

First Quarter CAP/DA-Choice Option Training

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Agenda

CAP/DA-Choice 1915 (c) Home & Community-Based Services Waiver Benefit Package

Names & Definitions

Building a Care Plan in conjunction with our Partners



In October 2008, The Centers for Medicare and Medicaid Services (CMS) approved DMA's request to renew its 1915 (c) Home and Community-Based Services Waiver for CAP/DA-Choice Option

The approved waiver application includes:

- The inclusion of consumer-direction and the traditional CAP/DA programs under one waiver
- An expanded benefit package that enhanced names and their definitions
- Waiver approval for 5 years
- Deinstitutionalization planning through Money Follows the Person (MFP)

CAP/DA-Choice Option
Benefit Package,

Definitions,
Limitations,
&
Authorization of Services

Personal Care Services

(Formerly in-home aide)

(S5125)

Personal Care:

- Is assistance with personal care and basic home management tasks for beneficiaries who are unable to perform these tasks independently due to physical or mental disabilities.
- Personal care tasks include activities such as eating, bathing, dressing and grooming (Activities of Daily Living)
- Basic home management tasks include activities such as light housekeeping, laundry, and meal preparation (Instrumental Activities of Daily Living).
- Can be provided in the community, including the home, workplace, and educational settings. However, provision of a Personal Care Aide in these settings is at the discretion of the Home Care Provider. Medicaid Infrastructure Grant.

Personal Care Services

Limitations:

- Two levels of Personal Care Aide as defined by the North Carolina Department of Health and Human Services:
- When assigning an Aide adhere to Medical Care Commission - 10A. NCAC 13J.0901

Qualifications for PCS:

- Employed with a Medicaid/Medicare enrolled Home Health Provider and meet the minimum competency requirements for the level of tasks to be performed as cited above.



Personal Care Services

Care Planning is based on:

- Needs of the beneficiary as identified in a comprehensive assessment
- The preference of the beneficiary and the primary caregiver

Coverage hours:

- Are arranged to meet the needs of the beneficiary or primary caregiver
- Is budgeted against total informal care needs

Personal Care Services

Case Manager will:

- Make referral to IHA provider
- Submit service authorization to provider
- Monitor service monthly and quarterly
- Document any deviation in coverage hours

Advantages:

Services are reimbursed day of admission
and discharge from hospital

Personal Assistant Services

(Choice Option Only)

(S5135)

Personal Assistant Services:

- Are basic daily living activities that must be performed to assure or support one's physical well-being.
- Involve home maintenance which are basic activities that help to promote a safe and healthy living environment, such tasks as vacuuming, cooking and grocery shopping
- Are available only for those beneficiaries who have elected the Choice Option under the CAP/DA-CHOICE Option Waiver.

Personal Assistant Services

Personal Assistant Services:

- Provides help with personal and home maintenance tasks for beneficiaries that are unable to meet these needs independently due to physical or mental impairments.
- Are provided in the community, including, but not limited to the home, workplace, and educational settings.

Personal Assistant Services

Care Planning is based:

- On needs of the beneficiary as identified in a comprehensive assessment
- The preference of the beneficiary and the primary caregiver

Coverage hours:

- Are arranged to meet the needs of the beneficiary Or primary caregiver
- Are budgeted against all informal care needs

Personal Assistant Services (PAS)

Limitations:

- PAS cannot be the legal guardian or legal representative for the beneficiary.
- Must have beneficiary's enrollment agreements completed, signed & on file with GT Financial
- Must complete a self-assessment tool and show competency to direct care

Qualifications for PAS:

- Complete employment application with the fiscal Intermediary, GT Financial
- Pass criminal background & registry check

Personal Assistant Services (PAS)

Case Manager will:

- Make referral to GT Financial
- Submit service authorization to GT Financial
- Give a copy of background check to beneficiary
- Monitor service monthly and Quarterly
- Spot check PCA claims periodically

Advantages:

Services are reimbursed day of admission and discharge from hospital

Personal Assistant Services (Choice Option)

When requesting pay rate that exceeds \$10.50/hour:

- Choice participant must provide needs justification for pay rate request via written statement.
- Care Advisor must complete a “Waiver Requisition” form & include the beneficiary’s justification.
- CAP/DA Consultant must approve all requests for pay rate over \$10.50/hour
- If approved by consultant, Care Advisor must revise POC and notify GT Financial by phone and via a service authorization with the new approved rate.

