social services may arrange to provide Adult Care Home Case Management Services by establishing a contract with another DSS in a nearby county or with another public agency in the county where the DSS is located or another public agency in a nearby county. Case managers in these situations must adhere to the following requirements.

- a. Have training in assessment and care planning of long term care services in residential and community care settings;

- b. Meet Office of State Personnel requirements for a Social Worker II or Public Health Nurse I;
- c. Perform all case management duties and activities in accordance with this policy;
- d. Obtain an application for services (DSS-5027) from the resident or other responsible party; and
- e. Provide any data needed for SIS.

Reimbursement for this method is limited to public agencies. The DSS may not establish a contract with a private agency to provide Adult Care Home Case Management Services. The DSS in the county in which the adult care homes are located is responsible for providing the matching funds for the case management. Reimbursement of costs associated with this method must be claimed in accordance with the reporting instructions in the Social Services Fiscal Manual.

a. Contract with Another County DSS

When a county DSS arranges for another DSS to provide Adult Care Home Case Management Services, adherence to the contract manual located in the Contract manual on the Division of Social Services web site, [www.dhhs.state.nc.us/dss/budget/contracts.htm](http://www.dhhs.state.nc.us/dss/budget/contracts.htm) is recommended. Counties may negotiate a rate that is reasonable and necessary.

b. Contract with Another Public Agency

County departments of social services may contract with another public agency such as the Local Management Entity (LME) or the health department to provide Adult Care Home Case Management Services. If the DSS arranges to provide the service through another public agency (non DSS agency), a written contract should be established that meets the recommended contracting requirements contained in the Contract manual on the Division of Social Services web site, [www.dhhs.state.nc.us/dss/budget/contracts.htm](http://www.dhhs.state.nc.us/dss/budget/contracts.htm)

## **X. RESOLVING DISAGREEMENTS ABOUT THE CASE MANAGER'S DECISION**

### **A. Requesting a Local Hearing**

#### **1. State Policies**

The resident or the resident's representative and adult care home have the right to request a hearing to review a case manager's decision to deny, continue, change, or discontinue Enhanced ACH/PC and Adult Care Home Case Management if either of them disagrees with the decision. The first step in resolving a disagreement over a resident's coverage is to request a local hearing. The local hearing cannot be waived in order to proceed directly to a state hearing.

The resident and adult care home have 60 days (plus an additional 30 days with good cause) from the date of the case manager's Decision Notice to request a local hearing. The resident or adult care home makes the request for a local hearing to the county department of social services responsible for making the decision about Enhanced ACH/PC and Adult Care Home Case Management coverage. The request may be made orally or in writing. The county department of social services must notify the Adult Care Home Services Unit in the Division of Medical Assistance when a request for a local hearing is received.

#### **a. Scheduling the Local Hearing**

The county department of social services must hold the local hearing within 10 calendar days of the request unless the resident or adult care home postpones the hearing. If the resident or adult care home postpones the hearing more than 15 days from the date of the original request, the right to a local hearing is waived.

#### **b. Notifying the Resident and Adult Care Home**

The county department of social services must send the resident and adult care home written notification of the date, time, and place of the local hearing. The notice must inform the resident and adult care home of their right to:

- (1) Be present at the hearing;
- (2) Examine at a reasonable time before the date of the hearing and during the hearing all documents to be used by the county department of social services at the hearing;
- (3) Bring witnesses;
- (4) Establish pertinent facts and circumstances;

- (5) Present an argument without undue interference; and
- (6) Question or refute any testimony or evidence.

c. Conducting the Local Hearing

The local hearing must be conducted by the county department of social services' hearing officer or designee, who was not directly involved in making the decision to deny, continue, change, or discontinue Enhanced ACH/PC and Adult Care Home Case Management. The proceedings are informal. The case manager presents information explaining the decision. The resident and/or adult care home must be given an opportunity to present their position.

The case manager presents the following information.

