

SECTION 1 CAP/C CONCEPTS AND PRINCIPLES

CHAPTER 1 Person/Family-Centered Planning and Practice

SP
Service
Plans

Much of this chapter deals with requirements for Service Plans.

WHAT IS FAMILY-CENTERED PLANNING?

This phrase refers to principles which if followed lead to partnership and collaboration between parents and professionals to ensure the best possible supports and services for a child with a disability and for the child's entire family. Family-centered care planning ensures the involvement and participation of family members in all aspects of care planning, so services are tailored to best address the family's needs and strengths. In fact, family members are not simply involved; they direct the process.

Family members choose who will help them; family members and friends are frequent contributors and the more traditional, professional service providers may also be included.

The assessment guides the care planning process.

Expected outcomes include recommendations from the family regarding the types of services that will be most helpful to them to enable the child and family to live a better and more complete life. Plans draw upon diverse resources, mixing paid and natural supports to best meet the goals set. Plans also are designed to ensure that these supports are delivered in a consistent, respectful manner.

The case manager ensures that services, supports and treatment recommended and incorporated into the plan of care are implemented in accordance with each family's unique needs, goals, expressed preferences and decisions concerning their life in the community.

Care planning requires frequent updates based on the case manager's and family's assessment of progress toward goals.

WHAT ARE THE PRINCIPLES OF FAMILY-CENTERED PRACTICE?

The principles of family centered practice are:

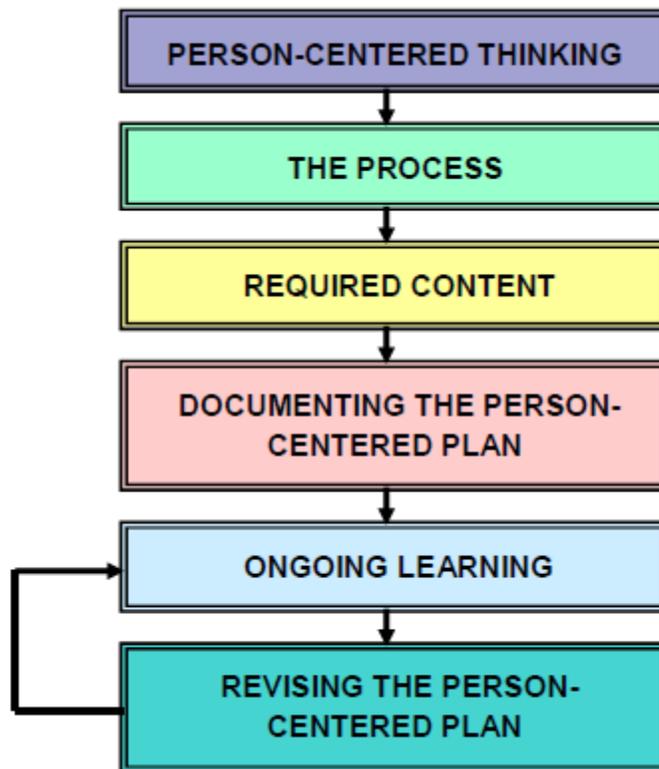
- Everyone desires respect
- Everyone needs to be heard
- Everyone has strengths
- Judgments can wait
- Partners share power
- Partnership is a process
- The principles of family-centered practice reflect the belief that the family is its own primary source of intervention and determines who its members are (i.e., they may want a close friend to be considered part of the family)
- The family is viewed as a system within a larger social and environmental context. As a result, interventions focus on accessing the family's immediate and extended community in needs assessment, resource identification and service delivery.
- Family-centered practice respects the family's right of self-control, capabilities, and assumes they have the capacity to grow and change when provided the proper supportive interventions.
- Family-centered practice develops strengths, enhances potential, and empowers families to identify and resolve their own problems.

WHAT ARE THE KEY CHARACTERISTICS OF FAMILY-CENTERED PLANNING?

- Incorporates into policy and practice the recognition that the family is the constant in a child's life, while the service system and support persons fluctuate.
- Strives for family and professional collaboration in all settings (home, community, hospital, school), especially in the areas of care giving, program development, program implementation, program evaluation, program evolution, and policy formulation.
- Exchanges complete and unbiased information between families and professionals in a supportive manner at all times.
- Incorporates into policy and practice the recognition and honoring of cultural diversity, strengths, and individuality within and across all families; including ethnic, racial, spiritual, social, economic, educational, and geographic diversity.
- Recognizes and respects different methods of coping.
- Implements comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial supports which meet the diverse needs of families.
- Encourages family-to-family support and networking.
- Ensures that all service and support systems for children with disabilities and their families are flexible, accessible, and comprehensive in responding to diverse family identified needs.
- Appreciates families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized services and supports.

HOW IS FAMILY-CENTERED PLANNING PUT INTO PRACTICE?

There are six phases that form a framework for person centered planning: Person-centered thinking, the process, required content, documenting the person centered plan, ongoing learning, and revising the person centered plan.



PERSON-CENTERED THINKING

For people/families receiving supports and services, it is not person-centered planning that matters as much as the pervasive presence of person-centered thinking.

- If people/families who use services are to have self directed lives within their own communities, then those who play a primary role in facilitating service plans and providing services and supports need to have person-centered thinking skills.
- Person-centered thinking is a set of value-based skills that change the way we see individuals/families, change the way we support individuals/families,

set the stage for ongoing learning about individuals/families and acting upon that learning.

Learning and supporting the use of person-centered thinking skills result in:

- Plans being developed that are used and acted on, so that the lives of people who use services will improve.
- Several ways to get plans started/revised/updated.
- Plans that occur 'naturally', needing less effort and time.

THE PROCESS

Person-Centered Planning is a process. This process enables people important to the person, as well as people that will provide supports and services to come together and state who, what, when, and where services will be offered. It is recognized that each plan will reflect the degree of information available/known at any given time. Therefore, information will continue to be gathered and added as more learning takes place. The Person-Centered Planning process will utilize:

- Information Gathering
 - The planning process may include one or more dialogues with the person to whom the plan belongs, and any others identified by this individual
 - The dialogues are initiated by the Case Manager. Dialogues may be formal or informal meetings, telephone conversations, or any discussions used to gather needed information
 - Discussions within the dialogues/meetings should include information about aspirations and goals.
 - Decisions are made by the individual/family/legally responsible person and professionals working together to determine services, supports, and treatments, including natural and community

resources, that can best meet the person's identified desires, goals, and needs.

Informal Services/Supports – Every effort should be made to use these resources before resorting to the utilization of paid supports.

a. Personal Resources: The person's own resources, such as special skills, capacities, or attributes, should be examined and included in the plan.

b. Natural Supports: Natural supports include family, neighbors, co-workers, and friends of the individual/family's choosing. Existing supports should be included if applicable and new ones explored.

c. Community Resources: Community resources are those that exist for any community member's use. Examples include church or faith-based organizations, Boy's or Girl's Clubs, YMCA or YWCA, special interest or civic groups, sports or any other group available to other community members. Opportunities to connect the individual/family to the community must be explored and offered.

Formal Services/Supports – This is paid assistance provided by qualified professionals or paraprofessionals in the publicly funded system of services.

- Unified Planning

Since the person-centered-plan is the umbrella under which all planning for supports and treatments occurs, all facets of support/treatment representing the individual's aspirations and goals must be documented within it. All resources, including personal, natural, and community resources are to be included in the plan.

- When agreed upon by the person and other planning participants, goals and supports/interventions may be developed by a provider for a specific service; however, separate plans may not be

developed by individual providers. Specialized sets of goals must be integrated into the unified plan of care.

- When specialized, service-specific goals are not included initially, they may be added when needed as an update/revision to the plan.
- Any specialized service-specific goals that are added to the plan of care need to relate to and be drawn from the Important TO and Important FOR information, as are all goals

What is **“important to”** a person/family includes only what that person is “saying” with their words and with their behaviors. (Example: Many people/families have lived in circumstances where they were expected to say what others wanted them to say. If a person is saying what they think we want to hear, it is important to “listen” to their behavior to help decide what is really being said, the underlying message of truth. We may need to use a symbolic “third ear” to hear fully and accurately.)

What is **“important for”** people/families includes those things that need to be kept in mind for people/families regarding issues of health or safety and what others see as important for the person to be a valued member of their community (in relationships, school, work, etc.)

(**EXAMPLE:** A young adult with a cognitive disability may see “adventure”, “new experiences”, “cars”, and “sports” as important **TO** him or her, while the parents may see “safety”, “protection”, and “security” as important **FOR** the young adult)

- Specialized providers may participate in the plan of care by:
 - Attending a full treatment team meeting meant to develop goals
 - Receiving copies of the information gathered during the assessment process to use to develop goals and submit them to the Case Manager

- Contacting the Case Manger by phone to discuss specialized service goals

Remember that nothing should be added to the Plan of Care without the agreement of the recipient/family/legally responsible person.

The Case Manager must ensure that the person to whom the plan belongs and all other providers documented in the plan receives a copy of the plan that includes all appropriate signatures and consequent updates/revisions.

- Authorization
 - After the Plan of Care is completed, the Case Manager submits the plan to DMA for review
 - DMA reviews the plan to ensure that medical necessity and other program criteria have been met for the requested treatments/services.

AA
Administrative
Authority



REQUIRED CONTENT

The following documentation is required to be submitted to DMA for an applicant who is requesting CAP/C services or for an annual review (CNR)

- Referral (for initial)
- FL-2
- Physicians Request Form, as applicable
- Assessment
- Plan of Care
- CMS 485, if applicable
- Service Notes (nurses' notes, MAR, physician letters) as available
- Employment verification, if applicable

- ‘Request from School for Nurse or Nurse Aide Services Under Medicaid Program’ form, if applicable

Please refer to Sections 4 and 5 for more information on requirements for initiating and continuing CAP/C services, including the specific requirements for the content of these forms.

