Department of Health & Human Services
Centers for Medicare & Medicaid Services
61 Forsyth St., Suite 4T20
Atlanta, Georgia 30303-8909

March 11, 2010

Craigan Gray, MD, MBA, JD
Director
Division of Medical Assistance
North Carolina Department of Health and Human Services
2501 Mail Service Center
Raleigh, North Carolina 27699-2501

Attention: Teresa Smith

RE: North Carolina Title XIX State Plan Amendment, Transmittal #08-020

Dear Dr. Gray:

We have reviewed the proposed amendment to the North Carolina Medicaid State Plan that was submitted under transmittal number 08-020 and received in the Regional Office on December 18, 2008. This amendment elevates the standards for providers and changes service definitions. Provider qualifications now include specificity in education to assure service provision by qualified providers.

Based on the information provided, we are pleased to inform you that Medicaid State Plan Amendment 08-020 was approved on March 10, 2010. The effective date of this amendment is March 1, 2009. We are enclosing the approved form HCFA-179 and plan pages.

If you have any questions or need any further assistance, please contact Cheryl Brimage at (404) 562-7116 or Rita Nimmons at (404) 562-7415.

Sincerely,

/s/

Jackie Glaze
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **08-020**

2. STATE: **NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **March 1, 2009**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.169

7. FEDERAL BUDGET IMPACT:
a. **FFY 2008-09 $0.00**
b. **FFY 2009-10 $0.00**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 1 to Supplement 1 of Attachment 3.1-A, Part G, Pages 1, 1a, 2, 2a, 3, and 3a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 1 to Supplement 1 of Attachment 3.1-A, Part G, Pages 1-3

10. SUBJECT OF AMENDMENT:

This new state plan amendment is for HIV-Case Management.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Dempsey Benton

14. TITLE: Secretary

15. DATE SUBMITTED: 12-18-08

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-20014

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12-18-08

18. DATE APPROVED: 03-10-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
03-01-09

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Jackie Glaze

22. TITLE: Acting Associate Regional Administrator
Division of Medicaid & Children Health Opns

23. REMARKS: Approved with the following changes to items 8 and 9 as authorized by state agency on email dated 02/23/10.

Block #8 Supplement 1 to attachment 3.1-A Part G pages 1,1a,2,2a,3,3a changed to read Supplement 1 to Attachment 3.1-A Part G Pages 1thur 15; and Attachment 4.19-B Section 19 page 5;

Block #9 Attachment 1 to Supplement 1of Attachment 3.1-A, Part G, Pages 1 thru 3;
Changed to read: Attachment 1 to Supplement 1 of Attachment 3.1-A, Part G pages 1 thru 3; and pages 4 thru 15 new.

Payments for Medical and Remedial Care and Services

E. Case Management (Persons With HIV Disease)

The agency's rates are set as of July 1, of each year and are effective for services on or after that date. These rates are set equal to the rates established under paragraph B (Adults and Children At-Risk For Abuse, Neglect, or Exploitation) of this section.

Medicaid reimbursement for HIV case management services will be the same per unit rate (one unit equals fifteen minutes) for all providers. Providers will be reimbursed the lower of the fee schedule rate or their usual and customary charge

Notwithstanding any other provision, if specified, these rates will be adjusted as shown on Attachment 4.19-B, Supplement 1 section of the State Plan.

All rates are published on the agency's website. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of targeted case management services and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the agency's website at http://www.ncdhhs.gov/dma/fee/fee.htm. The agency's fee schedule rate was set effective July 1, 2009 and is effective for services provided on or after that date.

Payments for this service will end on June 30, 2010.

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Target Group (42 Code of Federal Regulations 441.18(8)(i) and 441.18(9)):
The target group includes individuals below who meet the requirements defined in the HIV Case Management policy:

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

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

Areas of State in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
___ Only in the following geographic areas: [Specify areas]

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

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

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

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

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

- Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that
  - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
  - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
  - identifies a course of action to respond to the assessed needs of the eligible individual;

- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including
  - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

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

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

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

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

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

(PROVIDER)

Provider Qualifications

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

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

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

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

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

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Provider Certification

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

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

Administrative Requirements

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

The agency shall meet the following requirements:

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

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

Case Management Requirements

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

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

Human Resource Requirements:

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

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

Quality Assurance Monitoring

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

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

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

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

Recertification

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

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

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

Decertification Process

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

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

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

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

(STAFF)

Staff Qualifications

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

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

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

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

An HIV case manager shall meet the following *core competencies*:
- Able to perform the assessment
- Able to provide recipient centered goals for meeting desired outcomes developed in the care plan.
- Able to provide referral and linkage to recipients serviced
- Able to provide monitoring of care and service rendered to recipients
- Able to provide documentation and attestation as to accuracy of the entry by a personal signature

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

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

HIV Case Manager Supervisor

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

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

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

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

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

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

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

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Contract Staff

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

Training Requirements

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

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

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

Annual Training
All HIV case managers and supervisors are required to attend 20 hours annually of continuing education related to HIV case management. It is the responsibility of providers to retain copies of certificates of completion.
Annual training topics must include, but are not limited, to the following:

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

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Suggested resources include but are not limited to the following:
- Partners in Information Access for the Public Health Workforce http://phpartners.org/index.html
- Regional HIV/AIDS Consortium
- North Carolina AIDS Education Training Center
- North Carolina Area Health Education Centers

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

State Plan under Title XIX of the Social Security Act
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TARGETED CASE MANAGEMENT SERVICES
Persons with HIV Disease

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 may impose unit limits as approved by the Physician's Advisory Committee (PAG) according to Session Law 2003, Section 284 10.19. (bb)

Physician Orders

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