- (1) Resident's name, address, and Medicaid identification number;
- (2) Explanation of the reason(s) for denying, continuing, changing, or discontinuing Enhanced ACH/PC and Adult Care Home Case Management;
- (3) Reference to specific state policy supporting the decision, including copies of the policy;
- (4) Copy of the Decision Notice sent to the resident and the adult care home; and
- (5) Case manager's name, title, address, and phone number.

d. Getting Paid When a Local Hearing Decision is Pending

The adult care home may submit claims for the personal care assistance provided for the resident at either the Basic or Enhanced ACH/PC payment rate when a local hearing is pending. If the local hearing decision upholds the case manager's decision, the adult care home must return any overpayments made for dates of service on or after the effective date of the case manager's decision. If the adult care home bills for Enhanced ACH/PC while a local hearing decision is pending, the case manager must continue to provide case management services for the resident. The outcome of the local hearing will determine whether Adult Care Home Case Management is continued or discontinued.

e. The Local Hearing Decision

The local hearing decision is made by the hearing officer who conducted the hearing. The decision is based only on the testimony and documentation presented at the hearing. Once a decision is

made, the hearing officer must notify the resident in writing by certified mail within 10 calendar days of the hearing. A copy of the notice must also be sent to the adult care home within 10 calendar days of the hearing. The local hearing decision notice must explain whether the case manager's decision to deny, continue, change, or discontinue Enhanced ACH/PC and Adult Care Home Case Management is correct or incorrect. The local hearing decision notice must include the following information.

- (1) An explanation of the local hearing decision;
- (2) Reference to the specific policy on which the local hearing decision was based;
- (3) A statement that the resident and the adult care home have the right to request further review of the decision by the state; and
- (4) Procedures for requesting a state hearing.

A sample Local Hearing Decision Notice is in Appendix E. of this manual.

The hearing officer must also send a copy of the local hearing decision notice to the case manager, the Adult Care Home Case Management Services Program Manager in the Division of Aging and Adult Services, and the Adult Care Home Services Unit in the Division of Medical Assistance. The address and telephone number for the Adult Care Home Case Management Services Program Manager in the Division of Aging and Adult Services and the Adult Care Home Services Unit in the Division of Medicaid are in Appendix C. of this manual.

- f. Impact of Local Hearing Decision on Enhanced ACH/PC and Adult Care Home Case Management

Whether the adult care home is entitled to be reimbursed by Medicaid for Enhanced ACH/PC for dates of service on or after the effective date of the case manager's decision depends on the local hearing decision, and if the local hearing decision is also appealed. The possible outcomes for a local hearing and how these affect reimbursement are outlined below.

(1) Decision to Deny or Discontinue Enhanced ACH/PC and Adult Care Home Case Management

(a) Decision Upheld

If the case manager's decision to deny or discontinue Enhanced ACH/PC and Adult Care Home Case Management is upheld by the local hearing decision, the adult care home will not be reimbursed for Enhanced ACH/PC for dates of service on and after the effective date in the case manager's Decision Notice. Adult Care Home Case Management will be discontinued on the date of the local hearing decision notice.

(b) Decision Reversed

If the case manager's decision to deny or discontinue coverage is reversed by the local hearing decision, the adult care home will be reimbursed by Medicaid for Enhanced ACH/PC for dates of service on and after the effective date in the case manager's Decision Notice, as authorized by the local hearing decision. Adult Care Home Case Management will also continue.

(2) Decision to Continue the Current Level of Enhanced ACH/PC

(a) Decision Upheld

If the case manager's decision to continue the current level of Enhanced ACH/PC payments is upheld by the local hearing decision, the adult care home will continue to be reimbursed by Medicaid for the current level of Enhanced ACH/PC authorized by the case manager for dates of service on and after the effective date in the case manager's Decision Notice. Adult Care Home Case Management will also continue.