For an update/revision to the Plan of Care, only the Plan of Care and any supporting documentation as listed in Chapter 45 need be submitted.



DOCUMENTING THE PERSON-CENTERED PLAN

Please refer to Chapter 35 for specific instructions regarding documenting the plan of care.

ONGOING LEARNING

Ongoing learning involves review and discussion of the goals and interventions documented on the plan of care. For each intervention, ask the following:

- What did the person do?
- Who was there?
- What did you learn about what worked well? What did the person like about this activity? What needs to stay the same?
- What did you learn about what didn't work well? What did the person not like about this activity? What needs to be different?

REVISING THE PERSON-CENTERED PLAN

Based on the results of the ongoing learning, revise the plan of care to change the things that need to be different. At the times specified by your goals

and/or by program criteria, reevaluate using the ongoing learning questions, and revise again as needed. This evaluation and revision will continue for the duration of the person's CAP/C participation, and will follow the individual as he or she transitions to new programs.

THE KEY VALUES AND PRINCIPLES SERVING AS THE FOUNDATION OF PERSON-CENTERED PLANNING

- 1. Person-centered planning builds on the individual's /family's strengths, gifts, skills and contributions.*
- 2. Person-centered planning supports personal empowerment, and provides meaningful options for individuals/families to express preferences and to make informed choices in order to identify and achieve their hopes, goals and aspirations.*
- 3. Person-centered planning is a framework for providing services, treatment, supports and interventions that meet the individual's/family's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.*
- 4. Person-centered planning supports a fair and equitable distribution of system resources.*
- 5. Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community.*
- 6. Person-centered planning sees individuals/families in the context of their culture, ethnicity, religion and gender. All of the elements that compose a person's individuality and a family's uniqueness are acknowledged and valued in the planning process.*
- 7. Person-centered planning supports mutually respectful partnerships between individuals/families and providers/professionals, and recognizes the legitimate contributions of all parties involved.*

**Key Values and Principles That Serve As the Foundation of
A Person-Centered System for
The Department of Health and Human Services**

[A person-centered system involves person-centered thinking, planning and organizations.]

These guiding principles apply to the system serving all people who need long term services and supports, and their families. A person-centered system acknowledges the role of families or guardians in planning for children/youth and for adults who need assistance in making informed choices.

To be person-centered means:

- Treating individuals and family members with dignity and respect
- Helping individuals and families become empowered to set and reach their personal goals
- Recognizing the right of individuals to make informed choices, and take responsibility for those choices and related risks
- Building on the strengths, gifts, talents, skills, and contributions of the individual and those who know and care about the individual
- Fostering community connections in which individuals can develop relationships, learn, work/produce income, actively participate in community life and achieve their full potential
- Promising to listen and to act on what the individual communicates
- Pledging to be honest when trying to balance what is important to and important for the person
- Seeking to understand individuals in the context of their age, gender, culture, ethnicity, belief system, social and income status, education, family, and any other factors that make them unique
- Acknowledging and valuing families and supporting their efforts to assist family members
- Recognizing and supporting mutually respectful partnerships among individuals, their families, communities, providers and professionals
- Advocating for laws, rules and procedures for providing services, treatment, and supports that meet an individual's needs and honor personal goals
- Endorsing responsible use of public resources to assure that qualified individuals are served fairly and according to need

*Adopted by the Long Term Services and Supports Cabinet
January 10, 2008*

CHAPTER REVIEW

🔑 Key Points

1. The assessment is the basis for the family-centered plan of care.
2. A family-centered assessment includes the goals and aspirations of the child and family.
3. The family directs the planning process.
4. Outcomes are geared toward helping the child and family lead a better and complete life with meaningful involvement in the community. Outcomes involve things like love, learning, fun, relationships, and spirituality.
5. Outcomes are planned to achieve a balance between what is important to the child/family and what is important for the child/family.
6. The plan of care involves the use of personal, natural, and community supports in addition to formal supports.
7. The plan of care is constantly reevaluated and revised.
8. The Case Manager ensures that the agreed-upon services are incorporated into the plan of care and carried out according to the family's needs and goals.
9. Family-centered planning focuses on the child/family and their future, rather than on a set of services, programs, or treatments that can meet various needs and goals.



Test Your Knowledge

1. True or False: Family-centered planning focuses solely on the medical needs of the child.
2. True or False: A person-centered plan of care emphasizes what is important to the child.
3. True or False: A person-centered plan of care emphasizes the use of personal, natural, and community supports.
4. True or False: The family has the ultimate authority on what is or is not included in the plan of care to be submitted to DMA for approval.

1. False, 2. False, 3. True, 4. True

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SECTION 1

CAP/C CONCEPTS AND PRINCIPLES

CHAPTER 2

Principles of Case Management



This chapter gives a broad overview of case management in general. Please refer to Chapter 13 for information specifically about CAP/C Case Management and how these principles are implemented within the CAP/C program.

WHAT IS CASE MANAGEMENT?

Case management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. (CMSA, 2009)

The underlying premise of case management is based in the fact that, when an individual reaches the optimum level of wellness and functional capability, everyone benefits: the individuals being served, their support systems, the health care delivery systems and the various reimbursement sources. Case management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. ... Case management services are best offered in a climate that allows direct communication between the case manager, the client, and appropriate service personnel, in order to optimize the outcome for all concerned. (CMSA, 2009)

WHAT ACTIVITIES DO CASE MANAGERS PERFORM?

The primary functions of a case manager are assessment, planning, facilitation/monitoring and advocacy/linkage.

Role functions of case managers include:

- Conducting a comprehensive assessment of the client's health and psychosocial needs, including health literacy status and deficits, and developing a case management plan collaboratively with the client and family or caregiver.
- Planning with the client, family or caregiver, the primary care physician/provider, other health care providers, the payer, and the community, to maximize health care responses, quality, and cost-effective outcomes.
- Facilitating communication and coordination between members of the health care team, involving the client in the decision-making process in order to minimize fragmentation in the services.
- Educating the client, the family or caregiver, and members of the health care delivery team about treatment options, community resources, insurance benefits, psychosocial concerns, case management, etc., so that timely and informed decisions can be made.
- Empowering the client to problem-solve by exploring options of care, when available, and alternative plans, when necessary, to achieve desired outcomes.
- Encouraging the appropriate use of health care services and striving to improve quality of care and maintain cost effectiveness on a case-by-case basis.
- Assisting the client in the safe transitioning of care to the next most appropriate level.
- Striving to promote client self-advocacy and self-determination.

- Advocating for both the client and the payer to facilitate positive outcomes for the client, the health care team, and the payer. However, if a conflict arises, the needs of the client must be the priority.

WHAT IS THE PURPOSE OF CASE MANAGEMENT?

The purpose of case management is:

- To work collaboratively with the client/family; the physician; providers of healthcare; payers including Medicaid, private insurance, and other funding sources; the school system; and others to develop and implement a plan that meets the client's/family's individual needs and goals.
- To promote quality, safe, and cost-effective care
- To ensure appropriate access to care
- To promote utilization of available resources to achieve clinical and financial outcomes
- To interject objectivity, healthcare choices, and promotion of self-care where it is lacking.

WHAT ARE THE GOALS OF CASE MANAGEMENT?

The goals of case management are:

- To enhance a client's/family's safety, productivity, satisfaction, and quality of life
- To assure that appropriate services are generated in a timely and cost-effective manner
- To assist clients to achieve an enhanced level of health and to maintain wellness and function by facilitating timely, comprehensive, and coordinated health services

- To assist clients/families to appropriately self-direct care, self-advocate, and make informed healthcare decisions to the degree possible
- To maintain cost-effectiveness in the provision of health services
- To facilitate appropriate and timely benefit and treatment decisions
- To maintain ongoing documentation and reporting of goal achievement.
- To contribute to the development and improvement of social policy, and improve the scope and capacity of the delivery system.

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STANDARDS OF CARE FOR CASE MANAGEMENT**

A. Client Selection Process for Case Management Services

The case manager should identify and select clients who can most benefit from case management services available in a particular practice setting.

How Demonstrated:

- Documentation of consistent use of the selection process within the individual organization's policies and procedures.
- Use of high-risk screening criteria to assess for inclusion in case management programs. Examples of high-risk screening criteria include, but are not limited to:
 - Age
 - Poor pain control
 - Low functional status or cognitive deficits
 - Previous home health and durable medical equipment usage
 - History of mental illness or substance abuse, suicide risk, or crisis intervention
 - Chronic, catastrophic, or terminal illness
 - Social issues such as a history of abuse, neglect, no known social support, or lives alone
 - Repeated emergency department visits
 - Repeated admissions
 - Need for admission or transition to a post-acute facility
 - Poor nutritional status
 - Financial issues

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B. Client Assessment

The case manager should complete a health and psychosocial assessment, taking into account the cultural and linguistic needs of each client.

How Demonstrated

- Documentation of client assessments using standardized tools, when appropriate. Example criteria may include, but are not limited to the following components (as pertinent to the case manager's practice setting):
 - Physical/functional
 - Medical history
 - Psychosocial behavioral
 - Mental health
 - Cognitive
 - Client strengths and abilities
 - Environmental and residential
 - Family or support system dynamics
 - Spiritual
 - Cultural
 - Financial
 - Health insurance status
 - History of substance use
 - History of abuse, violence, or trauma
 - Vocational and/or educational
 - Recreational/leisure pursuits
 - Caregiver(s) capability and availability

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C. Standard Problem/Opportunity Identification

The case manager should identify problems or opportunities that would benefit from case management intervention.

