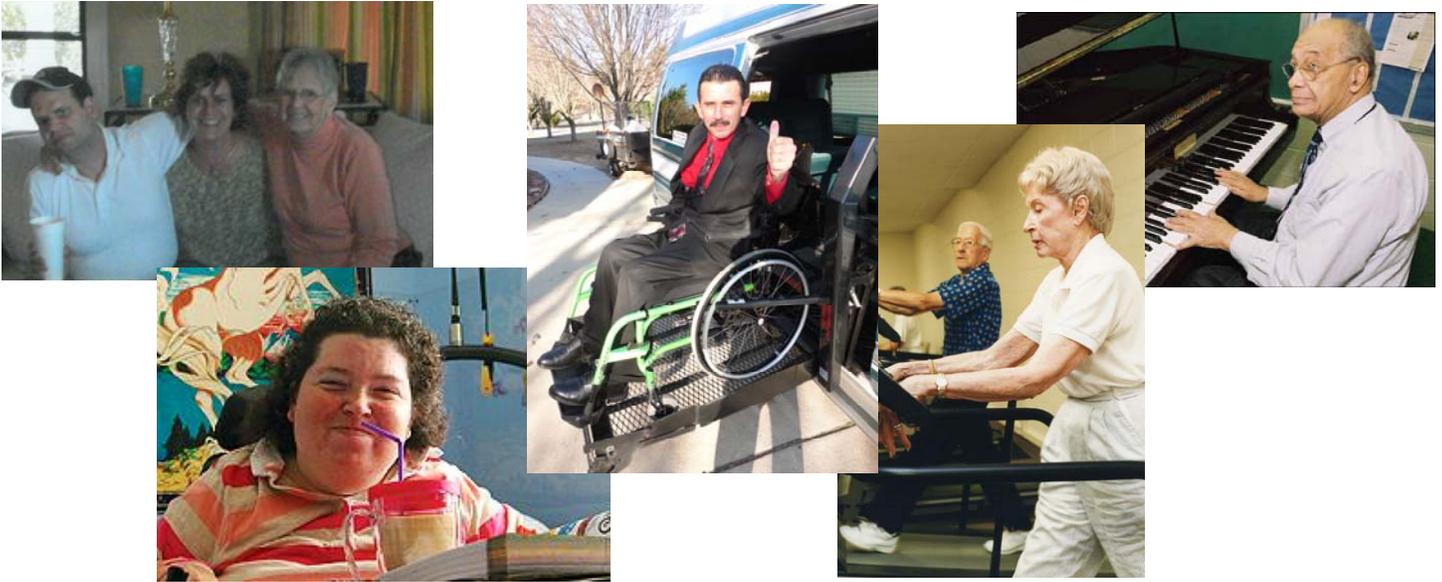


2013 North Carolina Medicaid Community-Based Long Term Services and Supports



Program Eligibility and Benefits Reference Guide



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NORTH CAROLINA MEDICAID

NC Medicaid

Medicaid is a health insurance program for certain low-income individuals or families who are in need of medical care. It is governed by federal and state laws and regulations. Medicaid is administered by the North Carolina Division of Medical Assistance and monitored by the U.S. Centers for Medicare and Medicaid Services. There are two major program areas in Medicaid: 1) Aged (MAA), Blind (MAB), and Disabled (MAD) and 2) Families and Children. There are some other Medicaid programs that only provide limited services.

What does Medicaid Cover?

The Medicaid State Plan must cover:

- Ambulance
- Durable Medical Equipment
- Family Planning
- Federally Qualified Health Centers
- Health Check
- Home Health
- Hospitalizations - Inpatient/Outpatient
- Nurse Midwife/Nurse Practitioner
- Nursing Facility
- Labs and X-rays
- Physicians

For Children Only:

- Dental Services
- Hearing Aids
- Routine Eye Exams and Visual Aids

A State may also elect to cover:

- Case Management
- Chiropractor Services
- Community Alternatives Programs
- Dental Services/Dentures for Adults
- Eye Care for Adults
- Home Infusion Therapy
- Hospice
- Intermediate Care Facilities
- Mental Health Services
- Non-Emergency Transportation
- Orthotics and Prosthetics
- Personal Care Services
- Physical, Occupational and Speech Therapy
- Podiatry
- Prescription Drugs
- Private Duty Nursing
- Rehabilitative Services