Care Advisor (T2041)

The Care Advisor:

- Is available only to participants who elect the Choice Option.
- Assesses the beneficiary's strengths, needs and ability to direct his/her own care.
- Assists the beneficiary in developing a plan of care that contains paid services, unpaid services, and supports needed by the beneficiary to live successfully in the home and community.
- Focuses on empowering consumers to define and direct their own personal assistance needs and services.
- Guides and supports the beneficiary, rather than directing and managing the beneficiary throughout the service planning and delivery process.

Care Advisor

Care Advisor responsible for:

- Making referral to GT Financial
- Submitting service authorization to providers
- Counseling with beneficiaries about background and registry checks
- Monitoring services monthly and Quarterly
- Spot checking PCA claims periodically

Advantages:

Service are reimbursed day of admission and discharge from hospital

Personal Emergency Response Service (PERS - *Formerly Telephone Alert*) (S5161)

PERS pays for the monthly service charges or monthly rental charges for a system used to alert a central monitoring facility of medical emergencies that threaten the beneficiary's health, safety, and well-being. This service may also alert the central facility of other situations that threaten the beneficiary's safety.

PERS

Limitations: Does not cover the purchase and installation of equipment in the beneficiary's home.

Provider Type: Emergency Response

Provider Qualifications: Must have the capability to provide a 24-hour monitoring system in accordance with service definition

PERS

Case Manager will:

- Make referral to PERS provider
- Submit service authorization to provider
- Monitor service monthly and quarterly
- Document any all alert calls

Advantages:

Service are reimbursed while in hospital and
Short Term Rehabilitation (STR)

Home Delivered Meals & Preparation (S5170)

(Formerly Preparation & Delivery of Meals):

Home Delivered Meals is often referred to as “Meals on Wheels” and provides for the preparation and delivery of daily nutritious meals to the beneficiary’s home.

Provider Type: Must be provided by agencies or organizations meeting the requirements for the service set by the Division of Aging and Adult Services (DAAS).

Provider Qualifications: 10A NCAC 06K.0101

Agencies/organizations which meet DAAS’ requirements for home delivered meals.

DAAS Rules Governing Meals

Eligibility for home-delivered nutrition services:

- People age 60+ who are physically or mentally unable to obtain food or prepare meals, who have no responsible person who is able and willing to perform this service, and who are unable to participate in congregate nutrition program because of physical or mental impairment.
- The spouse of an older person, if one or the other is homebound by reason of illness or incapacitating disability.
- The family caregiver of an eligible homebound older adult.
- Local option to offer home-delivered meals to volunteers who work during meal hours.
- Local option to offer home-delivered meals to people under age 60 with disabilities who reside at home with an eligible older adult.

<http://www.ncdhhs.gov/aging/meals.htm>

DAAS Rules Governing Meals

Ineligibility criteria:

- People whose dietary needs cannot be met through the meals offered.
- People residing in long-term care facilities or enrolled in care-providing programs (including adult day care/day health, except that people attending day/care/day health centers may receive meals on the days they do not participate in the adult day program).

DAAS Rules Governing Meals

Home-delivered nutrition service priority:

- People in adult protective services.
- People at risk of needing adult protective services.
- People without a caregiver or other responsible party assisting with care.
- People who have ADL impairments (self-care limitations) and IADL impairments (household management limitations).

Home Delivered Meals & Preparation

Case Manager will:

- Make referral to authorized provider
- Submit service authorization to provider
- Monitor service monthly and quarterly
- Adhere to the policies and procedures of DAAS

Limitations:

Service are not reimbursed while in hospital or Short Term Rehabilitation.