How Demonstrated

- Documentation of agreement among the client, family or caregiver, and other providers and organizations regarding the problems/opportunities identified.
- Documented identification of opportunities for intervention, such as:
 - Lack of established, evidenced-based plan of care with specific goals
 - Over-utilization or underutilization of services
 - Use of multiple providers/agencies
 - Use of inappropriate services or level of care
 - Non-adherence to plan of care (e.g. medication adherence)
 - Lack of education or understanding of:
 - The disease process
 - The current condition(s)
 - The medication list
 - Medical, psychosocial, mental health and/or functional limitations
 - Lack of a support system or presence of a support system under stress.
 - Financial barriers to adherence of the plan of care
 - Determination of patterns of care or behavior that may be associated with increased severity of condition.
 - Compromised client safety
 - Inappropriate discharge or delay from other levels of care

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- Learning and technology capabilities
- Self-care capability
- Health literacy
- Health status expectations and goals
- Transitional or discharge plan
- Advance care planning
- Legal
- Transportation capability and constraints
- Health literacy and illiteracy
- Readiness to change
- Documentation of resource utilization and cost management; current diagnosis(es); past and present course and services; prognosis; goals (short and long term); provider options; and available health care benefits.
- Evidence of use of relevant, comprehensive information and data required for client assessment from many sources including, but not limited to:
 - Client interviews
 - Initial assessment and ongoing assessments
 - Family or caregivers, physicians, providers, other members of the interdisciplinary health care team
 - Medical records
 - Data: claims and/or administrative

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- High cost injuries or illnesses
- Complications related to medical, psychosocial or functional issues
- Frequent transitions between settings

D. Planning

The case manager should identify immediate, short-term, long-term, and ongoing needs, as well as develop appropriate and necessary case management strategies and goals to address those needs.

How Demonstrated

- Documentation of relevant, comprehensive information and data using interviews, research, and other methods needed to develop a plan of care.
- Recognition of the client's diagnosis, prognosis, care needs, preferences, preferred role in decision-making, and outcome goals of the plan of care.
- Validation that the plan of care is consistent with evidence-based practice, when such guidelines are available and applicable.
- Establishment of measurable goals and indicators within specified time frames. Example measures could include access to care, cost effectiveness of care, and quality of care.
- Documentation of client's or client's support system participation in the written case management plan of care; documentation of agreement with plan, including agreement with any changes or additions.
- Facilitation of problem-solving and conflict resolution.
- Evidence of supplying the client with information and resources necessary to make informed decisions.

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- Awareness of maximization of client outcomes by all available resources and services.
- Compliance with payer expectations with respect to how often to contact and reevaluate the client or redefine long or short term goals.

E. Monitoring

The case manager should employ ongoing assessment and documentation to measure the client's response to the plan of care.

- Documentation of ongoing collaboration with the client, family or caregiver, providers, and other pertinent stakeholders, so that the client's response to interventions is reviewed and incorporated into the plan of care.
- Verification that the plan of care continues to be appropriate, understood, accepted by client and support system, and documented.
- Awareness of circumstances necessitating revisions to the plan of care, such as changes in the client's condition, lack of response to the care plan, preference changes, transitions across settings, and barriers to care and services.
- Collaboration with the client, providers, and other pertinent stakeholders regarding any revisions to the plan of care.

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F. Outcomes

The case manager should maximize the client's health, wellness, safety, adaptation, and self-care through quality case management, client satisfaction, and cost-efficiency.

How Demonstrated

- Evaluation of the extent to which the goals documented in the plan of care have been achieved.
- Demonstration of the efficacy, quality, and cost-effectiveness of the case manager's interventions in achieving the goals documented in the plan of care.
- Measurement and reporting of the impact of the plan of care.
- Utilization of adherence guidelines, standardized tools and proven processes. These can be used to measure individuals' preference for, and understanding of:
 - The proposed plans for their care
 - Their willingness to change
 - Their support to maintain health behavior change
- Utilization of evidence-based guidelines in appropriate client populations.
- Evaluation of client satisfaction with case management.

G. Disenrollment from case management services

The case manager should appropriately terminate case management services based upon established case closure guidelines. These guidelines may differ in various case management practice settings.

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How Demonstrated

- Identification of reasons for disenrollment from case management services, such as:
 - Achievement of targeted outcomes or maximum benefit reached
 - Change of health setting
 - Loss or change in benefits (i.e., client no longer meets program or benefit eligibility requirements)
 - Client refuses further medical/psychosocial services
 - Client refuses further case management services
 - Determination by the case manager that he/she is no longer able to perform or provide appropriate case management services (e.g., non-adherence of client to plan of care)
 - Death of the client
- Evidence of agreement of disenrollment from case management services by the client, family or caregiver, payer, case manager, and/or other appropriate parties.
- Documentation of reasonable notice of disenrollment from case management services that is based upon the facts and circumstances of each individual case.
- Documentation of both verbal and/ or written notice of disenrollment from case management services to the client and to all treating and direct service providers.
- With permission, communication of client information to transition providers to maximize positive outcomes.

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H. FACILITATION, COORDINATION, AND COLLABORATION

The case manager should facilitate coordination, communication, and collaboration with the client and other stakeholders in order to achieve goals and maximize positive client outcomes.

How Demonstrated

- Recognition of the case manager's professional role and practice setting in relation to that of other providers and organizations caring for the client.
- Development and maintenance of proactive, client-centered relationships and communication with the client, and other necessary stakeholders to maximize outcomes.
- Evidence of transitions of care, including:
 - A transfer to the most appropriate health care provider/setting
 - The transfer is appropriate, timely, and complete
 - Documentation of collaboration and communication with other health care professionals, especially during each transition to another level of care within or outside of the client's current setting
- Adherence to client privacy and confidentiality mandates during collaboration.
- Use of mediation and negotiation to improve communication and relationships.
- Use of problem-solving skills and techniques to reconcile potentially differing points of view.
- Evidence of collaborative efforts to optimize client outcomes: this may include:

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working with community, local and state resources, primary care physician or other primary provider, other members of the health care team, the payer, and other relevant health care stakeholders.

- Evidence of collaborative efforts to maximize regulatory adherence within the case manager's practice setting.

I. Qualifications for Case Managers

Case managers should maintain competence in their area(s) of practice by having one of the following:

- a) Current, active, and unrestricted licensure or certification in a health or human services discipline that allows the professional to conduct an assessment independently as permitted within the scope of practice of the discipline; and/or
- b) Baccalaureate or graduate degree in social work, nursing, or another health or human services field that promotes the physical, psychosocial, and/or vocational well-being of the persons being served. The degree must be from an institution that is fully accredited by a nationally recognized educational accreditation organization, and the individual must have completed a supervised field experience in case management, health, or behavioral health as part of the degree requirements.

How Demonstrated

- Possession of the education, experience, and expertise required for the case manager's area(s) of practice.
- Compliance with national and/or local laws and regulations that apply to the jurisdictions(s) and discipline(s) in which the case manager practices.
- Maintenance of competence through relevant and ongoing continuing education, study, and consultation.

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- Practicing within the case manager's area(s) of expertise, making timely and appropriate referrals to, and seeking consultation with, others when needed.

J. Legal

The case manager should adhere to applicable local, state, and federal laws, as well as employer policies, governing all aspects of case management practice, including client privacy and confidentiality rights. It is the responsibility of the case manager to work within the scope of his/her licensure.

NOTE: In the event that employer policies or the policies of other entities are in conflict with applicable legal requirements, the case manager should understand which laws prevail. In these cases, case managers should seek clarification of any questions or concerns from an appropriate and reliable expert resource, such as an employer, government agency, or legal counsel.

1. Standard: Confidentiality and Client Privacy

The case manager should adhere to applicable local, state, and federal laws, as well as employer policies, governing the client, client privacy, and confidentiality rights and act in a manner consistent with the client's best interest.

How Demonstrated:

- Up-to-date knowledge of, and adherence to, applicable laws and regulations concerning confidentiality, privacy, and protection of client medical information issues.

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- Evidence of a good faith effort to obtain the client's written acknowledgement that he/she has received notice of privacy rights and practices.

2. Standard: Consent for Case Management Services

The case manager should obtain appropriate and informed client consent before case management services are implemented.

How Demonstrated:

- Evidence that the client and support system were thoroughly informed with regard to:
 - Proposed case management process and services relating to the client's health conditions and needs
 - Possible benefits and costs of such services
 - Alternatives to the proposed services
 - Potential risks and consequences of the proposed services and alternatives
 - Client's right to refuse the proposed case management services, and potential risks and consequences related to such refusal
- Evidence that the information was communicated in a client-sensitive manner, which is intended to permit the client to make voluntary and informed care choices.
- If client consent is a prerequisite to the provision of case management services, documentation of the informed consent.

K. ETHICS

Case managers should behave and practice ethically, adhering to the tenets of the code of ethics that underlies his/her professional credential (e.g., nursing, social work, rehabilitation counseling, etc.).

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How Demonstrated

- Awareness of the five basic ethical principles and how they are applied: beneficence (to do good), nonmaleficence (to do no harm), autonomy (to respect individuals' rights to make their own decisions), justice (to treat others fairly), and fidelity (to follow-through and to keep promises).
- Recognition that a case manager's primary obligation is to his/her clients.
- Maintenance of respectful relationships with coworkers, employers, and other professionals.
- Recognition that laws, rules, policies, insurance benefits, and regulations are sometimes in conflict with ethical principles. In such situations, case managers are bound to address such conflicts to the best of their abilities and/or seek appropriate consultation.