Important Considerations:

North Carolina Medicaid is constantly changing. It is very important to regularly check for changes to Medicaid programs. A good way to stay informed is by reading the Medicaid Provider Bulletins which can be found at [:http://www.ncdhhs.gov/dma/bulletin/index.htm](http://www.ncdhhs.gov/dma/bulletin/index.htm)

For More Information About Medicaid:

Go to the N.C. Division of Medical Assistance Website - <http://www.ncdhhs.gov/dma/>

Call the N.C. Division of Medical Assistance at (919) 855-4000

Go to U.S. Centers for Medicare and Medicaid Services Website - <http://www.medicaid.gov>

WHO IS ELIGIBLE FOR MEDICAID?

Basic Medicaid Eligibility

General Eligibility Requirements include:

- being a resident of North Carolina and a U.S. citizen or qualified alien;
- not being an inmate of a public institution, except for individuals incarcerated in a NC DOP facility and have their Medicaid benefits placed in suspension;
- meeting income criteria;
- having assets at or below the allowable limits;
- providing verification of all health insurance; and,
- having a Social Security Number or applying for one.

Recipients of Supplemental Security Income (SSI) and State/County Special Assistance are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination is required.

How to Apply:

- In person at the local department of social services in the county where the individual resides. An appointment is not necessary, although one may be requested.
- By mail or fax — Applications are available at www.ncdhhs.gov/dma/medicaid/applications.htm
- Online at www.ePASS.nc.gov

Representatives may apply on behalf of individuals unable to apply for themselves.

What information may be needed to determine eligibility?

- Social Security Card
- Medicare Card
- Proof of Identity
- Proof of N.C. State Residency
- Bank Statements
- Life Insurance Policies
- Medical Bills
- Proof of Income
- Health Insurance Information
- Proof of Citizenship or immigration status
- Guardianship or Power of Attorney Papers (if acting on someone else's behalf)

Important Consideration:

- Even when an individual qualifies for Medicaid, it does not always mean they qualify for a specific Medicaid program. Most Community-Based Long-Term Services and Supports programs have criteria in addition to the requirements for basic eligibility.

For More Information About Medicaid Eligibility, Call (919) 855- 4000

Or go to the following web pages - <http://www.ncdhhs.gov/dma/medicaid/who.htm>
http://www.ncdhhs.gov/dma/medicaid/Medicaid_eligibility_0713.pdf

ADULT MEDICAID ELIGIBILITY REQUIREMENTS

Financial Eligibility

When applying for Medicaid, monthly income is calculated by subtracting certain deductions from the household's gross income. Social Security, veteran's benefits, wages, pensions and other retirement income are counted. Deductions vary with each Medicaid program. For Adult Medicaid, the countable monthly income cannot exceed \$958 for an individual or \$1293 for a family of two. Financial resources may not exceed \$2,000 for an individual or \$3,000 for a couple. Resources include cash, bank accounts, retirement accounts, stocks and bonds, cash value of life insurance policies, and other investments. The value of the primary residence, one car, home furnishings, clothing and jewelry are not counted.

There are two Medicaid coverage groups:

- **Categorically Needy (CN):** Provides full Medicaid coverage for individuals whose income and resources are at or below allowable limits.
- **Medically Needy (MN):** Allows individuals whose income is higher than the CN limit to qualify for Medicaid by meeting a deductible.

Aged, Blind, and Disabled Coverage Categories:

- **MAA** - Individuals aged 65 or older
- **MAD, MAB** - Individuals under the age of 65 who are disabled or blind according to Social Security standards.
- **MQB** - Limited coverage for Medicare beneficiaries

Medicaid Deductible:

If the family income and/or resources are over the limits, but there is a high cost for medical bills, the recipient may still qualify for Medicaid and have to incur medical expenses to meet a Medicaid deductible. Medical expenses include: 1) hospitalizations; 2) doctor, dentist or therapist; 3) clinic and laboratory charges; 4) Rx; 5) OTC drugs with receipts; 6) medical supplies; 7) equipment (e.g. dentures, eyeglasses, hearing aids, walkers, wheelchairs, etc.); 8) prescribed vitamins or supplements; 9) medical transportation; and 10) private insurance premiums. Individuals with deductibles who live in the community will have to spend down to \$242 per month. (A family of two=\$317/mo., three=\$367/mo., four=\$400/mo., five=\$433/mo.) Medicaid deductibles must be met on a monthly basis for CAP waivers.

