N.C. Department of Health and Human Services

Introduction to Renewed CAP/DA 1915(c)HCBS Waiver

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Agenda

- 2 Waiver Service Criteria
- Emergency Plan
- Selection of Entrant
- Expedited Criteria (Prioritization)
- Reserved Slots
- Waitlist Management
- Slot Surrendering
- Case Manager Qualifications
- Supervisor Qualifications

Agenda (cont'd)

- Lead Agency Qualifications
- Service Plan: Monitoring, ID Team, Assessment, POC
  Benefit Package
- Health & Welfare
- Risk Assessment & Mitigation
- Critical Incident Report
- Restraints
- Financial Accountability
- Case Documentation

Need for CAP-DA Services

- Requires two waiver services (excluding incontinence supplies, personal emergency response system, and meals preparation and delivery) on a monthly basis that mitigate institutionalization through coordinated case management and hands-on personal assistance.

  3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1 e

Need for CAP-DA Services (cont'd)

- Examples:

  If individual requires:

  - CM + PERS = Criteria Not Met
  - CM+ Personal Care Aide + PERS = Criteria Met

Need for CAP-DA Services (cont'd)

How to Implement New Criteria:

- During each beneficiary's next CNR, complete the assessment to establish whether they meet the 2 waiver service criteria.
- If assessed need does not meet the 2 waiver service criteria, and disenrollment is necessary, follow Due Process guidelines.
- Send the DMA 2002 if adverse decision is made at CNR for a current beneficiary.

Emergency Plan

- All CAP/DA beneficiaries (CAP/DA and CAP/Choice) must have emergency back-up plan with adequate formal and informal support to meet the basic needs outlined in the CAP/DA assessment and plan of care (POC) to maintain their health, safety and well-being.

3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1 h

Emergency Plan (cont'd)

- An emergency back-up plan is necessary for times when the formally (personal care aide or personal assistant) arranged support system is unavailable during regularly scheduled work hours and when the unpaid informal support system is unavailable.

3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1 h

Emergency Plan (cont'd)

How to Implement New Policy:

- All CAP/DA beneficiaries must have a completed Emergency Plan no later than **January 31, 2014**.

Selection of Entrant

- The HCBS waiver authority permits a state to offer home and community-based services to individuals who:
  - Are determined to require a level of institutional care under the NC State Medicaid Plan;
  - Are members of a target group that is included in the waiver;
  - Meet applicable Medicaid eligibility criteria;
  - Requires two waiver services (excluding incontinence supplies, personal emergency response system, and meals preparation and delivery) on a monthly basis that mitigate institutionalization through coordinated case management and hands-on personal assistance.

3K-2, CAP/DA Clinical Coverage Policy, Sections 2.1.2, 3.2.1 e

Selection of Entrant (cont'd)

- Exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care.
- Medicaid beneficiary who is a disabled adult 18 years of age and older in one of the categories specified below is eligible for CAP/DA Waiver:
  - Medicaid to the Aged (MAA)
  - Medicaid to the Blind (MAB)
  - Medicaid to the Disabled (MAD)

3K-2, CAP/DA Clinical Coverage Policy, Section 2.1.2

Expedited Criteria (Prioritization)

- The CAP/DA 1915 (c) HCBS waiver arranges for service consideration on a first-come first-serve basis due to similar acuity needs of individuals applying for participation in the waiver.
- Individuals meeting specific criteria shall be expedited for immediate consideration of waiver participation and prioritized to the top of an existing waitlist.

3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1

Expedited Criteria (cont'd)

- Age 18-21 transitioning from the CAP/C program.
- Individuals with an active Auto Immune Deficiency Syndrome (AIDS) diagnosis with a T-Count of below 200.
- Individuals transitioning from a nursing facility with Money Follows the Person (MFP) designation.

