

93.778

**MEDICAL ASSISTANCE PROGRAM**

**State Project/Program:**

**ADULT CARE HOME CASE MANAGEMENT –  
DIVISION OF AGING AND ADULT SERVICES**

**U. S. Department of Health and Human Services**

**Federal Authorization:** Social Security Act, Title XIX, as amended; Public Laws 89-97, 90-248, and 91-56, 42 U.S.C. 1396, et seq., as amended; Public Laws 92-223, 92-603, 93-66, 93-233, 96-499, 97-35, 97-248, 98-369, 99-272, 99-509, 100-93, 100-202, 100-203, 100-360, 100-436, 100-485, 100-647, 101-166, 101-234, 101-239, 101-508, 101-517, 102-234, 102-170, 102-394, 103-66, 103-112, 103-333, 104-91, 104-191, 104-193, 104-208, and 104-134; Balanced Budget Act of 1997, Public Laws 105-33 and 106-113.

**State Authorization:** HHS-approved Medicaid State Plan; NC General Statute 131D-4.3 as amended by Senate Bill 864; NC General Statute 143B-153; 10A NCAC 71D .0100.

**N. C. Department of Health and Human Services  
Division of Aging and Adult Services**

**Agency Contact Person – Program**

Nancy Warren, Program Administrator  
(919) 733-3818  
[Nancy.Warren@ncmail.net](mailto:Nancy.Warren@ncmail.net)

**Agency Contact Person - Financial**

Bob Harrell, Budget Officer  
(919) 733-8390  
[Bob.Harrell@ncmail.net](mailto:Bob.Harrell@ncmail.net)

**N. C. DHHS Confirmation Reports:**

SFY 2009 audit confirmation reports for payments made to Counties, Area Programs, Boards of Education, Councils of Government, District Health Departments, DCD State Level Contractors and HRSA Bioterrorism Grant Subrecipients will be available by around late August to early September at the following web address:

<http://www.dhhs.state.nc.us/control/>

At this site, page down to “Letters/reports/forms for ALL Agencies” and click on “Audit Confirmation Reports (State Fiscal Year 2008-2009)”. Additionally, audit confirmation reports for Nongovernmental entities receiving financial assistance from the DHHS are found at the same website except select “Non-Governmental Audit Confirmation Reports (State Fiscal Years 2007-2009)”.

**The auditor should not consider the Supplement to be “safe harbor” for identifying audit procedures to apply in a particular engagement, but the auditor should be prepared to justify departures from the suggested procedures. The auditor can consider the Supplement a “safe harbor” for identification of compliance requirements to be tested if the auditor performs reasonable procedures to ensure that the requirements in the Supplement are current. The grantor agency may elect to review audit working papers to determine that audit tests are adequate.**

**I. PROGRAM OBJECTIVES**

Adult Care Home Case Management Services are directed at the goal of improving the overall quality of care for 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 objective of Adult Care Home Case Management Services is to provide a case manager to work in partnership with eligible 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.

## II. PROGRAM PROCEDURES

Allocations are made to county departments of social services based on prior State fiscal year reimbursement levels and the amount of State funds available for the fiscal year. Allocations are 50% Federal (Title XIX Administrative Funds), 25% State funds, and require a 25% county match. When a county department of social services exhausts the allocated State funds for a fiscal year, the Federal portion can be matched with 50% county funds. Dependent upon availability, State funds may be reallocated among counties to cover additional needs. The amount of State funds available statewide is established by the NC General Assembly for each fiscal year, but the amount of Federal funds is not.

Counties are required to provide case management services to Medicaid eligible residents who receive Enhanced Adult Care Home Personal Care (Enhanced ACH/PC). Enhanced ACH/PC is a Medicaid per diem payment to adult care homes serving residents who need extensive or total assistance with toileting, feeding and/or ambulation/locomotion. The enhanced ACH/PC payments to the adult care home must be authorized by the case manager. Adult care homes with Medicaid eligible residents who require extensive or total assistance with toileting, feeding and/or ambulation/locomotion are potentially eligible for Enhanced ACH/PC payments. The adult care home must be enrolled as a Medicaid provider with the NC Division of Medical Assistance (DMA) in order to bill DMA for Enhanced ACH/PC.

Two agencies are authorized to provide the Adult Care Home Case Management Service to residents of adult care homes receiving Enhanced ACH/PC. The Local Management Entity (LME) and its contracted mental health providers are to provide case management to residents who are eligible for case management under Medicaid-funded mental health or developmental disability case management programs. For other residents, the county Department of Social Services (DSS) is to provide Adult Care Home Case Management Services (ACH/CMS). Counties may also negotiate other arrangements between these two agencies. The county DSS may provide case management directly, may contract with another public agency, or contract with a qualified individual professional to provide case management.