Important Considerations:

- When an individual lives in a nursing facility and has a spouse living at home, a portion of the income of the spouse in the facility may be protected to bring the income of the spouse at home up to a level specified by federal law. Currently, that amount is \$1,939/mo. and can be as much as \$2,898 depending upon the at-home spouse's cost for housing. The amount protected for the at-home spouse is not counted in determining the eligibility of the spouse living in the nursing facility.
- Additionally, the countable resources of a couple are combined and a portion is protected for the spouse at home. That portion is half the total value of the countable resources, but currently not less than \$22,728 or more than \$113,640. The amount protected for the at-home spouse is not countable in determining the eligibility of the spouse living in the facility.
- When a person gives away resources and does not receive compensation with a value at least equal to that of the resources given away, he/she may be penalized. Medicaid will not pay for care in a nursing facility or care provided under the Community Alternative Program or other in-home health services and supplies for a period of time that depends on the value of the transferred resource.

**COMMUNITY ALTERNATIVES PROGRAM
FOR DISABLED ADULTS AND THE ELDERLY**

CAP/DA

What is CAP/DA? This program is designed to provide an alternative to institutionalization for eligible individuals who prefer to be in their homes and who would be at risk of nursing facility placement without services. CAP/DA supplements rather than replaces the formal and informal services and supports already available to an individual. These services are intended for situations where no household member, relative, caregiver, landlord, community/volunteer agency, or third party payer is able or willing to meet the complete needs of the individual. CAP/DA benefits include Adult Day Health, personal care aide, home modification and mobility aids, meal preparation and delivery, institutional respite services, non-institutional respite services, Personal Emergency Response Services, supplies allowable under the waiver, participant goods and services, transition services, training and education services, assistive technology and case management. .

Important Considerations:

- The CAP Lead Agency completes a needs assessment to identify the appropriate service and funding level for each applicant. The cost for LTSS Medicaid services cannot exceed the monthly cost limit.
- Recipients may live in an institutional setting at the time of application and screening, but must be discharged to a private residence before receiving services from the program.
- If the individual has a Medicaid deductible, it must be met at the beginning of every month before CAP/DA will pay for services.
- Services suspended during a short-term nursing facility or rehab center stay are eligible to be reinstated into the program upon discharge.
- For most Adult Care Home residents, CAP/DA is not a good consideration to support a transition because they do not meet the Nursing Facility Level of Care criteria.

For more about CAP/DA services and eligibility, go to:

CAP/DA Clinical Coverage Policy;
<http://www.ncdhhs.gov/dma/mp/3K2.pdf>

Or

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

Who Qualifies for CAP/DA?

To be eligible for CAP/DA, the individual must:

- Be 18 years of age or older.
- Reside in or intend to transitioning to a private residence
- Be eligible for Long Term Services and Supports (LTSS) Medicaid under one of the Medically Needy Categories. This is determined by the county department of social services where the individual resides.
- Be determined to need Nursing Facility Level of Care.
- Have a documented medical diagnosis and need for the services provided under CAP/DA.
- Be at risk of institutionalization within 30 calendar days.
- Require one or more waiver services, in addition to case management services.
- Be compliant with the established Plan of Care. Non-compliance by the individual and the identified primary caregiver creates a health, safety and well-being risk.

This process begins with the completion of the FL2 (aka Long Term Services Form) that must be signed by a physician.

To Access CAP/DA services:

Contact the county CAP/DA Lead Agency-

<http://www.ncdhhs.gov/dma/cap/CAPContactList.pdf>

Contact the DSS in the county where the individual resides-

<http://www.ncdhhs.gov/dss/local/>

DSS staff will coordinate transfers for Medicaid recipients transitioning from one county to a home in a different county.

COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS AND THE ELDERLY-CHOICE OPTION

CAP/CHOICE

What is CAP/CHOICE? CAP/CHOICE is a self-directed care option under the Community Alternatives Program for Disabled Adults (CAP/DA) for individuals who wish to remain at home and have increased control over their services and supports. CHOICE allows participants to more fully direct their care by selecting and managing a personal assistant and by having more flexibility in tailoring plans to meet their care requirements. In addition to the services available under CAP/DA, CHOICE offers personal assistance services, financial management services (FMS), and a care advisor. The personal assistant is hired by the recipient to provide personal and home maintenance tasks. FMS, known as a fiscal intermediary, is available to: 1) conduct background checks and verifications on prospective personal assistants, 2) maintain a separate account on each recipient's services, 3) pay the personal assistants and withhold/calculate appropriate taxes, 4) create monthly payroll statements, and 5) file claims for work completed by the personal assistant with the funding agency. The care advisor is a specialized case manager who focuses on empowering participants to define and direct their own personal assistance needs and services, supporting the individual, rather than directing and managing their plan.

Important Considerations

- Individuals new to the program are encouraged to enroll in CAP/DA first, where they can be assessed for CHOICE participation before enrolling in the program.
- Self-direction is not for everyone. If the person is not appropriate for or comfortable with the responsibilities associated with the CHOICE he/she will be re-enrolled in traditional CAP/DA services.

For more about CHOICE services and eligibility, go to:

CAP/DA Clinical Coverage Policy
<http://www.ncdhhs.gov/dma/mp/3K2.pdf>

OR

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

Who Qualifies for CHOICE?

In addition to meeting the eligibility requirements for CAP/DA, the individual must:

- Understand the rights and responsibilities of directing one's own care.
- Be willing and capable of assuming the responsibilities for self-directed care, or select a representative who is willing and capable to assume the responsibilities to direct the recipient's care.

The prospective recipient or their designated representative will be given a self-assessment questionnaire to determine the recipient's ability to direct care or identify training opportunities to build competencies to aid in self-direction.

Access to the CHOICE program occurs:

Through the county CAP/DA Lead Agency-
<http://www.ncdhhs.gov/dma/cap/CAPContactList.pdf>

Through the DSS in the county where the individual resides-
<http://www.ncdhhs.gov/dss/local/>

NORTH CAROLINA INNOVATIONS WAIVER

Innovations

What is the Innovations Waiver? The NC Innovations Waiver provides an array of community-based services and supports for individuals with Intellectual Disabilities (ID) promoting choice, control and community membership. Innovations offers participants: 1) support to be fully functioning members of the community; 2) realization of real life outcomes using Promising Practices; 3) service options to facilitate living in homes of choice; 4) employment/engagement in a purposeful way of their choice; 5) opportunities to direct services; 6) educational opportunities; and, 7) support to foster development natural support networks and to be less reliant on formal support systems. Base Budget Services include Community Networking, Day Supports, In-Home Intensive Supports, In-Home Skill Building, Personal Care Services, Residential Supports, Respite, and Supported Employment. Add-On Budget services include Assistive Technology, Equipment & Supplies, Community Guide, Community Transition, Crisis Services, Financial Support Services, Individual Goods and Services, Home Modifications, Natural Supports Education, Specialized Consultation Services, and Vehicle Modifications. Base and Add-on Budget services are determined through participant assessment.

Important Considerations:

- There are times an individual with an intellectual disability (ID) is residing in a nursing facility.
- An individual cannot receive services from Innovations and CAP/DA at the same time.
- When a person is identified as having an ID diagnosis, it is essential to get the LME/MCO involved as quickly as possible. Services can only be accessed through the LME/MCO network.
- At times it may not be clear if the individual is appropriate for services or if they will qualify. The LME/MCO must conduct assessments and make all mental health related eligibility determinations. It is essential to get this process started as quickly as possible to avoid unnecessary delays in transitions.

For more about Innovations services and eligibility go to:

The N.C. Innovations 1915 (B) (C) Waiver Application -

http://www.ncdhhs.gov/dma/lme/1915BC_Waiver_Renewal.pdf

Contact the local LME/MCO

Call the NC Division of Medical Assistance Behavioral Health Section: phone 919-855-4100

Who Qualifies for Innovations? The individual must: 1) be eligible for Medicaid; 2) live in an ICF-IID facility and wish to leave or be at high risk of placement in an ICF-IID facility; 3) choose NC Innovations rather than live in an institution; 4) need NC Innovations services per the person-centered Individual Support Plan; 5) must use at least one service monthly; 6) have services exceeding the \$135,000 annual waiver cost limit; 7) Live in a private residence or a licensed facility with six or fewer persons; and, 8) be ICF-IID level of care (LOC).