L. Advocacy

The case manager should advocate for the client at the service-delivery, benefits-administration, and policy-making levels.

How Demonstrated

- Documentation demonstrating:
 - Promotion of the client's self-determination, informed and shared decision-making, autonomy, growth, and self-advocacy
 - Education of other health care and service providers in recognizing and respecting the needs, strengths, and goals of the client
 - Facilitating client access to necessary and appropriate services while educating the client and family or caregiver about resource availability within practice settings

CASE MANAGEMENT SOCIETY OF AMERICA
STANDARDS OF CARE FOR CASE MANAGEMENT

- Recognition, prevention, and elimination of disparities in accessing high quality care and client health care outcomes as related to race, ethnicity, national origin, and migration background; sex, sexual orientation, and marital status; age, religion, and political belief; physical, mental, or cognitive disability; gender, gender identity, or gender expression; or other cultural factors
- Advocacy for expansion or establishment of services and for client-centered changes in organizational and governmental policy
- Recognition that client advocacy can sometimes conflict with a need to balance cost constraints and limited resources. Documentation indicates that the case manager weighed decisions with the intent to uphold client advocacy, whenever possible.

M. Cultural Competencies

The case manager should be aware of, and responsive to, cultural and demographic diversity of the population and specific client profiles.

How Demonstrated

- Documentation demonstrating:
 - Case manager understands relevant cultural information and communicates effectively, respectfully, and sensitively within the client's cultural context
 - Assessment of client linguistic needs and identifying resources to enhance proper communication. This may include use of interpreters and material in different languages and formats, as necessary, and understanding of cultural communication patterns of speech volume, context, tone, kinetics, space, and other similar verbal/nonverbal communication patterns.

CASE MANAGEMENT SOCIETY OF AMERICA
STANDARDS OF CARE FOR CASE MANAGEMENT

- Evidence of pursuit of education in cultural competence to enhance the case manager's effectiveness in working with multicultural populations.

N. Resource Management and Stewardship

The case manager should integrate factors related to quality, safety, access, and cost-effectiveness in assessing, monitoring, and evaluating resources for the client's care.

How Demonstrated

- Documentation of evaluating safety, effectiveness, cost, and potential outcomes when designing care plans to promote the ongoing care needs of the client.
- Evidence of follow-through on care plan objectives, including assisting with referral and outsourcing as needed, based on the ongoing care needs of the client and the competency, knowledge, and skill of the health and human services providers.
- Evidence of utilizing evidence-based guidelines, as available, and guidelines specific to the case manager's practice setting in making decisions about resource allocation and utilization.
- Demonstration of linking the client and family or caregiver with resources appropriate to the needs and goals identified in the care plan. Fully informing the client and family or caregiver of the length of time for which each resource is available, their financial responsibility for each resource, and the anticipated outcome of resource utilization.
- Documented communication of the client and other providers, both internal and external, especially during care transitions or when there is a significant change in the client's situation.

CASE MANAGEMENT SOCIETY OF AMERICA
STANDARDS OF CARE FOR CASE MANAGEMENT

- Evidence of promoting the most effective and efficient use of health care services and financial resources.
- Documentation demonstrating that the intensity of case management services rendered corresponds with the needs of the client.

O. Research and Research Utilization

The case manager should maintain familiarity with current research findings and be able to apply them, as appropriate, in his/her practice.

How Demonstrated

- Evidence of familiarization with current literature pertaining to the case manager's expertise, and regular participation in appropriate training and/or conferences to maintain knowledge and skills.
- Compliance with legitimate and relevant research efforts, in order to quantify and define valid and reliable outcomes in case management.
- Incorporation of meaningful research findings into practice as appropriate.
- Participation in identification of practical, hands-on approaches to case management "best practices."

Case Management Society of America Standards of Care for Case Management reprinted with permission, the Case Management Society of America, 6301 Ranch Drive, Little Rock, AR 72223, www.cmsa.org

NASW Standards for Social Work Case Management

Standard 1. The social work case manager shall have a baccalaureate or graduate degree from a social work program accredited by the Council on Social Work Education and shall possess the knowledge, skills, and experience necessary to competently perform case management activities

Standard 2. The social work case manager shall use his or her professional skills and competence to serve the client whose interests are of primary concern

Standard 3. The social work case manager shall ensure that clients are involved in all phases of case management practice to the greatest extent possible

Standard 4. The social work case manager shall ensure the client’s right to privacy and ensure appropriate confidentiality when information about the client is released to others.

Standard 5. The social work case manager shall intervene at the client level to provide and/or coordinate the delivery of direct services to clients and their families

Standard 6. The social work case manager shall intervene at the service systems level to support existing case management services and to expand the supply of and improve access to needed services

Standard 7. The social work case manager shall be knowledgeable about resource availability, service costs, and budgetary parameters and be fiscally responsible in carrying out all case management functions and activities

Chapter 2 Principles of Case Management

NASW Standards for Social Work Case Management

Standard 8. The social work case manager shall participate in evaluative and quality assurance activities designed to monitor the appropriateness and effectiveness of both the service delivery system in which case management operates as well as the case manager's own case management services, and to otherwise ensure full professional accountability

Standard 9. The social work case manager shall carry a reasonable caseload that allows the case manager to effectively plan, provide, and evaluate case management tasks related to client and system interventions

Standard 10. The social work case manager shall treat colleagues with courtesy and respect and strive to enhance interprofessional, intraprofessional, and interagency cooperation on behalf of the client

CHAPTER REVIEW

Key Points

1. Case management services
 - assure that clients receive comprehensive, coordinated care
 - control costs
 - ensure quality
 - monitor outcomes.
2. Case management activities include
 - gatekeeping
 - assessment
 - service plan development
 - coordination of care across services
 - monitoring the delivery and quality of services
 - monitoring outcomes and revising the service plan as needed to reach goals
 - budget planning at both the client and the system level
 - family support
 - advocacy at both the client and the system level.
3. Case management is meant to
 - work collaboratively with the client/family; the physician; providers of healthcare; payers including Medicaid, private insurance, and other funding sources; the school system; and others to develop and implement a plan that meets the client's/family's individual needs and goals.
 - promote quality, safe, and cost-effective care
 - ensure appropriate access to care
 - promote utilization of available resources to achieve clinical and financial outcomes

- interject objectivity, healthcare choices, and promotion of self-care where it is lacking.

4. Case managers work to

- enhance a client's/family's safety, productivity, satisfaction, and quality of life
- assure that appropriate services are generated in a timely and cost-effective manner
- assist clients to achieve an enhanced level of health and to maintain wellness and function by facilitating timely and appropriate health services
- assist clients/family's to appropriately self-direct care, self-advocate, and make informed healthcare decisions to the degree possible
- maintain cost-effectiveness in the provision of health services
- facilitate appropriate and timely benefit and treatment decisions
- maintain ongoing documentation and reporting of goal achievement.
- contribute to the development and improvement of social policy, and improve the scope and capacity of the delivery system.

5. The Case Management Society of America and the National Association of Social Workers both set standards of practice for case managers.

 **Test Your Knowledge**

1. Which of the following is not a function of case management?
 - a. coordinating care
 - b. controlling costs
 - c. providing direct care
 - d. advocacy

2. True or False: Case Managers need to work both inside and outside of their own system (i.e., Medicaid or CAP/C) to develop and implement a plan that meets the client's needs.

3. Two organizations that set standards of practice for case management are: _____ and _____.

4. True or False: CAP/C Case Mangers are not expected to meet standards of practice.

Chapter 2 Principles of Case Management

1.c, 2. True, 3. Case Management Society of America and the National Association for Social Workers, 4. False

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SECTION 1

CAP/C CONCEPTS AND PRINCIPLES

CHAPTER 3

The Waiver

CAP/C is a Medicaid Home and Community-Based Services (HCBS) Waiver Program. The Centers for Medicare and Medicaid Services (CMS) granted North Carolina a HCBS waiver under *Section 1915(c) of the Social Security Act*. The waiver document is the basis for program operation. Federal regulations for HCBS waivers are in *42 CFR Part 441 Subpart G*.



The North Carolina Division of Medical Assistance CAP/C waiver document can be found online at <http://www.ncdhhs.gov/dma/services/capc.htm>.



WHAT IS A WAIVER?

A waiver is an optional state Medicaid program in which certain Medicaid rules are “waived” for the people to be served within the program. These rules include:

Comparability

Comparability is the requirement of a state to provide services comparable in amount, duration, and scope to all Medicaid beneficiaries. This requirement is waived so that CAP/C can give services (for example, home modifications, motor vehicle modifications, community transition funding, attendant care services, waiver supplies, caregiver training and education, and palliative care) to people on CAP/C that are not given to people who receive “regular Medicaid”. CAP/C can also offer “regular Medicaid” services in a different amount, duration, or scope than the same services offered to regular Medicaid beneficiaries.

Statewideness

Statewideness means that all Medicaid services need to be provided in equal amount, duration, and scope to all beneficiaries throughout the state. A waiver of statewideness would allow a state to provide services to people only in a specific geographic area within the state. North Carolina has elected NOT to waive statewideness; therefore, CAP/C services are available throughout the entire state.

Deeming of Income and Resources

Medicaid rules require that the income and resources of a spouse/parent be considered in determining Medicaid eligibility for a person who resides with a spouse/parent. This is "deeming" income and resources to the Medicaid beneficiary. The deeming requirement is waived to allow Medicaid eligibility to be considered similar to the methods used for institutionalized individuals. This means that a child on CAP/C is considered a "family of one"; only the child's income, if any, is considered in determining Medicaid eligibility.