Case managers employed by the county department of social services 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 NC 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 ACH/CMS policy;
- d. Obtain an application for services (DSS-5027) from the resident or other responsible party; and

## ADULT CARE HOME CASE MANAGEMENT – DIVISION OF AGING AND ADULT SERVICES

---

- e. Follow program reporting instructions in the SIS User’s Manual for this service.

Individual professionals under contract with the county department of social services to provide ACH/CMS 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 NC 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 ACH/CMS 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 contained in the Contract manual located on the Division of Social Services (DSS) website, [www.dhhs.state.nc.us/dss/budget/contracts.htm](http://www.dhhs.state.nc.us/dss/budget/contracts.htm). 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.

Program policies are provided in the Family Services Manual, Volume V, Chapter IX, Adult Care Home Case Management Services. Additionally, as changes occur in the program, the North Carolina Health and Human Services, Division of Aging and Adult Services notifies county departments in administrative letters or manual change notices. These administrative letters or manual change notices should be used in conjunction with the Family Services Manual for the determination of program requirements. The Family Services Manual and the administrative letters or manual change notices are available from the adult services supervisor in each county department of social services.

The program operates as follows: a potential ACH/CMS resident of an enrolled adult care home is identified either by staff of the adult care home or by a case manager employed by or under contract with the county DSS. A referral document, DMA-3050R or its equivalent, is completed by the adult care home staff and submitted to the case manager for review. The case manager, within 30 days of receiving the DMA-3050R, makes a decision as to whether the resident fits the criteria for ACH/CMS. The decision is based on the case manager’s assessment as to whether the resident is Medicaid eligible, and if so, whether the resident requires extensive or total assistance with toileting, feeding and/or ambulation/locomotion (i.e., 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 “disenfranchised” resident (A small number of Special Assistance (SA) recipients are known as “disenfranchised recipients”. This category of 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. Disenfranchised recipients are not eligible for ACH Personal Care Services and are not eligible for Adult Care Home Case Management Services);

- 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 toileting, feeding 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. determine whether the resident meets the Medicaid criteria for a heavy care resident.

The case manager sends a Decision Notice to the adult care home and to the resident that conveys the eligibility or ineligibility of the resident for ACH/CMS and Enhanced ACH/PCS; the Decision Notice is to be mailed within 30 days of receipt of the DMA-3050R. A copy of the Decision Notice is kept in the case manager's client record.

If the resident is deemed eligible, the case manager notifies EDS by telephone of the determination, documents the call on the DMA-3019 form, including the confirmation (SRN) number provided by EDS, and completes a DSS-5027, Services Information System (SIS) Client Entry Form. The DSS-5027 is to be signed by the client, if able, or if the client is not able, by another responsible person on behalf of the client.

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.

The case manager then conducts a comprehensive functional assessment of the eligible resident. Based on needs identified in the assessment, a service plan is developed that includes client needs, goals, activities to be carried out to meet goals, and target dates.

The case manager is required to have monthly contact with the adult care home (by phone or in person) to assure that services are being received by the resident. A quarterly face to face meeting with the resident is required. An annual reassessment of the resident's functioning is required (utilizing the DSS-6224 or equivalent local format) as is a reauthorization of Enhanced ACH/PC.

### III. COMPLIANCE REQUIREMENTS

**IMPORTANT:** The overall requirements of Supplement #93.778-1 (Medical Assistance Program) must be met as well as the program specific requirements noted in this supplement.

**Crosscutting Requirements**

**The compliance requirements in the Division of Social Services "Cross-Cutting Requirements" in Section D (DSS-0) are applicable to this grant.**

A. ACTIVITIES ALLOWED OR UNALLOWED

**Compliance Requirement** – Adult care home staff and case managers identify potential clients in need of Enhanced ACH/PC; verify client’s need for Enhanced ACH/PC; review adult care home records to determine that care is being provided consistent with the needs of residents; determine resident’s needs for other community based services; and provide assistance to access these other community based services. Allowable activities are eligibility determination, assessment, service planning, monthly contacts, quarterly reviews, reassessments, monitoring of service plan implementation, arranging of services. Eligibility determination includes determining if the resident is Medicaid eligible, verifying the resident’s need for Enhanced ACH/PC, notifying EDS and authorizing services, issuing a Decision Notice, and completing the DSS-5027.

**Audit Objective** – To determine that funds were spent only on allowable ACH/CMS activities.

**Suggested Audit Procedure** – review a sample of client records and determine that documentation exists that verifies the above activities occurred.

Eligibility determination activities are verified by reviewing:

- documentation showing that case manager verified Medicaid eligibility,
- case manager completed and mailed a Decision Notice to the resident and to the adult care home; a copy is kept in the case manager’s files. The Decision Notice should contain an explanation as to how the decision was achieved,
- case manager completed DSS-5027 form, and;
- case manager completed a DMA-3019.