To meet ICF-IID (Intermediate Care Facility) Level of Care, a person must require active treatment and have a diagnosis of Intellectual Disability (ID) or a condition closely related to ID as characterized by significant limitations in both intellectual functioning and in adaptive behavior. A closely related condition refers to individuals who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy and occurred before the age of 22 OR any condition, other than mental illness, found to be closely related to Intellectual Disability because the condition results in impairment of general functioning OR adaptive behavior similar to a person with ID and is manifested before the age of 22. This condition is likely to continue indefinitely and it results in functional limitations to three or more of the following: 1) self-care; 2) understanding/use of language; 3) learning; 4) mobility; 5) self-direction; or 6) capacity for independent living.

Access to the Innovations program can occur through:

The Local Mental Health Entity (LME) or Managed Care Organization (MCO) -

<http://www.ncdhhs.gov/dma/lme/LME-Contact-Info.html>

PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

PACE

What is PACE? The Program of All-inclusive Care for the Elderly (PACE) is a managed care model centered around the belief that it is better for the well-being of seniors with chronic care needs and their families to be served in the community whenever possible. PACE can provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. Medical care is provided by an Inter-Disciplinary Team (IDT) led by a PACE physician. This team is familiar with the history, needs and preferences of each participant. PACE services include delivery of all needed medical and supportive services, medical specialists (e.g. cardiology, dentistry, optometry), adult day health care, physical, occupational, speech and recreational therapies, meals and nutritional counseling by a registered dietician, social work and social services, hospital and nursing home care when necessary, home health care and personal care, all necessary prescription drugs and respite care.

Important Considerations:

- All services are provided directly by the program or through its provider network
- PACE will only pay for services delivered by providers in its network
- While enrolled in PACE, providers will no longer be able to bill Medicare or Medicaid
- Individuals enrolled in PACE who move outside the service area will no longer be eligible for PACE services, unless the move is to another program's service area.
- PACE IDT members can perform assessments while the individual is in the nursing facility

For more information about PACE services and eligibility go to:

North Carolina PACE Association

<http://ncpace.org>

NC PACE Programs List

<http://ncpace.org/pace-in-nc/pace-sites>

National PACE Association site

<http://www.npaonline.org/website/article.asp?id=4&title=Home>

PACE Clinical Coverage Policy

<http://www.ncdhhs.gov/dma/mp/3B.pdf>

Call the Home and Community Care Section of the NC Division of Medical Assistance: phone 919-855-4100

Who Qualifies for PACE?

To be eligible for PACE, the individual must:

- Be 55 years of age or older.
- Live in a PACE program service area.
- Be eligible for Long Term Services and Supports (LTSS) Medicaid under one of the Medically Needy Categories.
- Be determined by a physician to need Nursing Facility Level of Care. This process begins with the completion of the FL2 form that must be signed by a physician.
- Meet program specific criteria that includes: 1) ensuring the person lives in a home that does not jeopardize the health, safety and well-being of the individual, the family, or the service provider, and 2) compliance with the plan of care.

Only about percent of participants reside in a nursing facility, even though all must be certified to need nursing facility level of care. If a PACE recipient needs nursing facility care, the PACE program pays for it and continues to coordinate the individual's care.

To Access PACE:

- A referral can be made to the PACE program that has a service area covering the address where the individual resides. The program will assess the individual and facilitate the enrollment process for those determined eligible.
- Medicaid recipients and individuals who are dually-eligible may request PACE services through their local DSS <http://www.ncdhhs.gov/dss/local/>

PERSONAL CARE SERVICES

PCS

What is PCS? For eligible Medicaid recipients, PCS provides an in-home aide who delivers person-to-person hands-on assistance for the five activities of daily living (ADLs) that include eating, dressing, bathing, toileting, and mobility. Basic PCS provides up to 60 hours of service per month and PCS Plus provides up to 80 hours. The number of PCS service hours is determined through an independent assessment conducted by an Independent Assessment Entity and is based upon each individual's functional limitations and need for ADL assistance.