Adult Day Health (ADH) (S5102)

ADH is:

- Care for the beneficiary in a certified Adult Day Health Care facility
- For adults who are aging and adults with disabilities who need a structured day program of activities and services with nursing supervision.
- An organized program of services during the day in a community group setting.
- A support of the adult's independence and promotes social, physical, and emotional well-being.
- Available up to 5 days per week.

Adult Day Health (ADH)

Services are provided in a certified ADHC and include:

- Health services
- A variety of program activities designed to meet the individual needs and interests of the beneficiary
- Food and food services (nutritious meals and snacks as appropriate)

http://www.ncdhhs.gov/aging/manual/ADCADHS_PolicyProcedureManual.pdf

Adult Day Health (ADH)

Case Manager will:

- Make referral to ADHC provider
- Submit service authorization to ADHC
- Monitor service monthly and Onsite Visit quarterly
- Document deviations in attendance

Limitations:

- Block Grant funding is not eligible under the CAP/DA-Choice Option waiver
- Service are not reimbursed while in hospital or Short Term Rehabilitation.

Institutional Respite (H0045)

Institutional Respite Services:

- Are provided in a Medicaid-certified nursing facility or a hospital with swing beds.
- Will be provided to beneficiaries who are unable to care for themselves and need service on a short-term basis because of the absence of, or need for relief to, those persons normally providing the care.
- May be used to meet a wide variety of needs, including family or caregiver emergencies and planned special occasions when the caregiver needs to be away from town for some extended period of time.

Institutional Respite

Limitations:

- Can not exceed 30 days in one year (July-June) for combined use of both Institutional Respite Care and Non-Institutional Respite Care.
- Beneficiary is responsible for personal care items, ex: incontinence supplies
- Institutional Respite must be billed as a daily rate.

Advantages:

- Can be pro-rated over 12 months
- Can be itemized on the POC as short-term intensive
- Nursing facility does not have to admit the beneficiary as a permanent placement, but as respite

Institutional Respite

Provider Qualifications:

Nursing facilities and hospital swing beds

Limitations:

- Submit claims for the service using H0045 at the Medicaid maximum daily rate
- Enroll as a CAP/DA-Choice Option provider

Case manager will:

- Provide service authorization
- Track the utilization of respite hours

Non-Institutional Respite (S5150)

(Formerly in-home respite)

Non-Institutional Respite:

Is the provision of temporary support to the **primary unpaid caregiver** (s) of the beneficiary by taking over the tasks of that person for a limited period of time.

- May be used to meet a wide variety of needs, such as family emergencies, planned special circumstances (such as vacations, hospitalizations, or business trips), relief from the daily responsibility and stress of caring for an individual with a disability, or the provision of time for the caregiver (s) to complete essential personal tasks.

Non-institutional Respite

Provider Qualifications:

In Home Aide providers

Limitations:

- Can not exceed 720 hours in one year (July-June) for combined use of both Institutional Respite Care and Non-Institutional Respite Care.

Advantages:

- Can be pro-rated over 12 months
- Can be itemized on the POC as short-term intensive

Case Manager will:

- Send Service Authorization to IHA providers
- Inform GT Financial of the revised Plan of Care approving respite services
- Track the utilization of respite hours

Waiver Services

Waivers Supplies:

- Are provided to the waiver beneficiary to promote the health and well-being of the individual. The service is necessary to avoid institutionalization.
- **Waiver Services are:**
 - Nutritional supplements taken by mouth when ordered by a physician (B4150BO, B4152BO, B4155BO, B4157BO, & B4162BO Ex: Ensure, Boost, Glucerna, Carnation)

Waiver Services

- **Waiver Services are:**
 - Nutritional supplements taken by mouth when ordered by a physician (B4150BO, B4152BO- B4155BO, B4157BO, & B4162BO Ex: Ensure, Boost, Glucerna, Carnation)
 - Reusable incontinence undergarments (**T4539**)
 - Disposable liners for reusable incontinence undergarments, and incontinence pads for personal undergarments (**T4535**);
 - Medication dispensing boxes(**T2028**)

