PART He-E 805 TARGETED CASE MANAGEMENT SERVICES

Statutory Authority: 42 USC § 1396n(g); RSA 151-E:12; RSA 151:9

He-E 805.01 Purpose. The purpose of this rule is to describe the requirements for targeted case management services provided to participants in the home and community based care for the elderly and chronically ill Choices for Independence (CFI) program.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.02 Definitions.

(a) "Activities of daily living" means those activities associated with personal care, including personal hygiene, bathing, eating, dressing, toilet use, walking, transferring from one surface to another, moving between locations, and bed mobility.

(b) "Biopsychosocial history" means information about a participant's past and present functioning in the areas of:

(1) Physical health;

(2) Psychological health, including emotional/coping ability;

(3) Decision-making ability;

(4) Social environment, including interactive skills, activities and supports;

(5) Family relationships;

(6) Financial considerations;

(7) Employment;

(8) Any vocational interests and activities, including spiritual preferences; and

(9) Any other area of significance in the participant's life, including, but not limited to, substance abuse or misuse, involvement with the behavioral health care system, developmental disability system, or legal system.

(c) "Case management agency" means an agency that is licensed in accordance with RSA 151:2, I(b), and enrolled as a New Hampshire medicaid provider to provide targeted case management services to CFI participants, and that operates without a conflict of interest. This term includes independent case management agencies.

(d) "Case manager" means an individual employed by, or contracted with, a case management agency who:

(1) Meets the qualifications described in He-E 805.06;

(2) Is responsible for the ongoing assessment, person-centered planning, coordination, and monitoring of the provision of services included in the comprehensive care plan; and

(3) Does not have a conflict of interest.

(e) "Complaint" means:

(1) Any allegation or assertion that a right of a participant has been violated;

(2) Any allegation or indication that an individual has been abused, neglected, or exploited by an employee of, or a volunteer or consultant for, a facility, provider, or program; or

(3) Any allegation or assertion that the department or a facility, agency, or service provider has acted in an illegal or unjust manner with respect to a participant or category of participants.

(f) "Comprehensive assessment" means a person-centered process of gathering information about a participant's abilities and needs through a face-to-face interview with the participant, and other methods as needed, which culminates in a written document.

(g) "Comprehensive care plan" means an individualized plan described in He-E 805.05(c) that is the result of a person-centered process that identifies the strengths, capacities, preferences, and desired outcomes of the participant.

(h) "Conflict of interest" means a conflict between the private interests and the official or professional responsibilities of a person, such as providing other direct services to the participant, being the guardian of the participant, or having a familial or financial relationship with the participant.

(i) "Department" means the New Hampshire department of health and human services.

(j) "Home and community-based care for the elderly and chronically ill (Choices for Independence)" means a system of long-term care services provided in non-institutional settings and described in He-E 801, and provided under a waiver of Section 1902(a)(10) and 1915(c) of the Social Security Act for participants who are elderly or adults who have a disability or chronic illness.

(k) "Incident" means an occurrence or event that interrupts normal procedure, including a serious injury or other event threatening the health or safety of a participant or staff.

(l) "Individualized contingency plan" means the person-centered plan that addresses unexpected situations that could jeopardize the participant's health or welfare, and which:

(1) Identifies alternative staffing resources in the event that normally scheduled care providers are unavailable; and

(2) Addresses special evacuation needs that require notification of the local emergency responders.

(m) "Instrumental activities of daily living" means those activities associated with home management, including grocery shopping, meal preparation, telephone use, and managing finances, and routine housework such as washing dishes, making beds, dusting, and laundry.

(n) "Medical eligibility assessment (MEA)" means an initial assessment and subsequent re-assessments conducted in accordance with RSA 151-E:3, I.

(o) "MEA needs list/support plan" means a document generated by the department that identifies participant needs to be addressed in the comprehensive care plan.

(p) "Participant" means an individual who has been found by the department to be eligible for the CFI program.

(q) “Person-centered” means a process for planning and supporting the participant receiving services that builds upon the participant’s capacity to engage in activities that promote community life and honors the participant’s preferences, choices, and abilities, and which involves families, friends, and professionals as the participant desires or requires.