Important Considerations

PCS:

- Has an average wait time of two weeks for an independent assessment.
- Does not require nursing facility level of care for participation.
- Must be ordered by a physician.
- Is appropriate for individuals whose needs can be met safely in the home by family members and other informal caregivers, with support by scheduled visits from specially trained PCS aides.
- Does not provide enough assistance to replace facility-based services for individuals who require ongoing care, supervision, or monitoring by a nurse or other health care professional.
- Cannot duplicate in-home aide services provided under Medicaid waiver programs, private duty nursing, state block grants, and other state and local programs that provide hands-on assistance with ADLs.
- Cannot solely provide house keeping or homemaking tasks.
- Cannot be provided by a live-in aide, spouse, child, parent, sibling, grandparent, grandchild, or equivalent step or in-law relationship to the recipient.

For more information about PCS services and eligibility go to:

<http://www.ncdhhs.gov/dma/mp/3C.pdf>

OR

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

Who Qualifies for PCS?

Medicaid covers the cost of PCS if:

- The individual qualifies for Medicaid
- The individual has either 1) three of five ADLs which require limited hands-on assistance; 2) two ADLs, one of which requires extensive assistance; or 3) two ADLs, one of which requires complete assistance
- PCS is linked to a documented medical condition(s) causing the functional limitations requiring the PCS
- The individual is under the ongoing direct care of a physician for the medical condition(s) causing the functional limitations
- The individual is medically stable and does not require continuous monitoring by a licensed nurse or other licensed health care professional
- The home is safe for the recipient and PCS provider(s) and is adequately equipped to implement needed services
- There is no available, willing, or able household member to provide ADL assistance on a regular basis
- There is no other third-party payer responsible for covering PCS or similar in-home aide services

Eligible individuals may live in a private living arrangement, a licensed adult care home, a combination home, a licensed group home or a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency.

To Access PCS:

The individual's primary care physician must make a referral for PCS.

PRIVATE DUTY NURSING

PDN

What is Private Duty Nursing? PDN is a skilled nursing service comparable to the care provided by hospital nursing or skilled nursing facility staffs, but is provided in the individual's private residence. PDN is based upon a written individualized plan of care approved by an attending physician. Case Management is not provided with this service. PDN must be provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) employed by a licensed home care agency. Eligible individuals may receive up to 112 hours per week.

Important Considerations

- PDN services may be used outside the home for normal life activities, such as supported or sheltered work settings, licensed child care, school, school related activities, and religious services/activities.
- It is recommended that there be a second trained informal caregiver for instances when the primary informal caregiver is unavailable due to illness, emergency, or need for respite.
- An individual may receive expanded PDN services if they qualify for PDN services and either: 1) use a respiratory pacer; 2) have dementia or a cognitive deficit and are otherwise alert or ambulatory; 3) requires IV, PICC or central line infusions; 4) require a licensed nurse for assessment and interventions using Diastat, oxygen, etc for seizures; 5) have a primary caregiver 80 years or older or who has a disability that interferes with the ability to provide care; or, 6) Adult Protective Services has determined that additional hours would help ensure health, safety and welfare. Beneficiaries receiving expanded PDN services are eligible for more hours of care within the program maximum of 112 hours per week.

For more about PDN services and eligibility go to:

PDN Clinical Coverage Policy

<http://www.ncdhhs.gov/dma/mp/3G.pdf>

Call the Home and Community Care Section of the N.C. Division of Medical Assistance: phone 919-855-4100

Who Qualifies for PDN?

To be eligible for PDN standard nursing services, the individual must:

- Be eligible for Medicaid under one of the Medically Needy Categories as determined by the local county department of social services where the individual resides.
- Reside in a private residence.
- Have a documented medical need for skilled nursing care in the home, with a prior approval from the individual's attending physician.
- Have at least one trained, informal caregiver to provide direct care to the beneficiary during planned or unplanned absences of PDN staff.
- Be ventilator-dependent for at least eight hours per day, or meet four of the following criteria: 1) unable to wean from a tracheostomy; 2) require nebulizer treatments at least two scheduled times per day and one as needed; 3) require pulse oximetry readings every nursing shift; 4) require skilled nursing or respiratory assessments every shift due to a respiratory insufficiency; 5) require oxygen as needed or rate adjustments at least two times per week; 6) require daily tracheal care; 7) require PRN tracheal suctioning requiring a suction machine and a flexible catheter; or 8) at risk for requiring ventilator support.