(b) Decision Reversed

If the case manager's decision to continue the current level of Enhanced ACH/PC payments is reversed by the local hearing decision, the adult care home will be reimbursed by Medicaid for the level of Enhanced ACH/PC authorized by the local hearing decision for dates of service on and after the effective date in the case

manager's Decision Notice. Adult Care Home Case Management will also continue.

(3) Decision to Change the Level of Enhanced ACH/PC

(a) Decision Upheld

If the case manager's decision to change the level of Enhanced ACH/PC payment is upheld by the local hearing decision, the adult care home will be reimbursed by Medicaid for the new level of Enhanced ACH/PC authorized by the case manager for dates of service on and after the effective date for the change in the case manager's Decision Notice. Adult Case Home Case Management will also continue.

(b) Decision Reversed

If the case manager's decision to change the level of Enhanced ACH/PC payments is reversed by the local hearing decision, the adult care home will continue to be reimbursed by Medicaid for the current level of ACH/PC for dates of service on and after the effective date in the case managers' Decision Notice. Adult Care Home Case Management will also continue.

The adult care home may not continue to submit claims for unauthorized Enhanced ACH/PC once a local hearing decision has been made upholding the case manager's decision to deny or discontinue coverage, or to lower the authorized Enhanced ACH/PC payment. A resident whose coverage is denied or discontinued by a case manager's decision or local hearing decision will continue to be eligible for Basic ACH/PC payments to the home. It is the adult care home's responsibility to adjust any overpayments or underpayments made to the home.

B. Requesting a State Hearing After a Local Hearing

1. State Policies

If the resident or the resident's representative or the adult care home is dissatisfied with the outcome of the local hearing decision, either may request a state hearing. The request must be in writing to the county department of social services within 15 calendar days of the date of the local hearing decision. When a state hearing is requested, the case

manager must prepare a Request for State Appeal and forward it to the Chief Hearing Officer in Hearings and Appeals Section in the Division of Social Services. A copy of the Request for State Appeal must also be sent to the Adult Care Home Services Unit in the Division of Medical Assistance. A copy of the Request for State Appeal is in Appendix L. of this manual.

a. Scheduling the State Hearing

The state hearing officer for the Division of Social Services must schedule the hearing, hold the hearing, and make the hearing decision within 90 days of the date of the request. The state hearing officer notifies the resident or the resident's representative, the adult care home, and the case manager of the date, time, and location of the state hearing in writing.

b. Preparing for the State Hearing

The case manager must prepare a local hearing summary and send it to the state hearing officer for review prior to the state hearing. The local hearing summary must contain the following information.

- (1) Resident's name, address, and Medicaid identification number;
- (2) Explanation of the reason(s) for denying, continuing, changing, or discontinuing Enhanced ACH/PC and Adult Care Home Case Management;
- (3) Reference to the specific state policy supporting the decision, including copies of the policy;
- (4) Summary of the proceedings at the local hearing, including all testimony and documentation presented;
- (5) Copy of the Decision Notice sent to the resident and the adult care home;
- (6) Copy of the notice of the local hearing decision; and
- (7) Case manager's name, title, address, and phone number.

c. Conducting the State Hearing

A hearing officer from the Division of Social Services must conduct the state hearing. State hearings are typically held at the county department of social services. The case manager, adult care home's administrator or representative, and the resident may participate in the hearing to verify the accuracy of the information and provide clarification and/or additional information as requested by the hearing officer.

d. The State Hearing Decision

The state hearing officer must notify the resident of the state hearing decision by certified mail within 90 days of the request for the state hearing. A copy of the state hearing decision will be sent to the adult care home, case manager, and the Adult Care Home Services Unit in the Division of Medical Assistance. The State Hearing Decision Notice must contain the following information.