WHAT THE WAIVER SAYS

North Carolina's CAP/C waiver sets the following requirements for administration of the program:

Duration of the Waiver

The waiver is approved by CMS for a specified time period and may be renewed. CAP/C currently operates under a waiver that was renewed July 1, 2010, for five years. The waiver may be amended with the approval of CMS. CMS may terminate the waiver whenever it believes that the waiver is not being properly implemented.

Monitoring of the Waiver

CMS monitors the waiver operation through annual reports required of the state and through on-site reviews. DMA will provide annual reports to CMS about the impact of the waiver on the type, amount, and cost of services provided under the state plan and on the health and welfare of beneficiaries. The information will be consistent with a data collection plan designed by CMS. CMS can come on site to DMA for audits, and even visit local agencies and CAP/C beneficiaries.

Target Population

CAP/C services are targeted to children who require the type of long-term care provided by a nursing facility or hospital, and who need Medicaid coverage of certain services and supplies to remain safely at home. Subject to service availability and program requirements, the CAP/C program may be offered to individuals who meet ALL of the following criteria:

- Nursing Facility Level of care
- Medically Fragile
- 20 years of age or younger
- Meets the Medicaid eligibility criteria for MAD, MAB, I-AS or H-SF, using institutional income and resource rules for the medically needy
- The individual is not an inpatient of a hospital, nursing facility, or ICF-MR facility (except these individuals may receive case management that does not duplicate discharge planning up to 30 days prior to discharge to allow the individual to transfer into the home and community)

Services Offered

CAP/C waiver services include:

- Case Management

- Nursing Care
- Personal Care
- Pediatric Nurse Aide Care
- Respite Care, In-Home and/or Institutional
- Waiver Supplies/Specialized Medical Equipment and Supplies
- Home Modifications
- Motor Vehicle Modifications
- Community Transition Funding
- Caregiver Training and Education
- Palliative Care

(In addition to these waiver services, beneficiaries may be eligible for other Medicaid services as well.)

Each service is covered in detail in its own chapter.

Number of Beneficiaries

The CAP/C waiver specifies the maximum number of children to be served each waiver year (July through the following June).

YEAR	DATES	MAXIMUM NUMBER OF CHILDREN THAT MAY BE SERVED
1	July 1, 2010 to June 30, 2011	1057
2	July 1, 2011 to June 30, 2012	1167
3	July 1, 2012 to June 30, 2013	1284
4	July 1, 2013 to June 30, 2014	1412
5	July 1, 2014 to June 30, 2015	1553

The waiver does not designate how many children may be served per county. However, the resources to provide CAP/C Case Management and the other CAP/C services affect its availability in each part of the state. A particular county or region may have a wait list based upon their own



resources and caseloads, or a particular child may have to wait for services because of a shortage of nurses or nurse aides in the area.

The State's Assurances to CMS

In order to operate the waiver, the state must meet the following federal (CMS) requirements:

- Demonstrate that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution
- Ensure that measures will be taken to protect the health and welfare of consumers
- Provide adequate and reasonable provider standards to meet the needs of the target population
- Ensure that services are provided in accordance with a plan of care

In addition, and more specifically, CMS requires the following, which is the basis for the HCBS Quality Framework:

BENEFICIARY ACCESS

Individuals must have access to home and community based services and supports in their communities.

This means that

- potential beneficiaries can readily obtain information about CAP/C and how to apply for it
- the referral and initial process is understandable and user-friendly, and assistance is available to the applicant in completing the process
- applicants who are determined not to need CAP/C services are referred to other community resources
- services are initiated promptly once CAP/C is approved

FA
Financial
Accountability

HW
Health
and
Welfare

QP
Qualified
Providers

SP
Service
Plans

FC
Free
Choice

Perhaps most importantly, this includes the assurance of Free Choice, which means, in part, that

Each individual is given timely information about available services to exercise his or her choice in selecting between CAP/C and institutionalization. Free choice also applies to the selection of providers once on CAP/C.

BENEFICIARY SERVICE PLANNING AND DELIVERY

SP
Service
Plans

Services and supports are planned and effectively implemented in accordance with each beneficiary's unique needs, expressed preferences and decisions concerning his/her life in the community.

This means that:

- A comprehensive, beneficiary-centered assessment is completed and is used as the basis for plan of care development.

An important assurance included within this is that of Level of Care, which means that

Beneficiaries have needs consistent with an institutional level of care, and that the level of care is re-evaluated annually. Please refer to Chapter 30 for more detailed information about level of care determinations.

- Beneficiaries receive information and support so that they can make informed decisions regarding service options.
- Beneficiaries receive information and support so they can make informed choices among qualified providers.
- Beneficiaries can manage their own services to the extent they wish.

LOC
Level of
Care



MORE
INFORMATION

FC
Free
Choice

- Beneficiaries have continuous access to service coordination and support in addressing issues encountered in community living.
- Another important assurance included within this is that of Health and Welfare, (Health, Safety, and Well-Being) which means, in part, that
 - There is ongoing monitoring of the beneficiary’s well-being, health status, and the effectiveness of the waiver services in meeting the beneficiary’s goals.
- There is also an assurance regarding service plans, which states that beneficiaries have a plan of care that is appropriate to their need and that they participate in developing, and the services are delivered according to that plan of care. Specifically,
 - The Plan of Care is comprehensive and person-centered
 - Services are furnished in accordance with the Plan of Care
 - The Plan of Care is revised when there is a significant change in the beneficiary’s needs or circumstances.

Please refer to Chapters 34 and 42 for additional information about developing and monitoring service plans.

BENEFICIARY RIGHTS AND RESPONSIBILITIES

Beneficiaries must receive support to exercise their rights and in accepting personal responsibilities.

This means that

- Beneficiaries are informed of and supported to freely exercise their fundamental constitutional and federal or statutory rights.
- Beneficiaries receive training and support to exercise and maintain their own decision-making authority.

HW
Health
and
Welfare

SP
Service
Plans


MORE
INFORMATION

FH
Fair
Hearing

- Beneficiaries are informed of how to register grievances and complaints and supported in seeking their resolution. Grievances and complaints are resolved in a timely fashion.

This includes the assurance of due process, which means that DMA will provide an opportunity for a fair hearing to individuals who have a request denied, suspended, or reduced, or who are disenrolled from a service or from the program.

Please refer to Chapter 53 for more information about CAP/C appeals.

PROVIDER CAPACITY AND CAPABILITIES

There must be sufficient HCBS providers and they must possess and demonstrate the capability to effectively serve beneficiaries.

This means that

- There are sufficient qualified agencies and individual providers to meet the needs of the beneficiaries in the community
- All waiver providers demonstrate the ability to provide services and supports in an effective and efficient manner consistent with the individuals plan

This includes the assurance of Qualified Providers, which means that all waiver agency and individual providers possess the requisite skills, competencies, and qualifications to support beneficiaries effectively; specifically,

- Adequate standards exist for each provider of services under the waiver, and all provider standards will be met. Standards may include licensure, certification, educational, professional, or other standards that ensure safe provision of care.
- There will be a provider agreement between Medicaid and each provider of service.

QP
Qualified
Providers



Detailed information about provider qualifications for each CAP/C service is included in the Chapter 11 and in the chapter describing the particular service (Section 3).

BENEFICIARY SAFEGUARDS

Beneficiaries are safe and secure in their homes and communities, taking into account their informed and expressed choices.

This means that

- Health risk and safety are assessed and a plan of care to promote health, independence, and safety is developed with the informed involvement of the beneficiary.
- The safety and security of the living arrangement is assessed, and modifications are offered to promote independence and safety in the home.
- Chemical and physical restraints are avoided .
- Medications are managed effectively and appropriately.
- There are safeguards in place to protect and support beneficiaries in the event of natural disasters and public emergencies.

This also includes the assurance of Quality Management, which means, in part, that

- There are systematic safeguards in place to protect beneficiaries from critical incidents and other life-endangering situations.

BENEFICIARY OUTCOMES AND SATISFACTION

Beneficiaries are satisfied with their services and achieve desired outcomes.

This means that

- Beneficiaries and family members, as appropriate, express satisfaction with their services and supports.

HW
Health
and
Welfare

QM
Quality
Management

QM
Quality
Management

SP
Service
Plans

- Services and supports lead to positive outcomes for each beneficiary.

SYSTEM PERFORMANCE

The system supports beneficiaries efficiently and effectively and constantly strives to improve quality.

This means that

QM
Quality
Management

- The service system promotes effective and efficient provision of services by engaging in data collection and analysis.
- There is a systematic approach to the continuous improvement of quality in the provision of the waiver.
- The waiver effectively supports beneficiaries of diverse cultural and ethnic backgrounds.
- Beneficiaries and stakeholders have an active role in program design, performance appraisal, and quality improvement activities.

This includes the assurance of Administrative Authority, which means that

AA
Administrative
Authority

- The State Medicaid agency is involved in the oversight of the waiver, and is ultimately responsible for all facets of the waiver program. The CAP/C waiver states that the waiver will be directly operated by Medicaid.

This also includes the assurance of Financial Accountability, which means

FA
Financial
Accountability

- Claims for waiver services are paid for in accordance with the reimbursement methodology specified in the waiver.
- Reports must be submitted to CMS which document the cost of services provided under the waiver.
- The total amount of money that Medicaid spends (including waiver and non-waiver services and supplies) to care for beneficiaries in their homes can not be more than the amount of money Medicaid would

have spent on those beneficiaries if they were in a nursing facility or hospital. This is referred to as cost neutrality.