(r) “Sentinel event” means an unexpected occurrence, including:

(1) The death of a participant from suicide or homicide; or

(2) A serious physical or psychological injury, or risk thereof, resulting from:

a. A sexual assault;

b. An unauthorized departure from a facility;

c. A medication error which results in paralysis, coma, permanent loss of function, or death;

d. A delay in the provision of departmental services resulting in a negative outcome; or

e. Abuse and/or neglect that results in paralysis, coma, permanent loss of function, or death, of a participant who:

1. Is receiving department funded services;

2. Has received department funded services within the preceding 30 days; or

3. Has been evaluated by a contract provider within the preceding 30 days.

(s) “Targeted case management” means the collaborative process of assessment, planning, facilitation, advocacy, coordination, and monitoring that is accomplished with a person-centered process, and which:

(1) Assists participants to gain access to needed CFI waiver services, services contained in the medicaid state plan, and other medical, social, spiritual, vocational, educational, and community supports, regardless of the funding source; and

(2) Provides for coordination of participant service plans from all providers to assure adequacy and, appropriateness of care and cost effectiveness of planned services that yield positive outcomes.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.03 Eligibility.

(a) Targeted case management services shall be provided to all participants, except those excluded pursuant to the Laws of 2007, Chapter 263:108.

(b) Targeted case management services shall be available to participants who reside in hospitals or nursing facilities licensed in accordance with RSA 151, provided that such services:

(1) Do not exceed a total of 30 cumulative days of services provided prior to discharge to home from an aforementioned facility or combination of facilities; and

(2) Do not duplicate discharge planning services that the facility is normally expected to provide as part of inpatient services.

(c) Notwithstanding (a) above, the commissioner of the department shall grant waivers to allow case management services to be provided to the excluded beneficiaries in (a) above as necessary to protect their health and safety.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

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He-E 805.04 Provider Agency Requirements.

(a) Case management agencies shall:

(1) Comply with the requirements contained in He-E 801.29, including the requirement to be enrolled as a medicaid provider; and

(2) Be licensed in accordance with requirements of state law, including RSA 151.

(b) Case management agencies shall employ a full-time administrator responsible for the development and implementation of the policies of the case management agency and for compliance with applicable rules.

(c) Case management agencies shall establish and maintain agency written policies and procedures regarding the following areas, and shall ensure that they are properly followed and enforced:

(1) Completion and documentation of a criminal background check for all employees pursuant to RSA 151:2-d;

(2) A process for confirming that each employee is not on the NH central registry of abuse, neglect or exploitation pursuant to RSA 169-C:35 or BEAS state registry established pursuant to RSA 161-F:49;

(3) Verification of discipline specific licensing for those employees whose profession requires licensing;

(4) The requirements for the mandated reporting of abuse, neglect, or exploitation in accordance with RSA 161-F: 46;

(5) The procedures for reported complaints, incidents, and sentinel events;

(6) Staff orientation including, at a minimum, a review of:

a. The federal and state laws and rules governing the CFI program;

b. The local community service network;

c. The procedures for crisis intervention; and

d. The philosophy governing person-centered planning, as defined in He-E 805.02(q);

(7) Staff development, including procedures for addressing performance or training needs;

(8) Staff performance evaluations, including how performance or training needs will be addressed throughout the case manager's employment tenure;

(9) A clinical supervision protocol which includes, at a minimum:

a. Monthly meetings between the case manager and his or her supervisor; and

b. As a focus of supervision, the review of participant records to ensure compliance with the requirements described in He-E 805.04(f) and He-E 805.05(b)-(d);

(10) Participant complaints, including how participants are informed about the agency's policies and procedures;

(11) Evaluation of participant satisfaction with the agency and the case manager, and how a participant may request a change in case manager or case management agency;

(12) Procedures for protection of participant records that govern use of records, storage, removal, conditions for release of information, and compliance with the Health Insurance Portability and Accountability Act (HIPAA); and

(13) Procedures related to quality assurance and quality improvement.

(d) Case management agencies shall accept assignments made, pursuant to He-E 805.07(b), according to the system maintained by the department's bureau of elderly and adult services (BEAS) unless there is a conflict of interest or the agency has informed BEAS in writing that it must be temporarily removed from the list of available agencies due to staffing shortages.

(e) Case management agencies shall maintain access to a toll free number for all participants served and respond to calls as follows:

(1) Responses to calls received on Monday through Friday shall be made within 24 hours; and

(2) Responses to calls received on Saturdays, Sundays, and holidays shall be made within 48 hours.

