STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

December 20, 2017

Trina Roberts
Acting Associate Regional Administrator
Division of Medicaid
Centers for Medicare and Medicaid Services
Region IV
Atlanta Federal Center
61 Forsyth Street, SW Suite 4T20
Atlanta, GA 30303-8909

SUBJECT: State Plan Amendment
Title XIX, Social Security Act
Transmittal #2017-0014

Dear Ms. Roberts:

Please find attached an amendment for North Carolina's State Plan under Title XIX of the Social Security Act for the Medical Assistance Program. The affected pages Supplemental 1 of Attachment 3.1-A, Part G. Pages 2-15.

This state plan change will carve out non-essential language in the SPA that is reflected in the Clinical Coverage Policy 12B for HIV Case Management and to reflect changes made to provider requirements. Provider requirement changes are as follows:

1. Annual Case Manager Training Requirements (Reduced from 20 hours to 12 hours annually)
2. Reduced number of quality assurance visits during first year of certification (reduced from 4 visits to two visits).
3. Removed provider requirement to secure a performance bond (no current rule that reflects this as a provider requirement).
4. Specified that a physician or attending practitioner can provide a written order for the initiation of services however, ongoing case management services beyond two calendar months require a written order from the beneficiary's primary care physician.

This amendment is effective December 1, 2017.

Your approval of this state plan amendment is requested. If you have any questions or concerns, please contact me or Teresa Smith at 919-855-4116.

Sincerely,

Mark T. Benton

for Mandy Cohen, MD, MPH
Secretary
Enclosures

State Plan under Title XIX of the Social Security Act
State/Territory: North Carolina
TARGETED CASE MANAGEMENT SERVICES
Persons with HIV Disease

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

- coordination and follow-up of medical treatments;
- provision of treatment adherence education;
- physical needs to include activities of daily living and instrumental activities of daily living;
- mental health/substance abuse/developmental disability needs;
- housing and unmet needs related to physical environment;
- financial needs; and
- socialization and recreational needs.

❖ Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that

- specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
- includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- identifies a course of action to respond to the assessed needs of the eligible individual;

❖ Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including

- activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

❖ Monitoring and follow-up activities:

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

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

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

(PROVIDER)

Provider Qualifications

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

- Have a documented record of three (3) years of providing or managing HIV Case management programs.
- Ensure the provision of HIV case management services by qualified case managers as described in HIV Case Management Policy 12B
- Ensure supervision of HIV case managers by qualified supervisors as described in the HIV Case Management policy.
- Enroll each physical site with DMA as a provider of HIV case management services in accordance with §1902(a)(23) of the Social Security Act.

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- Meet applicable state and federal laws governing the participation of providers in the Medicaid program.
- Maintain certification as a qualified provider HIV case management services and have a collaborative relationship with the physician record.
- Demonstrate compliance with initial and ongoing certification processes.
- Demonstrate compliance with the monitoring and evaluation of case management records through a quality improvement plan.
- Allow DMA to review recipient records and inspect agency operation and financial records.
- Notify DMA of proposed changes such as business owner or name change, address or telephone number change, or plans for business dissolution within 30 calendar days of the proposed change and no later than five business days of the actual change.
- Achieve national accreditation with at least one of the designated accrediting agencies within one year of enrollment with Medicaid as a provider.

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

- Be enrolled in accordance with section 1902(a)(23) of the Social Security Act; and
- Meet applicable State and Federal laws governing the participation of providers in the Medicaid program; and
- Meet applicable state and federal laws, including licensure and certification requirements; and
- Bill only for services that are within the scope of their clinical practice, as defined by HIV Case Management policy.
- Attest by signature that services billed were medically necessary and were actually delivered to the recipient.

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Provider Certification

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

To be certified and to qualify for reimbursement a provider shall submit a complete and signed application to DMA to include documentation of requirements indicated in the application. The application shall include information as identified under *Administrative, Case Management and Human Resource Requirement* in Clinical coverage policy 12B

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Quality Assurance Monitoring

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

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

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(STAFF)

Staff Qualifications

It is the responsibility of the provider agency to verify staff qualifications and credentials prior to hiring and assure during the course of employment that the staff member continues to meet the requirements set in forth in the HIV Case Management policy as identified in *HIV Case Manager, Case Management Experience, Knowledge Skills and Abilities, HIV Case Manager Supervisor, Case Management Supervisor's Experience, and Contract Staff sections.* Verification of staff credentials shall be maintained by the provider agency.

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Training Requirements

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

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

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

Annual Training
All HIV case managers and supervisors are required to complete 12 hours annually of continuing education related to HIV case management. It is the responsibility of providers to retain copies of certificates of completion.

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Freedom of choice (42 CFR 441.18(a)(1):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

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

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
____ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services: [Identify any limitations to be imposed on the providers and specify how these limitations enable providers to ensure that individuals within the target groups receive needed services.]

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):
The State assures the following:

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

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

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

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

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

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

Physician Orders

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