To Access PDN Services:

The individual must ask a primary care or attending physician to make a referral for PDN.

Nurse Consultants at the North Carolina Division of Medical Assistance provide prior approval determinations for PDN.

DURABLE MEDICAL EQUIPMENT AND SUPPLIES

DME

What is DME? Durable medical equipment (DME) refers to the following categories of equipment and related supplies for use in a Medicaid recipient's home:

- Inexpensive or Routinely Purchased Items
- Capped Rental/Purchased Equipment
- Enteral Nutrition Equipment
- Oxygen and Oxygen Equipment
- Related Medical Supplies
- Service and Repair
- Other Individually Priced Items
- Equipment Requiring Frequent and Substantial Servicing

DMA has designated Roche Diagnostics Corporation Diabetes Care as the preferred manufacturer for glucose meters, test strips, control solutions, lancets and lancing devices. Additional information on ACCU-CHEK diabetic supplies is available under the "What's New" provider section on the DMA website. Questions should be directed to ACCU-CHEK Customer Care at 1-877-906-8969.

What Qualifies as DME? There are two DME categories for equipment and related supplies for use in a beneficiary's home: 1) *Inexpensive or Routinely Purchased* are items purchased for a beneficiary and 2) *Capped Rental or Purchased Equipment* are rented or purchased as follows:

- The item is **rented** if the physician, physician assistant, or nurse practitioner documents that the anticipated need is six months or less.
- The item may be **rented** or **purchased** if the physician, physician assistant, or nurse practitioner documents that the anticipated need exceeds six months. Once rental is initiated on an item, a subsequent request for prior approval of purchase of that item will be denied. The item becomes the property of the beneficiary when the accrued rental payments reach NC Medicaid (Medicaid) allowable purchase price.

The following requirements must be met before an item can be considered DME:

It 1) can withstand repeated use; 2) is primarily and customarily used to serve a medical purpose; 3) is not useful to a beneficiary in the absence of an illness or injury; 4) is appropriate for use in the home (for the purpose of this policy, home includes a private residence for both a Medicaid and NCHC beneficiary or an adult care home for only a Medicaid beneficiary); and, 5) is intended to be used by only one beneficiary. All requirements above must be met before an item can be considered medical equipment. The item becomes the property of the beneficiary when the accrued rental payments reach the NC Medicaid allowable purchase price.

Medical supplies are non-durable supplies that: 1) are disposable, consumable, and non-reusable in nature; 2) cannot withstand repeated use by more than one beneficiary; 3) are primarily and customarily used to serve a medical purpose; 4) are not useful to a beneficiary in the absence of illness or injury; and 5) are ordered or prescribed by a physician, physician assistant, or nurse practitioner. For a list of covered Durable Medical Equipment, reference the most recent DME Fee Schedule:

<http://www.ncdhhs.gov/dma/services/dme.htm> (Bottom of the web-page) **Please note that items with an asterisk require prior approval.**

For more information - DME Clinical Coverage Policy <http://www.ncdhhs.gov/dma/mp/dmepdf.pdf> or call (919) 855-4310

EPSDT

What is EPSDT? Early and Periodic Screening, Diagnostic, and Treatment is a federal Medicaid requirement where the state Medicaid agency has to cover services, products, or procedures for Medicaid recipients under 21 years of age. A service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). Treatment need not improve the recipient's condition taken as a whole, but need only be medically necessary to improve one of the child's diagnoses or medical conditions. Under EPSDT, there is: 1) no waiting list; 2) no monetary cap on the total cost; 3) no upper limit on the number of hours or units; 4) no limit on the number of visits to a physician, therapist, dentist, or other licensed clinician; 5) no set list that specifies when or what services or equipment may be covered; 6) no co-payment or other cost to the recipient; 7) coverage for services that are never covered for recipients 21 years of age and older; and, 8) coverage for services not listed in the N.C. State Medicaid Plan.