3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1

Expedited Criteria (cont'd)

- Individuals transitioning from a nursing facility utilizing service of community transition.
- Eligible CAP/DA or CAP/Choice beneficiaries who are transferring to another county.
- Previously eligible CAP/DA or CAP/Choice beneficiaries who are transitioning from a short-term rehabilitation placement within 90 days of the placement.

3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1

Expedited Criteria (cont'd)

- Individuals identified at risk by their local Department of Social Services (DSS) who have an order of protection by Adult Protective Services (APS) for abuse, neglect and exploitation and the CAP/DA waiver is able to mitigate risk.

3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1

County Policy on Prioritization

- Lead Agency Policy can no longer designate county specific priority groups other than those specified in DMA policy.

- County policy must “mirror” exactly state policy.

Reserved Slots

- If the Lead Agency has no available slots to process a referral that meets "Expedited Criteria", then DMA reserves a portion of the participant capacity of the waiver for the specified purpose of accommodating referrals that meet expedited criteria.

CAP/DA Waiver - Appendix B: Participant Access and EligibilityB-3: Number of Individuals Served c. Reserved Waiver Capacity, pg 40.

Reserved Slot (cont'd)

- The Lead Agency must request a "Reserved Slot" from their assigned DMA Consultant.
- Use the DMA template provided to request a "Reserved Slot".

Waitlist Management

- Counties will continue to manage their waiting lists according to DMA policy.
- Counties will continue to submit monthly slot reports by the 10th of each month until further notice.

Slot Surrendering

- Process to redistribute any unassigned slots.
- Process will consist of:
  - DMA will review slots beginning the month of November (October data);
  - DMA will notify Lead Agencies regarding their unassigned slots to implement a written plan.
  - DMA will review slot usage again in January.
  - DMA will provide second notification in January to inform Lead Agencies that if slots are not filled or assigned to a potential participant by March, slots will be **reassigned in March 2014**.

Case Management Qualifications

- New hires effective October 1, 2013 must qualify according to the new policy.
- The case manager or care advisor shall meet one of the following qualifications:
- Bachelor's degree in social work from an accredited school of social work, and (1) years of directly related experience of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA certified training program within 90 calendar days of employment;

3K-2, CAP/DA Clinical Coverage Policy, Section 6.4 a

Case Management Qualifications (cont'd)

- Bachelor's degree in a human services or equivalent field from an accredited college or university with two(2) or more years of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA certified training program within 90 days;

3K-2, CAP/DA Clinical Coverage Policy, Section 6.4 a

Case Management Qualifications (cont'd)

- Bachelor's degree in a non human services field from an accredited college or university with two (2) or more years of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA certified training program within 90 days; or

3K-2, CAP/DA Clinical Coverage Policy, Section 6.4 a

Case Management Qualifications (cont'd)

- Registered nurse who holds a current North Carolina license, two (2) year or four (4) year degree, one (1) year case management in homecare, long-term care, personal care or related work experience and the completion of a DMA certified training program within 90 days.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.4 a

Case Management Qualifications (cont'd)

- **Note:** Candidates with a higher educational background than listed shall also have one (1) year of community experience (preferably case management in the health or medical field directly related to homecare, long-term care, or personal care).
- Trainee Status Candidates shall be directly supervised for one (1) year by the Supervisor and complete a DMA certified training program within 90 days of employment. The supervisor must approve and sign all work produced by the trainee.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.4 a

Case Management Qualifications (cont'd)

- Case managers without a college degree who have been employed with an existing CAP lead agency before the implementation of this clinical coverage policy will be eligible for a grandfathering clause. The case manager or care advisor shall have been employed with the organization for more than five (5) years and have an equivalent combination of education and experience that equal 10 years.
- Case managers or care advisors who do not meet these criteria shall not be eligible for this grandfather clause.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.4 a

Supervisor Qualifications

- The case manager or care advisor supervisor shall meet one of the qualification of a case manager or case advisor in section 6.4 a, plus they must possess three (3) or more years of directly related experience in the health or medical field directly related to homecare, long-term care, or personal care, one (1) of those years to have been in case management.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.4 b