MORE
INFORMATION

Please refer to Chapter 4 for more information regarding many of these assurances.



MORE
INFORMATION

These seven areas are the focus of CMS' quality framework for home and community based waivers. This framework is discussed in more detail in Chapter 54.

CHAPTER REVIEW

Key Points

1. A waiver program offers services and supplies not normally covered by the state's Medicaid program. Beneficiaries also get all regular Medicaid services (subject to program criteria, prior approval requirements, etc.)
2. Under the waiver, the income of the parents or other household members does not count in determining eligibility for Medicaid. Only the child's income, if any, is counted.
3. In order to operate the waiver, the state must make assurances to CMS. These assurances involve
 - Health and Welfare
 - Service Plans
 - Qualified Providers
 - Level of Care Determination
 - Administrative Authority
 - Financial Accountability
 - Quality Assurance
 - Fair Hearings
4. These assurances are the basis for a Quality Framework developed by CMS for home and community based waivers such as CAP/C. The framework focuses on the following areas:
 - Beneficiary Access
 - Beneficiary Service Planning and Delivery
 - Beneficiary Rights and Responsibilities
 - Provider Capacity and Capabilities
 - Beneficiary Safeguards
 - Beneficiary Outcomes and Satisfaction
 - System Performance.



Test Your Knowledge

1. The CAP/C waiver is approved by _____.
2. The assurance regarding level of care means that beneficiaries must meet _____ level of care, and that this determination is reevaluated _____.
3. If a potential beneficiary applies for CAP/C, and CAP/C is denied, that potential beneficiary is entitled to a _____.
4. Free choice means that the beneficiary has the freedom to choose between _____ and _____, and among _____.
5. During contact with beneficiaries, the Case Manager must ask specifically about the beneficiary's satisfaction with services. This is because our quality management program must include a focus on _____.
6. True or False: An applicant who is determined not to be eligible for CAP/C should be referred to other community resources.
7. CAP/C imposes dollar limits on each waiver service. This is because of the cost neutrality requirement. Cost neutrality means that
 - a. Claims are paid correctly and promptly
 - b. The cost of care for the beneficiaries of CAP/C must not be more than the cost of caring for those beneficiaries in an institution such as a nursing facility.
8. According to CAP/C's Administrative Authority assurance, can a CAP/C Case Manager approve or deny a beneficiary for services?
9. Any provider of a waiver service to CAP/C beneficiaries must enroll with Medicaid. This is to ensure _____.

1. The Center for Medicare and Medicaid Services (CMS). 2. Institutional or Nursing Facility; annually. 3. fair hearing. 4. institutionalization; CAP/C; all Medicaid enrolled qualified providers. 5. beneficiary satisfaction and outcomes 6. True 7. B 8. No, the waiver is directly operated by Medicaid. 9. Qualified Providers/Provider Capacity and Capability.

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SECTION 1 CAP/C CONCEPTS AND PRINCIPLES

CHAPTER 4 CAP/C Basics

THE HISTORY OF CAP/C

Home-based care for children needing long-term medical care was recognized as a viable alternative to institutional care when Katie Beckett's situation became a national issue. Katie Beckett is a child in Iowa who was hospitalized for an extended period. She reached a point where hospitalization was no longer needed, but she could not return home because of the cost of care. Medicaid paid for her hospital care, but her parents' income prevented Katie from being eligible for Medicaid at home. Her situation received national attention, which resulted in home-based care similar to that for disabled adults becoming available for children. North Carolina implemented CAP/C in 1983. In 1995, DMA expanded the program beyond the "Katie Beckett" model to include children who are eligible for Medicaid without applying special rules for the parents' income and resources.

LOC
Level of
Care

THE PURPOSE OF CAP/C

The Community Alternatives Program for Children (CAP/C) is a special Medicaid-waivered home and community care program. It is designed to serve medically high risk children who would be at risk for institutionalization in a nursing facility or hospital without Medicaid payment for the home care services and supplies available through CAP/C. With proper case management, a complete package of services and supplies, and support

MF
Medically
Fragile

LOC
Level of
Care

MN
Medically
Necessary

HWHealth and
Welfare

from the parents or substitute parents, some of these children may remain safely at home at a lower cost to Medicaid than institutional care.

FAFinancial
Accountability**THE GOAL OF CAP/C**

The goal of the CAP/C program is to allow children needing long-term medical care to return to or remain in the community and live as independently as possible in their homes.

LOCLevel of
Care

CAP/C can be provided to children who are either at home facing nursing home or long-term hospital placement, or to children in a nursing facility or hospital who want to come home.

WHAT CAP/C OFFERS

When a person is considered for CAP/C, the child's and family's strengths and needs are assessed by a Registered Nurse or a Registered Nurse/qualified Case Manager (usually Social Worker) team from the local case management agency. Either the Registered Nurse or the qualified Case Manager, depending upon agency policy and on the level of care of the child, becomes the child's Case Manager. After the assessment, the Case Manager develops a plan of care that builds on those strengths and meets the child's and family's needs and goals.

QPQualified
Providers

The Plan of Care must include the following CAP/C services:

- Case management
- At least one other waiver service per rolling 90 days, excluding respite and incontinence supplies) from the list below:

The Plan of Care may include the following CAP/C services:

- In-home CAP/C Nursing Care, Pediatric Nurse Aide Care, or Personal Care, on a regularly scheduled basis

SPService
Plans

- Respite Care (In-Home Nurse, In-Home Nurse Aide, In-Home Pediatric Nurse Aide or Institutional)
- Home Modifications
- Motor Vehicle Modifications
- Waiver Supplies
- Caregiver Training and Education
- Palliative Care
- Community Transition Funding

In addition to the CAP/C services, the client also may receive “regular”, “non-waivered”, or “state plan” Medicaid services, without co-pay, under the guidelines for those services. Some examples of these services would be physical, occupational, or speech therapy; durable medical equipment; physician visits; and prescriptions.

WHAT CAP/C DOES NOT OFFER

MN
Medically
Necessary

Medicaid coverage of a CAP/C service is available to the extent that the service is a necessary component of a Plan of Care to prevent institutionalization. The amount and duration of each CAP/C service must not exceed the amount necessary to meet the program’s health and welfare requirements. Services are planned and authorized to meet the unmet needs of the child, not the needs or preferences of caregivers, provider agencies, or others involved in the child’s care.

LOC
Level of
Care

CAP/C exists to supplement rather than replace the formal and informal services and support already available to the child. It is not the role of CAP/C to assume long-term responsibility for the care of the client, but rather to assist family members. CAP/C services are provided only in cases when assistance is needed by informal caregivers to meet specific unmet needs of the child.

HW
Health and
Welfare

SP
Service
Plans

An individual is placed on CAP/C because of a need for Medicaid coverage of CAP/C services, in addition to CAP/C Case Management, to avoid institutional care. A child is not placed on CAP/C solely to become eligible for Medicaid or other Medicaid services. CAP/C is not intended to replace other sources of funding, such as private insurance.

FA
Financial
Accounta-
bility

CAP/C services are not covered when the cost of those services exceed the annual hourly or fiscal limitations for those services.

AA
Administra-
-tive
Authority

CAP/ C services are not covered when the provider does not comply with all Medicaid guidelines and CAP/C procedures.

CAP/C does not cover services that duplicate another provider's service.

CAP/C does not cover convenience items or features.

CAP/C does not cover services that are experimental, investigational, or part of a clinical trial.

GUIDING PRINCIPLES

MF
Medically
Fragile

Medically Fragile

Medically Fragile refers to children who have:

- A primary diagnosis or diagnoses that is/are medical – not psychological, behavioral, cognitive, or developmental

Children with diagnoses such as Down's syndrome, autism, and behavioral disorders as their sole diagnosis usually do not qualify for CAP/C. [Those children should be referred to CAP-MR/DD (the Community Alternatives Program for Persons with Mental Retardation and/or Developmental Disabilities). More information about CAP-MR/DD can be found at

<http://www.ncdhhs.gov/dma/services/capmrdd.htm> and
<http://www.ncdhhs.gov/mhddsas/> .

- Needs that are directly related to the medical diagnosis.



MORE
INFORMATION

In addition to having a medical diagnosis, the CAP/C service or supply that is being requested needs to relate directly to that diagnosis.

For instance, there is no doubt that a child with congenital heart defects, cystic fibrosis, or cancer has a medical diagnosis.

However, the care needs associated with those diagnoses are usually more physician-related, and there is not normally a need for an in-home nurse or nurse aide to provide care for the child.

Therefore CAP/C Nursing, Pediatric Nurse Aide Service, or Personal Care services would not be approved. Conversely, a child with a minor nursing need that is related to a cognitive, behavioral, or developmental diagnosis; for example, incontinence related to the developmental delays associated with Down's syndrome, would also not qualify for in-home CAP/C Nursing, Pediatric Nurse Aide Care, or Personal Care services, because the care need is not related to a medical diagnosis.

- A serious, ongoing illness or chronic condition requiring prolonged hospitalization and ongoing medical treatments and monitoring
- Long-term care needs. CAP/C can not be provided for short-term needs such as postoperative care of an otherwise ineligible child.
- A need for devices or care to compensate for the loss of bodily function
Devices or care to compensate for the loss of bodily function may include, but are not limited to, incontinence care/supplies, orthoses, mobility aids, feeding tubes, or respiratory support devices.