- (1) Summary of the facts of the case;
- (2) Explanation of the state hearing decision;
- (3) Reasons for the state hearing decision;
- (4) Supporting evidence and policy upon which the state hearing decision is based;
- (5) Explanation of how Enhanced ACH/PC and Adult Care Home Case Management are affected by the state hearing decision;
- (6) A statement which says: "If you are not satisfied with the decision of the agency during the informal dispute resolution process, you may request a formal appeal hearing under NC General Statute 150B. To do this, fill out enclosed Petition for a Contested Case Hearing. You have 60 days from the date of this letter to send this petition to the Office of Administrative Hearings and the Department of Health and Human Services at the addresses printed on the petition. You may represent yourself at this hearing or use a lawyer, a relative, a friend, or other spokesperson"; and
- (7) A copy of a "Petition for a Contested Case Hearing" (Form H-06).

e. Impact of State Hearing Decision on Enhanced ACH/PC and Adult Care Home Case Management

If the local hearing decision is reversed at the state level, the case manager must immediately notify the Adult Care Home Services Unit in the Division of Medical Assistance and authorize services as directed by the state hearing decision. The possible outcomes for a state hearing and how these affect reimbursement are outlined below.

(1) Decision to Deny or Discontinue Enhanced ACH/PC and Adult Care Home Case Management

(a) Decision Upheld

If the local hearing decision to deny or discontinue Enhanced ACH/PC payments and Adult Care Home Case

Management is upheld by the state hearing decision, the adult care home will not be reimbursed by Medicaid for Enhanced ACH/PC for dates of service on and after the effective date in the case manager's Decision Notice. Adult Care Home Case Management will be discontinued on the date of the state hearing decision notice.

(b) Decision Reversed

If the local hearing decision to deny or discontinue coverage is reversed by the state hearing decision, the adult care home will be reimbursed by Medicaid for Enhanced ACH/PC for dates of service on and after the effective date in the case manager's Decision Notice, as authorized by the state hearing decision. Adult Care Home Case Management will also continue.

(2) Decision to Continue the Current Level of Enhanced ACH/PC

(a) Decision Upheld

If the local hearing decision to continue the current level of Enhanced ACH/PC payments is upheld by the state hearing decision, the adult care home will be reimbursed by Medicaid for the current level of Enhanced ACH/PC authorized by the case manager for dates of service on and after the effective date in the case manager's Decision Notice. Adult Care Home Case Management will also continue.

(b) Decision Reversed

If the local hearing decision to continue the current level of Enhanced ACH/PC payments is reversed by the state hearing decision, the adult care home will be reimbursed by Medicaid for the level of Enhanced ACH/PC authorized by the state hearing decision for dates of service on and after the effective date in the case manager's Decision Notice. Adult Care Home Case Management will also continue.

(3) Decision to Change the Level of Enhanced ACH/PC

(a) Decision Upheld

If the local hearing decision to change the level of Enhanced ACH/PC payments is upheld by the state hearing decision, the adult care home will be reimbursed by Medicaid for the new level of Enhanced ACH/PC authorized by the case manager for dates of service on and after the effective date for the change in the case manager's Decision Notice. Adult Care Home Case Management will also continue.

(b) Decision Reversed

If the local hearing decision to change the level of Enhanced ACH/PC payments is reversed by the state hearing decision, the adult care home will continue to be reimbursed by Medicaid for the current level of ACH/PC for dates of service on and after the effective date in the case manager's Decision Notice. Adult Care Home Case Management will also continue.

## **APPENDICES**

- A. Personal Care Services Physician Authorization and Care Plan (DMA-3050R) and Instructions for Use of the Form
- B. Individual Authorization Form (DMA-3019) and Instructions for Completing the Form
- C. Key Addresses and Telephone Numbers
- D. Decision Notice
- E. Sample Local Hearing Decision Notice
- F. The 6-Item Short Blessed Test (SBT)
- G. Geriatric Depression Scale
- H. Ecomap
- I. Eating Assessment Tool and Tips
- J. Adult Incontinence Assessment Tool and Tips
- K. Tips for Communicating with Residents with Dementia and Non-Verbal Residents
- L. Request for State Appeal Form
- M. Medical Abbreviations and Symbols List
- N. Date Chart
- O. Adult Care Home/DSS Case Management Adult Ambulation Assessment Tool