(f) Case management agencies shall maintain an individual case record for each participant receiving case management services which includes:

(1) A face sheet describing demographic and other important information, including:

a. The participant's name, date of birth, and address;

b. The participant's medicaid identification number; and

c. The name, phone number, and address of the participant's emergency contact person;

(2) The comprehensive assessment document, described in He-E 805.05(b) below;

(3) The comprehensive care plan, described in He-E 805.05(c) below;

(4) The CFI MEA assessment and MEA needs list or support plan;

(5) Medicaid financial eligibility information, including the cost share described in He-E 801.11;

(6) Release of information forms;

(7) Progress notes that reflect areas contained in the comprehensive care plan;

(8) All contact notes, including those required by He-E 805.05(d)(1) below;

(9) A written record of all monitoring and case management activities;

(10) All pertinent correspondence relating to the participant's case management; and

(11) Any and all electronic records.

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He-E 805.05 Required Case Management Services.

(a) For each participant who selects or is assigned to a case management agency, the agency shall designate a case manager to provide case management services.

(b) The designated case manager shall conduct a comprehensive assessment of a participant within 15 working days of the date on which the agency receives department notification of the assignment, which shall:

(1) Utilize a formal assessment tool to evaluate the participant's status based on information gathered at a face-to-face meeting, and through other methods as needed; and

(2) Culminate in a written document that describes the participant's abilities and needs in the following areas:

a. Biopsychosocial history;

b. Functional ability, including activities of daily living and instrumental activities of daily living;

c. Living environment, including the participant's in-home mobility, accessibility, and safety;

d. Social environment, including social/informal relationships and supports, activities and interests, such as avocational and spiritual;

e. Self-awareness, or the degree to which the participant is aware of his or her own medical condition(s), treatment(s), and medication regime;

f. Risk, including the potential for abuse, neglect, or exploitation by self or others, as well as health, social or behavioral issues that may indicate a risk;

g. Legal status, including guardianship, legal system involvement, and availability of advance directives, such as durable power of attorney;

h. Community participation, including the participant's need or expressed desire to access specific resources, such as the library, educational programs, restaurants, shopping, and medical providers; and

i. Any other area identified by the participant as being important to his or her life.

(c) Within 20 working days of the date on which the agency receives BEAS notification of the assignment, the designated case manager shall develop a written comprehensive care plan for the participant, which shall:

(1) Be a person-centered agreement;

(2) Contain measurable objectives and goals, with timelines;

(3) Contain the following, based on the participant's needs as identified in the comprehensive assessment document and the MED needs list or support plan:

a. Paid services to be provided under medicaid or other funding sources, including:

1. The needs to be met by paid services;

2. Service costs;

3. Service funding source;

4. Provider names; and

5. The beginning and ending dates of each service, and the frequency of service provision;

b. Non-paid services or supports, including the needs to be met and the names of those individuals or groups providing such services or support;

c. Unfulfilled needs and gaps in services, including those that pose a risk to the participant's health and safety;

d. Any existing risks for abuse, neglect or exploitation, as defined in RSA 161-F:43;

e. A plan for mitigating any existing risks; and

f. An individualized contingency plan, as defined in He-E 805.02(l); and

(4) Be updated with written documentation as follows:

a. At least annually for as long as the participant is receiving CFI services;

b. Whenever changes occur in the participant's medical condition and/or in the participant's needs and desires; and

c. With progress notes reflecting each case management contact in (e)(1) below.

(d) The designated case manager shall monitor the services provided to a participant, as follows:

(1) Conduct the case management contacts required for each participant, as follows:

a. Case management contacts shall include no less than one monthly telephonic contact and one face-to-face contact every 60 days; and

b. Each case management contact shall be documented in a contact note;

(2) Ensure that services are adequate and appropriate for the participant's needs, and are being provided, as described in the comprehensive care plan;

(3) Ensure that the participant is actively engaging in the services described in the comprehensive care plan;

(4) Ensure that the participant is satisfied with the comprehensive care plan; and

(5) Identify any changes in the participant's condition, discuss these changes with the participant in order to determine whether changes to the comprehensive care plan are needed, and make changes to the comprehensive care plan as needed.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.06 Qualification Requirements for Case Managers.