Some Common Primary Diagnoses of CAP/C Children

cerebral palsy

other diplegia, quadriplegia, paresis

muscular dystrophy

spina bifida

spinal muscular atrophy

hydrocephalus

congenital malformations of respiratory tract –

laryngomalacia, tracheomalacia, bronchomalacia, vocal cord paralysis, tracheal stenosis, pharyngomalacia, tracheo-esophageal fistula

GE reflux

seizures

stroke

microcephalus

agenesis of the corpus callosum

genetic/chromosomal syndromes

short bowel syndrome

prematurity

intraventricular hemorrhage, periventricular leucomalasia, BPD

inborn errors of metabolism

arthrogryposis

Some of the Technology Commonly Used by CAP/C Children

ventilator

CPAP/BiPAP

tracheostomy

oxygen

feeding tube

vagal nerve stimulator

urinary catheterizations

braces, orthoses

ambulation/transfer assist device

Risk of Institutionalization

Risk of Institutionalization refers to children who:

- Are prior-approved through the fiscal agent for nursing facility level of care

Because CAP/C is an alternative to institutionalization, children must meet the criteria for institutionalization in order to qualify for CAP/C.

The process for prior approval consists of approval of the FL-2.

- Without in-home nursing care, would need to be institutionalized in a nursing facility or hospital as determined by statement of the parents or responsible party

This statement is obtained in writing on the 'Letter of Understanding and Freedom of Choice'.

- Do not have other available resources, formal or informal, including daycare/developmental daycare or family support which can meet their needs.

Since CAP/C is an alternative to institutionalization, and since Medicaid is always a payer of last resort, if other alternatives exist, CAP/C is not needed. CAP/C is meant to supplement, not replace, the formal and informal services and supports already available to the child. So, for example, if a developmental daycare is a valid option for a child, CAP/C could not replace that daycare. CAP/C may be able to supplement the daycare by providing in-home services such as bathing that would not be provided at daycare.

Continuous Nursing Care, Continuous Pediatric Nurse Aide Care, and Continuous Personal Care

Continuous is defined as:

LOC
Level of Care

CONT
Continuous

- intervention which is performed at least every two to four hours during the hours that Medicaid reimbursed nursing or nurse aide service is provided
- intervention that lasts for the duration of the Medicaid reimbursed nurse or nurse aide's shift and could not be provided as a home health visit.

CAP/C is designed for hourly private duty nursing or nurse aide care, not visits. Generally, a visit is of two hours duration or less. If the child's care can be completed in that time, CAP/C is probably not appropriate, and a referral to Home Health may be needed.

The continuous care must be provided while the nurse or nurse aide is in the home. For example, a child who receives bolus tube feedings throughout the day but no care at night would not be eligible to have CAP/C staff in the home overnight, even if the parent worked third shift and was not available.

Complex Nursing Care, Complex Pediatric Nurse Aide Care, and Complex Personal Care

COMP Complex

Complex means that there are actual, scheduled, hands-on interventions to be performed by the Nurse or Nurse Aide during the hours that the service is provided.

Having a Nurse or Nurse Aide with the beneficiary for observation or "just in case something happens" does not constitute complex care, and is not coverable under CAP/C Nursing, CAP/C Pediatric Nurse Aide Services, or CAP/C Personal Care Services.

Monitoring of a beneficiary, which involves active assessment of a beneficiary's condition and communication of those findings to a physician or other healthcare professional, is usually more appropriately done as a home health visit, but may be covered when the need meets CAP/C or EPSDT criteria.

Substantial Nursing Care

SUB
Substantial

Substantial means that the child has assessments and interventions that require the scope of practice of a licensed nurse and therefore are not delegable to a Nurse Aide.

Substantial Pediatric Nurse Aide Care

Substantial means that the child has interventions that require the scope of practice of a Nurse Aide I+ or Nurse Aide II. The services are not delegable to a Nurse Aide I or lower level of care.

Substantial Personal Care

Substantial means that the child has interventions that require the scope of practice of a Nurse Aide I. The services are not delegable to an aide not listed on the registry.

 MORE INFORMATION

Please refer to Appendix H for information regarding scope of practice for Nurses and Nurse Aides.

Health and Welfare

HW
Health and Welfare

A state must provide various assurances to CMS (Center for Medicare and Medicaid Services) in order to operate a waiver program such as CAP/C. North Carolina has assured CMS that we will protect the health and welfare of our beneficiaries. These safeguards include: provider standards; certification/licensure requirements; specifications on the location of service delivery; case management oversight of the home, the care provided, and the parental involvement in the plan of care; and prevention, identification, and treatment of instances of abuse, neglect, and exploitation.

 MORE INFORMATION

Please refer to Chapter 3 for more information regarding Health and Welfare.

Beneficiary Choice/Freedom of Choice

FC
Free
Choice

Each CAP/C beneficiary has the right to select:

- Between CAP/C services and institutionalization, and
- Among enrolled Medicaid provider agencies for CAP/C and other Medicaid services, and
- Among individuals within those provider agencies who will provide the CAP/C and other Medicaid services.

Case managers ensure that beneficiaries are aware of these rights, and take steps to avoid conflicts of interest.



MORE
INFORMATION

Please refer to Chapter 3 for more information regarding Free Choice.

Nursing Facility Level of Care

LOC
Level of
Care

CAP/C is an alternative to placement in a nursing facility, so the child must qualify for care in a nursing facility in order to be approved for CAP/C. Nursing facilities use the FL-2 form to qualify people for nursing home placement, so CAP/C uses that form as well. The fiscal agent (currently CSC) will approve the FL-2 for “nursing facility level of care” (formerly ‘Intermediate’ level of care or ‘skilled’ level of care).



MORE
INFORMATION

Please refer to Chapter 29 for more information regarding the FL-2 and level of care determination.

Financial Accountability

FA
Financial
Accountability

Financial Accountability refers in part to cost-effectiveness and cost-neutrality.

Cost-Effectiveness

For any Medicaid service to be approved, there must be no other as effective and less costly option available statewide.

For example, if Medicaid Personal Care Services (PCS) can meet the child's needs, then CAP/C Pediatric Personal Care can not be approved.

Cost Neutrality

The cost of CAP/C care must be less than the cost of its alternative: nursing home placement or hospitalization. For this reason, there are limits on the amount of time or money that can be provided for most waiver services. By making sure that beneficiaries adhere to these limits, we can assure CMS that our CAP/C program is cost-neutral.

'not for Medicaid only'

An individual is placed on CAP/C because of a need for CAP/C services, in addition to CAP/C case management, to avoid institutional care. A child is not placed on CAP/C solely to become eligible for Medicaid or other Medicaid services.

Although a family doesn't have to financially qualify for Medicaid to get CAP/C, once they get CAP/C, they get Medicaid. This means that in addition to their CAP/C services, Medicaid pays doctors office bills, hospital bills, prescriptions, etc. Many people apply for or try to keep CAP/C because of this financial assistance. However, this is not an appropriate use of CAP/C. CAP/C can only be approved because a beneficiary needs case management plus at least one other waiver service (excluding respite and incontinence supplies) at least every 90 days. CAP/C will not be approved for any other reason.

Please refer to Chapter 3 for more Information regarding Financial Accountability.

Administrative Authority

Unlike other waivers, which designate some authority to local lead agencies (such as CAP-DA does) or to contracted entities such as Value Options (such



MORE
INFORMATION



Administra-
-tive
Authority

as CAP-MR/DD does), the state Division of Medical Assistance (DMA) maintains complete administrative authority over the CAP/C waiver. This means that all referrals, assessments, plans of care, and disenrollment requests must be submitted to DMA for approval or denial.

Please refer to Chapter 3 for more Information regarding Administrative Authority.

Fair Hearings

FH
Fair
Hearing

Fair Hearings is also sometimes referred to as 'due process', or as 'appeal rights'. It means that any time the request of a beneficiary or applicant is denied, in whole or in part, that beneficiary or applicant must be given the right to a hearing. The hearing could be because of DMA's denial of a beneficiary's

- choice between CAP/C and institutionalization,
- services of choice, and/or
- providers of choice

At the hearing, the decision will be re-evaluated and either upheld or overturned.

Please refer to Chapter 53 for more information regarding fair hearings.



MORE
INFORMATION

Medical Necessity

MN
Medically
Necessary

Medically necessary, as defined by CMS, refers to services or supplies that are proper and needed for the diagnosis and treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of the condition, and meet the standards of good medical practice.

Medicaid coverage of a CAP/C service is available to the extent that the service is a necessary component of a Plan of Care to prevent institutionalization. The amount and duration of services covered is individually determined, but is subject to both CAP/C and Medicaid policies and

guidelines. The amount and duration of CAP/C services must not exceed the amount necessary to meet the program's requirements for the health and welfare of its beneficiaries. Convenience items or features are not covered.

Medical Necessity encompasses the following two principles:

'specific unmet needs' of the child

Services are planned and authorized to meet the specific unmet needs of the child, not the needs or preferences of caregivers, provider agencies, or others involved in the child's care when those needs do not coincide with the child's needs.

Staffing issues cannot be a factor in planning care. We cannot approve CAP/C Nursing instead of Pediatric Personal Care because a nurse is available and an aide is not.

'supplement rather than replace'

CAP/C exists to supplement, rather than replace, the formal and informal support already available to a child. It is not the role of CAP/C to assume long-term responsibility for the care of the client, but rather to assist family members. CAP/C services are provided only in cases where assistance is needed by informal caregivers to meet specific unmet needs of the child.

CAP/C is not intended to replace other sources of funding, such as private insurance.

Formal support includes services provided by private insurance, school, or daycare. Informal support includes care provided by family, relatives, neighbors, etc.

This concept is important in terms of overall CAP/C approval, but it is of particular importance when determining the number of nurse, nurse aide, or attendant hours that can be approved on the Plan of Care.