Important Considerations:

- Prior approval from the Division of Medical Assistance may be required to verify medical necessity for some services.
- Any request for services for a CAP Waiver recipient under age 21 must be evaluated under BOTH the CAP Waiver and EPSDT.
- A child enrolled in a CAP waiver can receive BOTH waiver services and EPSDT services. However, if enrolled in CAP/DA, the cost of the recipient's care must not exceed the monthly cost limit. A child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.
- If enrolled in the Community Alternatives Program for Persons with Intellectual Disabilities (CAP-ID), prior approval must be obtained to exceed \$85,000 per year.

For more information about EPSDT go to:

NC EPSDT Policy Instructions-

www.ncdhhs.gov/dma/epsdt/epsdtpolicyinstructions.pdf

OR

Call the N.C. DMA Clinical Policy and Programs Section: (919) 855-4100

EPSDT services must be:

- Covered within the scope of those services listed in the federal law, 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act.
<http://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXIX-sec1396d.pdf>
- Medically necessary to correct or improve a physical or mental illness, or a health problem diagnosed by the individual's physician, therapist, or other licensed practitioner.
- Determined to be medical in nature, safe and effective
- Recognized as an accepted method of medical practice or treatment and must not be experimental or investigational

In order to receive payment, the provider must be enrolled with Medicaid Services for the specific service being billed and have prior approval.

To Access Services Through EPSDT:

If a child needs a treatment or service not normally covered by Medicaid, the physician or other licensed clinician must request prior approval by writing to:

Assistant Director for Clinical Policy and Programs
Division of Medical Assistance
2501 Mail Services Center
Raleigh, NC 27699-2501
Fax 919-715-7679

CCNC/CA

What is Community Care of North Carolina/Carolina Access? It is a statewide managed care program with 14 regional networks serving all 100 counties and more than 1 million Medicaid recipients. Participating network primary care physicians (PCPs) receive a per-member-per month fee to provide a medical home and participate in disease management and quality improvement programs. CCNC links recipients to a primary care medical home and creates networks that: 1) join primary care homes with other segments of the local health care system (e.g. hospitals, health departments, mental health agencies, social services); 2) are capable of creating systems of care; 3) are responsible for managing recipient care; 4) supports a patient-centered medical home; and 5) provides critical supports during care transitions.

Important Considerations:

- If a medical home is not chosen by the enrollee, one may be assigned.
- The medical home provides treatment and/or medical advice 24 hours a day, 7 days a week.
- CCNC has health care managers who can assist enrollees with understanding a physician's instructions, making appointments, explaining how to take medications and teaching the recipient how to manage chronic care needs.
- The PCP will make referrals to specialists as needed.

For More Information About CCNC/CA go to:

The CCNC Website - <https://www.communitycarenc.org/>

Call a CCNC Regional Managed Care Consultant -

http://www.ncdhhs.gov/dma/ca/MCC_0212.pdf

Call the N.C. DMA Managed Care Program: 919-855-4780

Who Qualifies For CCNC?

Enrollment in CCNC/CA is automatic for Medicaid recipients unless an individual has certain medical conditions. Reasons for exemption include a terminal illness, active chemotherapy or radiation therapy (until the completion of the therapy), and impaired mental/cognitive status that makes it impossible for the adult recipient to comprehend and participate in the program. Other diagnoses and information is considered on a case-by-case basis. CCNC enrollees must have a designated medical home.

For the Care Transitions Program, CCNC targets Aged, Blind, and Disabled (ABD) and chronically ill individuals who have complex care needs and meet the CCNC screening criteria for intensive Chronic Care Management services. It is anticipated that these individuals would require care in multiple settings. CCNC has a standardized care management process to provide critical interventions that empower the individual/caregiver with self-management skills. The ultimate goals for all CCNC Transitional programs are to promote better health outcomes for individuals served and to decrease utilization of inpatient and emergency department services through focused Care Management interventions.

Access to CCNC can occur through:

The departments of social services (DSS) in the county where the individual resides-<http://www.ncdhhs.gov/dss/local/>. Local DSS offices have a complete list of participating primary care physicians.