Waiver Services

Limitations:

- MD order required
- Oral Nutritional Supplements must be ordered according to Medicaid fee schedule; 1 unit = 100 calories, not by number of cans in a package
- Services can not be provided while temporarily in an institution (hospital or STR Rehab)

Waiver Services

Provider Qualifications:

- Lead Agencies & Durable Medical Equipment and Supplies

Case Manager will:

- Obtain MD order
- Provide the service as prescribed
- Submit Service Authorization to approved providers

Home Modification & Mobility Aids (HMMA - S5165)

(formerly Home Mobility Aids)

HMMA is:

- Equipment and physical adaptations to the beneficiary's home that are required by his/her needs and documented in the approved plan of care.
- Are provided to increase the beneficiary's mobility, safety, and independence in the home. This service often plays a key role in preventing institutionalization.

Home Modification & Mobility Aids (HMMA)

Provisions of HMMA:

- Repairs equipment when covered and the cost is efficient compared to the cost of the replacement of the item and only after coverage of any warranties are explored.
- Will reimburse the purchase, installation, and repair of home modifications only for the purposes listed above.

Examples of HMMA

- Plumbing changes,
- Wiring reconfigurations,
- Reinforcement of structure to accommodate change,
- ramps, grab bars, and handrails,
- Widening of doorways/passages for wheelchair or walker accessibility, Non-skid surfaces
- Modification of bathroom facilities to improve accessibility, including toilet, shower/tub (including hand-held showers), and sink fixtures or modifications; water faucet controls; floor urinal adaptations; plumbing modifications; and modification for turnaround space
- Bedroom modifications to accommodate hospital beds and/or wheelchairs and Kitchen
- cabinets, sink fixtures or modifications, water faucet controls, related plumbing modifications, and modification for turnaround;
- Floor coverings for ease of ambulation
- Hydraulic, manual, or electronic lifts, including portable lifts or lift systems that can be removed and taken to a new location and are used primarily inside the participant's home
- Lift chairs
- Other modifications outside of these general categories must be approved by the Division of Medical Assistance

Home Modification & Mobility Aids

Limitations:

- Not able to add to the total square footage of the home
- Provided only in the following settings:
 - A dwelling where the waiver beneficiary resides that is owned by the individual or the family
 - In rented residences when the modifications are portable
- Not able to purchase locks
- The total cost of HMMA cannot exceed \$10,000 over the lifetime of the waiver (5 years)
- Service are reimbursed while in NF/Hospital

Home Modification & Mobility Aids

Provider Qualifications:

- Durable Medical Equipment Supplies company or Local Lead Agency through contract

Case Manager will:

- Make referral to vendor
- Monitor service monthly and quarterly
- Track the utilization of the waiver amount

Transition Services (T2038)

Transitions services are:

- Available to cover one-time expenses, not to exceed \$2500 per beneficiary.
- Expenditures for initial set-up expenses for individuals who make the transition from an institution to their own home or apartment in the community.
- Funds may be used to pay the necessary expenses for an individual to establish his or her basic living arrangement and to move home.

Transition Services

Limitations:

- May not include ongoing payment for rent
- Must be of sufficient quality and appropriate to the needs of the participant
- Must provide a receipt for each purchase or invoice for each payment
- A one-time procedural process per beneficiary per lifetime of the waiver
- Must be used within 90 days from the date the beneficiary transitioned from an institution

Examples of Transition Items

- Equipment, essential furnishings, and household products
- Moving expenses
- Security deposits or other such payments (e.g., first month's rent) required to obtain a lease on an apartment or home
- Environmental health and safety assurances, such as pest eradication, allergen control, one time cleaning prior to occupancy
- Personal hygiene supplies
- First week supply of groceries
- Up to a one month supply of medication in instances when the participant is not provided with medication upon discharge from the nursing facility and/or when Medicaid coverage lapses during the transition process.
- Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating)

Transition Services

Provider Qualifications:

- Medicaid providers who have the capacity as verified by the Case Manager/Care Advisor to provide items and services of sufficient quality to meet the need for which they are intended

Case Manager will:

- Make referral to vendor
- Submit service authorization
- Monitor service monthly and quarterly

Advantages:

Services are reimbursed while in NF/Hospital

Training & Education (S5111)

Training and Education includes:

- Training for the individual, a family member who is the primary caregiver, or, under the Choice Option, the personal assistant.
- Information and techniques for the use of specialized equipment and supplies
- Conference registration and enrollment fees for classes

The purpose of this training is:

- To enhance the decision-making ability of the beneficiary,
- Enhance the ability of the individual to independently care for themselves, or
- Enhance the ability of the family member or personal assistant in caring for the beneficiary.

Training & Education

Limitations:

- All training and education services will be documented in the beneficiary's service plan as a goal with the expected outcomes.
- Individuals who are paid service providers, with the exclusion of the personal assistant (Choice Option), cannot be trained or educated using this service
- Can not exceed \$500 per year
- Service are not reimbursed while in NF/Hospital

Training & Education

Provider Qualifications:

- Universities, Colleges, and Community Colleges
- An organization with a training/class curriculum approved by the Division of Medical Assistance

Case Manager/Care Advisor will:

- Make referral for and authorize training
- Reimburse associated approved costs for the training
- Monitor completion or participation in the training

Participant Goods & Services (T2025)

(Formerly Consumer-Directed Goods and Services)

Services, equipment, or supplies not otherwise provided through this waiver or through the **Medicaid State Plan** that meet the following requirements:

- Increase the individual's ability to perform ADLs or IADLs;
- Decrease dependence on Personal Assistant Services or other Medicaid-funded services; AND
- The participant does not have the funds to purchase the item/service.

CHOICE Option beneficiaries may direct the FM (through the approved plan of care) to save a portion of their monthly consumer-directed budget for these items/services

Participant Goods & Services

Limitations:

- Cannot exceed a limit of \$800.00 annually, items over \$200 must be approved by a DMA consultant
- Must provide a receipt for each purchase
- Must meet the specifications of this service's service definition
- Must be of sufficient quality and appropriate to the needs of the beneficiary

Participant Goods & Services

Provider Qualifications:

- CAP/DA Lead Agencies
- Financial Management Services

Case Manager will:

- Approve requests for participant goods and services
- Submit payment to vendor for participant goods and services
- Monitor acquisition of service and appropriateness of use
- Request approval for items \$200.00 or greater from the assigned CAP/DA Consultant

Advantages:

Services are reimbursed while in NF/Hospital

Assistive Technology (AT) (T2029)

AT allows:

- Beneficiaries access to items, product systems, supplies, and equipment necessary to the proper functioning of items and systems (whether acquired commercially, modified, or customized) that are used for the purposes of improving or maximizing functional capabilities.
- Improved accessibility and use of the beneficiary's environment.
- Provisions to address 24/7 care needs of the beneficiary.

Assistive Technology (AT) (T2029)

- Adaptive or therapeutic equipment to enable participants to increase, maintain, or improve functional capacity in performing daily life tasks that would not be possible otherwise.
- Installation of specialized monitoring systems; and specialized accessibility/safety adaptations or additions.

Assistive Technology

Provisions of this service include:

- Technical assistance in device selection
- Training in device use by a qualified assistive technology professional
- Assessment and evaluation
- Purchases, shipping costs, as necessary & repair of such devices.

Limitations:

The maximum limitation of \$3,000 over the lifetime of the waiver (5 years).

Assistive Technology

Provider Qualifications:

- CAP Lead Agencies (*confirm that you indicated this on your current provider enrollment application.*)
- NC Assistive Technology Program
- Hospitals, Home Health Agencies and Rehab Centers

Case Manager/Care Advisor will:

- Make referral for AT to approved vendors
- Authorize service via service authorization
- Submit claim when applicable and reimburse vendor
- Monitor acquisition of service and appropriateness of use

Advantages:

Service are reimbursed while in NF/Hospital

Questions

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