Lead Agency Qualifications

Qualified Case Management Providers must have:

- A resource connection of the service area as to provide continuity and appropriateness of care;
- Experience in Geriatric and physical disabilities;

CAP/DA Waiver - Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service, pg 67-68

Lead Agency Qualifications (cont'd)

- Polices/procedures in place that aligns with the waiver governance of the state and federal laws and statues;
- 3 years of progressive and consistent home and community base experience;
- Ability to provide case management by both social worker and Nurse;

CAP/DA Waiver - Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service, pg 67-68

Lead Agency Qualifications (cont'd)

- Maintain a physical location;
- Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
- Meet the regulatory criteria under DHHS/DHRS
- Staff to participant ratio (appropriate case mix);

CAP/DA Waiver - Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service, pg 67-68

Lead Agency Qualifications (cont'd)

- Ability to implement of services within 10 days of POC approval;
- A clear understanding of person-centered planning;
- Participate in peer reviews; and
- Sufficient cash revenue or reserve

CAP/DA Waiver - Appendix C: Participant Services, C-1/C-3: Provider Specifications for Service, pg 67-68

Lead Agency Qualifications (cont'd)

CAP/DA

- DMA will establish 1 Lead Agency per county.

- If DMA monitors to see that there are eligible individuals in a county and current Lead Agency is not providing for those individuals due to staff resources, DMA will seek alternate agency to meet needs of eligible individuals who would otherwise go unserved.

Lead Agency Qualifications (cont'd)

- CAP/C beneficiaries transitioning to the CAP/DA program have the option to continue receiving services from their CAP/C provider or select an already established CAP/DA provider in their county to provide case management.

- If the transitioning CAP/C beneficiary prefers to remain with the CAP/C provider as their case management agency, the CAP/C provider must already be trained in CAP/DA or willing to obtain training prior to the transition. The CAP/C Agency must also enroll as a CAP/DA Lead Agency through a managed change request in NCTracks.

- If the CAP/C Agency is the provider preference during the transition, the CAP/DA slot will be subtracted from the county's total approved allocation.

Service Plan

Case manager or care advisor shall:

- Complete a home visit and an adult day health visit at least quarterly during the hours of CAP/DA service provision with the CAP/DA beneficiary or the responsible party. This visit is conducted to assess the beneficiary's needs, services and supplies and to ensure appropriateness and satisfaction. The case manager or care advisor shall observe the home environment for continued health and welfare and the provision of services provided by paid caregiver. An annual visit must be conducted to perform the continued need review assessment and the plan of care. Home visits are conducted with the goal of ensuring the development of a safe and person-centered treatment plan.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.3 s

Service Plan (cont'd)

- Make a monthly contact (monthly means at least every 30 calendar days) with the beneficiary or responsible party to review the health and care needs, satisfaction with services, and assess the provision of all services and supplies to confirm their continued appropriateness.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.3 s

Service Plan-ID Team

- The case manager shall hold a quarterly Interdisciplinary Team meeting with all providers identified in the plan of care to review the provision of and continued appropriateness of these services.
- All ID Teams should be implemented by January 1, 2014.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.3 s

Service Plan (cont'd)

- Document changes in medical, functional and psychosocial status to ensure needs are met.
- Contact the beneficiary or responsible party following the construction of or installation of home modifications to confirm that the modifications were constructed to building code and safely meet the beneficiary's needs.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.3 s

Service Plan (cont'd)

- Contact the beneficiary or responsible party within two (2) business days of learned discharge from a hospital or rehabilitation facility to assess the beneficiary's health status and changes in his or her needs.
- Ensure that services offered to a CAP/DA beneficiary do not duplicate other services.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.3 s

Service Plan (cont'd)

- Locate and coordinate sources of assistance from informal sources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal health and social agencies.
- Ensure that the policies and procedures of the CAP/DA program are consist with DMA's policy and upheld to maintain the health, safety, and well-being of the beneficiary.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.3 s

Service Plan (cont'd)

- Authorize services in the amount, duration and frequency as identified on the plan of care along with a description of the tasks required. Review service provisions quarterly to ensure that services are authorized in accordance with the plan of care (POC).
- Ensure that CAP/DA beneficiaries are aware of their right to choose to participate in the CAP/DA program instead of institutional care and the right to select from among enrolled service providers.