(a) Case managers employed by case management agencies shall have the following minimum requirements:

(1) Have demonstrated knowledge of the local service delivery system and the resources available to participants;

(2) Have demonstrated knowledge of the development and provision of integrated, person-centered services; and

(3) Have a degree in a human-services related field and one year of supervised experience, or a similar combination of training and experience.

(b) Case manager supervisors employed by case management agencies shall have the following minimum requirements:

(1) Have a bachelor's level degree; or

(2) Be a registered nurse with 2 years of related experience.

(c) Case management agencies shall not employ individuals who:

(1) Have a felony conviction;

(2) Have been found to have abused, neglected or exploited an individual based on a protective investigation completed by the BEAS in accordance with He-E 700 and an administrative hearing held pursuant to He-C 200, if such a hearing is requested; or

(3) Are listed in the state of NH central registry of abuse, neglect or exploitation pursuant to RSA 169-C:35 or the BEAS state registry pursuant to RSA 161-F:49.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.07 Participant Selection of Case Management Agency.

(a) After being determined eligible for CFI services in accordance with He-E 801, the participant shall select a case management agency from a list provided by BEAS.

(b) If the participant does not choose a case management agency after being determined eligible for CFI services, then the participant shall be assigned to a case management agency through a system maintained by BEAS.

(c) The participant shall be informed that the case manager selected will also be responsible for coordinating mental health and developmental disability-related services if such services are needed by the participant.

(d) The participant shall be informed in writing of the case management agency to which he or she is assigned.

(e) The participant shall be informed in writing and orally of the process to request a change in case management agency:

(1) At the time of eligibility determination and re-determination; and

(2) By the case management agency during the assessment process.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

New. #12115, eff 2-22-17

He-E 805.08 Payment for Services.

(a) Providers shall submit claims for payment to the department's fiscal agent.

(b) Providers shall meet all NH medicaid provider requirements, including those regarding timely claims submission.

(c) Providers shall not bill the applicant if medicaid does not pay due to billing practices of the provider which result in non-payment for service.

(d) Reimbursement to providers shall be made in accordance with rates established pursuant to RSA 161:4, VI.

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He-E 805.09 Third Party Liability. All third party obligations shall be exhausted before medicaid may be billed.

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New. #12115, eff 2-22-17

He-E 805.10 Quality Management.

(a) On a quarterly basis, case management agencies shall conduct a participant record review to evaluate the delivery of services identified in the comprehensive care plan to ensure that participants' needs are being met in the community, and shall document the results of the review in a quarterly quality management report, including:

(1) The number of records reviewed;

(2) A summary of the review results;

(3) A description of any deficiencies identified;

(4) The remedial action taken or planned to address the deficiencies identified in (3) including the dates action was taken or will be taken; and

(5) A summary of unmet service needs.

(b) On a quarterly basis, case management agencies shall conduct a review of all reported complaints, incidents, and sentinel events related to the delivery of services identified in the comprehensive care plan, and shall document the results of the review in a quarterly quality management report, including:

(1) The number of reported complaints, incidents and sentinel events;

(2) A summary of the review results;

(3) A description of the deficiencies identified; and

(4) The remedial action taken or planned to address the deficiencies identified in (3) including the dates action was taken or will be taken.

(c) Case management agencies shall plan and take any remedial action necessary to address deficiencies in service delivery identified in the quarterly quality management reports in (a) and (b) above.

(d) Case management agencies shall retain the quarterly quality management reports in (a) and (b) above for 2 years and make them available to the department upon request.

(e) Case management agencies shall retain clinical records:

(1) To support claims submitted for reimbursement for a period of at least 6 years from the date of service; or

(2) Until resolution of any legal action(s) commenced during the 6-year period.

(f) Case management agencies shall be subject to monitoring visits by BEAS to ensure that services are provided in accordance with He-E 805.

(g) Monitoring visits shall:

(1) Be announced or unannounced;

(2) Occur at least annually;

(3) Include, but not be limited to:

a. A review of participant case records;

b. A review of the portion of employee records pertinent to the provider qualification requirements of He-805; and

c. A review of the quarterly quality management reports in (a) and (b) above and

(4) Be made during the agencies regular business hours.

Source. #9242, eff 8-26-08; ss by #11167, INTERIM, eff 8-25-16, EXPIRED: 2-21-17

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