Monthly contacts are verified by reviewing:

- monthly entries by case manager on DSS-6222 (Contact Log) or equivalent local format.

Quarterly reviews and service plan monitoring contacts are verified by reviewing:

- quarterly entries by case manager documented on the DSS-6223 (Quarterly Reviews) or equivalent local format. Documentation must reflect that the quarterly included a face-to-face contact with the resident at the adult care home and that the quarterly review included a review of the adult care home’s care plan (DMA-3050R or equivalent) and the case manager’s service plan (DSS-6221 or equivalent).

Initial and annual comprehensive functional assessments are verified by reviewing:

ADULT CARE HOME CASE MANAGEMENT – DIVISION OF AGING AND ADULT SERVICES

---

- an initial assessment (DSS-6220 or equivalent) completed by case manager and, when the case has been open for 12 months or longer, the case manager completed an annual reassessment (DSS-6224 form or an equivalent).

Service plans are verified by reviewing:

- case manager has completed a DSS-6221 or equivalent form.

The time spent conducting these activities are coded on Day Sheets, DSS-4263, utilizing service codes 396 and 397. Service code 396 affiliates time spent assisting specific clients; service code 397 captures time spent on screening and conducting administrative activities not attributed to a specific client

**B. ALLOWABLE COSTS/COST PRINCIPLES**

All grantees that expend State funds (including federal funds passed through the N. C. Department of Health and Human Services) are required to comply with the cost principles described in the N. C. Administrative Code at 09 NCAC 03M .0201.

**C. CASH MANAGEMENT**

This requirement has not been passed to the subrecipients; therefore additional testing is not required. Funding is on a reimbursement basis.

**E. ELIGIBILITY**

In order to receive case management services, a client must be Medicaid eligible (and not a “disenfranchised” resident) and meet the Medicaid criteria for heavy care. Current criteria are that residents require extensive or total assistance in toileting, feeding and/or ambulation/locomotion. Documentation of eligibility must be maintained by the agency providing case management along with authorization for Enhanced ACH/PC. Eligibility for services and documentation requirements are outlined above under II. PROGRAM PROCEDURES heading and in the Family Services Manual, Volume V, Chapter IX (available in the county department of social services).

**G. MATCHING, LEVEL OF EFFORT, EARMARKING**

Funding for assistance under this program comes from 50% Federal (Title XIX) funds, and requires a 25% State and 25% county match (or a 50% county match).

Level of Effort and Earmarking do not apply at the local level.

**H. PERIOD OF AVAILABILITY OF FEDERAL FUNDS**

Federal funds are available for expenditure by counties during the State fiscal year for which they are allocated to the county.

I. PROCUREMENT AND SUSPENSION AND DEBARMENT

Refer to the State of North Carolina Agency Purchasing Manual, which can be accessed at <http://www.doa.state.nc.us/PandC/agpurman.htm>.

All grantees that expend federal funds (received either directly from a federal agency or passed through the N. C. Department of Health and Human Services) are required to conform with federal agency codifications of the grants management common rule accessible on the Internet at <http://www.whitehouse.gov/omb/grants/chart.aspx>.

All grantees that expend State funds (including federal funds passed through the N. C. Department of Health and Human Services) are required to comply with the procurement standards described in the North Carolina General Statutes and the North Carolina Administrative Code, which are identified in the State of North Carolina Agency Purchasing Manual accessible on the Internet at [http://www.doa.state.nc.us/PandC/agpurman.htm#P6\\_65](http://www.doa.state.nc.us/PandC/agpurman.htm#P6_65).

Nongovernmental subrecipients shall maintain written Procurement policies that are followed in procuring the goods and services required to administer the program.

J. PROGRAM INCOME

This requirement has not been passed to the subrecipients; therefore additional testing is not required.

L. REPORTING

County departments of social services are required to submit monthly reports of all expenditures using the DSS-1571 to the DHHS Controllers Office for reimbursement. Social work time spent delivering the service is reported on Day Sheets (DSS-4263) as Service Codes 396 and 397.

M. SUBRECIPIENT MONITORING

This requirement has not been passed to the subrecipients; therefore additional testing is not required.

N. SPECIAL TESTS AND PROVISIONS

**Compliance Requirement** – For the purposes of providing Adult Care Home Case Management Services, county departments of social services are not to contract with or deploy a registered nurse who does not hold a valid license.

**Audit Objective** – To determine that registered nurses contracted with by the county hold a valid license.

**Suggested Audit Procedure** – If the county department of social services is contracting with a registered nurse, review contract documents and locate a copy of the current North Carolina license of the nurse. Verification of a nurse's license can be done at the NC Board of Nursing internet web site at: <http://www.ncbon.org/> or by telephone at (919) 881-2272.