3K-2, CAP/DA Clinical Coverage Policy, Section 6.3 s

Service Plan (cont'd)

- Review claims to ensure that services are being provided as authorized to meet the beneficiary's needs until further notice.

Service Plan (cont'd)

- The CNR assessment includes the following:
  - Completed interdisciplinary comprehensive assessment that identifies LOC, the beneficiary's preferences, strengths, needs, and ability to live safely in the community;

3K-2, CAP/DA Clinical Coverage Policy, Section 5.3.3 a

Service Plan (cont'd)

- A CNR assessment must be completed every 12 consecutive months to determine the continued medical, functional and psychosocial care needs of the beneficiary for safe community living.
- The CNR assessment must be completed by **week three** of the CAP effective month.

3K-2, CAP/DA Clinical Coverage Policy, Sections 5.3.3 c

Service Plan (cont'd)

- The POC must not be initiated prior to the completion of the interdisciplinary comprehensive assessment.
- The annual/CNR POC must be completed during the month of the CAP effective date. The CNR POC is effective the first day of the month following the CAP effective date and expires one calendar year later

3K-2, CAP/DA Clinical Coverage Policy, Sections 5.3.3 c, 5.3.4

Service Plan (cont'd)

Benefit Package:

- Adult day health (S5102)
- Personal care aide (S5125)
- Home accessibility and adaptation (S5165)
- Meal preparation and delivery (S5170)
- Institutional respite services (H0045)
- Non-institutional respite services (S5150)
- Personal Emergency Response Services (S5161)
- Oral Nutritional Supplement (age 21>) (B4150 BO to B4154 BO)
- Food Thickener (B4100)

3K-2, CAP/DA Clinical Coverage Policy, Sections 1.0, 6.1.5, 6.1.12, 6.1.13

Service Plan (cont'd)

- Specialized medical equipment and supplies
  - Disposable Liner (T4535) and Reusable diaper/brief (T4539)
  - Medication Dispensing Boxes (T2028)
- Participant goods and services (T2025)
- Community transition services (T2038)
- Training, education and consultative services (S5111)
- Assistive technology (T2029)
- Case management (T1016)
- Care advisor (CAP/Choice only) (T2041)
- Personal assistant (CAP/Choice only)(S5135)
- Financial management services (CAP/Choice only)(T2040)

3K-2, CAP/DA Clinical Coverage Policy, Sections 1.0, 6.1.5, 6.1.12, 6.1.13

Risk Assessment & Mitigation

- An Individual Risk Agreement (IRA) that outlines the risks and benefits to the beneficiary of a particular course of action that might involve risk to the beneficiary, the conditions under which the beneficiary is responsible for the agreed upon course of action, and the accountability trail for the decisions that are made. An individual risk agreement permits individuals to accept responsibility for their choices personally, through surrogate decision makers, or through planning team consensus.

3K-2, CAP/DA Clinical Coverage Policy, Section 7.5 & Appendix C

Critical Incident Reports

- Critical Incident will be reported based on whether it is a Level I or Level II Incident.

CAP/DA Waiver - Appendix G: Participant Safeguards, Appendix G-1: Response to Critical Events or Incidents, pg 169-170

Critical Incident Reports (cont'd)

Level I Incidents must be documented on a "Critical Incident Report" within 5 *business* days & filed in agency file as you do now. These incidences include:

- hospitalizations,
- ER visits,
- falls,
- death by natural causes,
- failure to take medication as ordered.

CAP/DA Waiver - Appendix G: Participant Safeguards, Appendix G-1: Response to Critical Events or Incidents, pg 169-170

Critical Incident Reports (cont'd)

Level II Incidents must be documented on a "Critical Incident Report" form and submitted to DMA within 5 *business* days. These incidences include:

- APS referrals,
- death other than expected or natural causes,
- restraints and seclusions,
- misappropriation of consumer-directed funds,
- falls requiring hospitalization or results in death,

CAP/DA Waiver - Appendix G: Participant Safeguards, Appendix G-1: Response to Critical Events or Incidents, pg 169-170

Critical Incident Reports (cont'd)

Level II Incidents (cont):

- traumatic injury,
- medication administration that results in injury or hospitalization,
- wandering away from home,
- homicide/suicide and media related events.

CAP/DA Waiver - Appendix G: Participant Safeguards, Appendix G-1: Response to Critical Events or Incidents, pg 169-170

Restraints

- CAP/DA does not permit the use of restrictive interventions that restrict participant movement; participant access to other individuals, locations, or activities; restrict participant rights; or that employ aversive methods to modify behavior, unless provided for a waiver participant for whom it is not used as a restraint, but for safety - such as bed rails, Gerri chair, lift chair, safety straps on wheelchairs.

3K-2, CAP/DA Clinical Coverage Policy, Sections 3.2.1 e

Restraints (cont'd)

- **Inappropriate use of Restraint is a Level II Critical Incident** & must be reported within 5 *business* days to DMA.

3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1 e

Financial Accountability

- The monthly Medicaid cost limits of the budget should only include waiver services.
- List all services to be received by the beneficiary in the cost summary.
- Include the cost for waiver services under the Medicaid column. (see services on slide 45 & 46 of power point)
- For all other Regular State Plan Medicaid services, include the cost in the "other" column.

CAP/DA Waiver - Appendix E: Participant Direction of Services, E-2: Opportunities for Participant-Direction, b, ii

Sample Cost Summary

Client SSN# 555-55-5555

SECTION D **Cost Summary**

List all services to be provided. When payor is not Medicaid, use the following codes in column S.

1 Medicare 2 Title XX 3 Title III 4 Insurance 5 Local Funds 6 Voc Rehab 7 Family/Friends 8 Client (non-covered services only) 9 ..... 10 .....

Service	Code	P/R	Prov Agcy	Quantity	From Date	To Date	Unit Rate	Mcaid Cost	Other Cost	S
CM Assessment	T1016		A-1Agency	4H/Y	11-1-2013	10-31-2014	$14.14	18.85		
CM	T1015		A-1Agency	3 H/Mnth	11-1-2013	10-31-2014	$14.14	169.68		
Personal Care Serv	S5125		New Hope	30 H/Wk			3.47	1790.52		
PERS	S5161		Call Me	1/Mnth			29.70	29.70		
Semi Elec Hosp Bed	E0260	R	MedHome		10-02-13	10-01-14	124.58		124.58	
Power Wheelchair	K0824	P	MedHome		04-12-13	04-11-14	4709.78		392.48	
Commode Chair	E0163	P	MedHome		10-02-13	10-01-14	91.58		7.63	
Skilled Nursing	RC550		Nice Nurse	1/Mnth			103.33		103.33	

Subtotal	2008.75	628.02	
Grand Total	2636.77		

Program Integrity
Case Documentation

- All assessment, care planning, monitoring, referral, follow-up and linkage activities in the case record and on approved agency forms. The documentation must fully detail the purpose of the intervention of the case management or advisement activity to include date and duration of time taken to complete the case management or advisement task.

  3K-2, CAP/DA Clinical Coverage Policy, Section 7.9

Program Integrity
Case Documentation (cont'd)

- The documentation is completed within three (3) business days of the intervention and is signed and dated by the case manager or care advisor.

- Timely and accurate documentation is required for all Medicaid services.

3K-2, CAP/DA Clinical Coverage Policy, Section 7.9

DMA's CAP Unit Contact Information

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