Qualified Providers

QP
Qualified
Providers

Qualified Providers is a term meaning that the people, both individuals and agencies, who provide services for CAP/C beneficiaries must be qualified to do so. Each agency must be enrolled with Medicaid as a CAP/C service provider, and each individual must meet appropriate standards for education, experience, oversight, and other criteria.

MORE
INFORMATION

Please refer to Chapter 11 and to each chapter in which a CAP/C service is described (Section 3) for more information regarding Qualified Providers.

Service Plans**SP**
Service
Plans

Service Plans is a term used to encompass the necessary aspects of a plan of care. These are

- The Plan of Care is comprehensive and person-centered
- Services are furnished in accordance with the Plan of Care
- The Plan of Care is revised when there is a significant change in the beneficiary's needs or circumstances.

MORE
INFORMATION

Please refer to Chapters 1, 34 and 42-44 for additional information about developing and monitoring service plans.

CHAPTER REVIEW

Key Points

1. To qualify for a CAP/C service or supply, a child has to be medically high risk (medically fragile).
2. To qualify for a CAP/C service or supply, a child must need and be eligible for the same level of care that could be received in a nursing home or hospital (level of care).
3. To qualify for a CAP/C service or supply, the amount and cost of the child's home care must be less than the cost of institutionalization (financial accountability/cost neutrality).
4. To qualify for a CAP/C service or supply, a child must be able to be safely cared for at home (health and welfare).
5. Medicaid payment of the service or supply must be needed. If private insurance or some other funding source completely covers the need, there is no need for CAP/C (medically necessary).
6. Case Management (plus at least one other waiver service per 90 days, excluding respite and waiver incontinence supplies) is required.
7. Although beneficiaries of CAP/C are also eligible for other Medicaid services and supplies, eligibility for Medicaid is not a reason by itself for approval of CAP/C.
8. Family/caregivers must participate in the child's care and in the CAP/C program.
9. Nurse Care, Pediatric Nurse Aide Care, and CAP/C Personal Care must be continuous, meaning that there are interventions to be done every two to four hours during the shift, or that there are enough interventions to last the duration of a shift. The care could not be provided as a Home Health visit (continuous).

10. Nurse Care, Pediatric Nurse Aide Care, and CAP/C Personal Care must also be complex, meaning that there are scheduled, hands-on tasks to be performed, not merely observation (complex).
11. Nurse Care must be substantial, meaning that it could not be delegated to a Nurse Aide; the care needs require the scope of practice of an LPN or RN. Pediatric Nurse Aide Care must be substantial, meaning that it could not be delegated to a NA I; the care requires the scope of practice of a NA I+ or NA II. CAP/C Personal Care must be substantial, meaning that it could not be delegated to a staff person not on the nurse aide registry; the care requires the scope of practice of a NA I (substantial).
12. Beneficiaries have a choice between CAP/C and institutionalization, and among enrolled qualified Medicaid providers (free choice).
13. DMA is the 'lead agency' for CAP/C. It retains complete administrative authority over the waiver (administrative authority).
14. A beneficiary that is denied their choice of CAP/C or institutionalization, or their choice of service or choice of providers, in whole or in part, by DMA, is entitled to a fair hearing (fair hearing).
15. Providers of CAP/C services must meet Medicaid and CAP/C provider qualifications (qualified providers).



Test Your Knowledge

Match the terms in the first column with the definitions in the second column.

Each term is used only once.

- | | |
|-----------------------------|---|
| a. medically fragile | 1. ____ Care that is provided every two to four hours during the time that the paid CAP/C staff is there. |
| b. level of care | 2. ____ Needing the same type of care as would be received in a nursing facility or hospital. |
| c. medically necessary | 3. ____ The cost of home care is less than the cost of institutionalization. |
| d. fair hearing | 4. ____ Care needs that require the scope of practice of an RN or LPN. |
| e. financial accountability | 5. ____ DMA is the 'lead agency' for CAP/C. |
| f. administrative authority | 6. ____ A beneficiary is entitled to appeal any time that DMA denies a requested service or supply. |
| g. service plan | 7. ____ Having a diagnosis that is primarily medical, chronic, has care needs that directly relate to that medical diagnosis, and requires devices or care to compensate for a loss of bodily function. |
| h. health and welfare | 8. ____ Care that requires hands-on tasks rather than observation. |
| i. continuous | 9. ____ Care that is not age-appropriate and does not take over for other available resources. |
| j. complex | |
| k. substantial | |
| l. qualified providers | |
| m. free choice | |

10. ___ Services are furnished in accordance with the plan of care, change as the beneficiary's need change, and are comprehensive and person-centered.
11. ____ Measures taken to ensure that the beneficiary can be cared for safely in the home.
12. ____ Beneficiaries have the right to choose between CAP/C and institutionalization, and among enrolled Medicaid providers.
13. ____ Providers of waiver services must meet Medicaid and program standards for education, experience, oversight, and other criteria.

1. i, 2. b, 3. e, 4. k, 5. f, 6. d, 7. a, 8. j, 9. c, 10. g, 11. h, 12. m, 13. l

SECTION 1

CAP/C CONCEPTS AND PRINCIPLES

CHAPTER 5

Medicaid Basics

This section gives the case manager general information about Medicaid as well as information specific to CAP/C.

The details of Medicaid require considerable expertise to understand. Do not try to be a Medicaid expert. Please do not advise beneficiaries or their families/caregivers about Medicaid eligibility. If they or you have questions about Medicaid eligibility, please contact your county DSS Medicaid staff.

WHAT MEDICAID IS

Medicaid pays medical bills for certain people with limited income. Title XIX of the Social Security Act contains the Federal law for Medicaid. The Centers for Medicare and Medicaid Services (CMS) carries out the law by writing regulations and overseeing each State's operation of the program. States have some flexibility within the Federal law and regulations to have their own rules. Program costs are paid by Federal and State funds.

Many aspects of Medicaid are similar to private health insurance. There are ID cards, deductibles to be met in certain situations, co-payments for some services and prior approval requirements for certain coverage. Just as a private insurer's coverage may not be the same for all policy holders, Medicaid coverage differs across categories of beneficiaries.

WHO'S INVOLVED

Division of Medical Assistance

The Division of Medical Assistance (DMA), in the Department of Health and Human Services (DHHS), administers Medicaid in North Carolina. It establishes the rules and procedures for the program and directs its operation. DMA's activities must follow Federal guidelines.

Case Managers

As a case manager, you help to assure that care is appropriate, medically necessary and provided according to Medicaid guidelines. Your efforts are needed to get the best care for CAP/C beneficiaries as well as the best use of public funds.

Providers, Physicians, and Health Care Professionals

These individuals provide care and confirm that care orders are appropriate to the beneficiary's needs. They help assure the quality and the cost-effectiveness of care.

County Departments of Social Services

County Departments of Social Services (DSS) use State-issued policies to accept Medicaid applications and determine Medicaid eligibility.

The Fiscal Agent

The fiscal agent processes Medicaid claims and performs a variety of other administrative tasks, including prior approval of some services. All of this is done through terms of a contract between DMA and the fiscal agent. In addition, local Social Security Administration offices process applications for Supplemental Security Income (SSI). SSI applications are also applications for Medicaid.

Beneficiaries and Caregivers

Beneficiaries and those who assist them are important to the success of the program. Their mutual cooperation in establishing eligibility and in the delivery and receipt of health care is essential to meeting the goals of Medicaid.

WHO IS ELIGIBLE

Persons who receive Supplemental Security Income (SSI) automatically qualify to Medicaid in North Carolina.

Other individuals may receive Medicaid if they are in an eligible group or category and meet North Carolina Medicaid income and assets limits. These individuals must apply to and be determined eligible by the DSS in the county in which they live.

Medicaid eligibility is linked to the income and, usually, the resources of the individual. Eligibility may also involve the income and resources of parents and spouses. This is called the "deeming" of income and resources.

When the spouse or child is in institutional care under specific conditions, deeming may not apply. Because CAP/C is an alternative to nursing facility care and long term hospital care, CMS has allowed North Carolina to waive the deeming requirement and consider the income and resources of a parent similar to a long term care situation.

The DSS Medicaid staff will ask for the income and resources of the parents when the potential CAP/C beneficiary applies for Medicaid. DSS is required to look at all ways that a beneficiary may be eligible for Medicaid. In some instances, this is advantageous for the beneficiary, as it will allow the beneficiary to get on regular Medicaid before the CAP/C Plan of Care is approved. Do not tell parents that they will not be asked about income and resources.

RETROACTIVE ELIGIBILITY

Medicaid eligibility usually begins the month of application. A person may apply for coverage for one, two or three months prior to the month of application. Medicaid payment is available for regular Medicaid

services provided during this period if all requirements for the service are met. The dates on the Medicaid ID card will show this type of eligibility.

Retroactive coverage is not available for CAP/C services. The effective date that coverage of CAP/C services begins is the latest of:

- The Medicaid application date;
- The FL-2 approval date; or
- The date of deinstitutionalization.

This is known as the CAP effective date.

If a new CAP/C beneficiary is moving from another CAP program, the effective date may be adjusted to avoid an overlap of CAP programs. Contact your CAP/C Consultant in DMA for guidance when this situation occurs.

DEDUCTIBLES

A Medicaid deductible (also referred to as a “spend down”) is similar to a private insurance deductible. It is the amount of medical expenses for which the beneficiary is responsible before Medicaid will pay for covered services.

Unlike private insurance, the Medicaid deductible is based on income; therefore, the amount is not the same for each person.

SSI beneficiaries and most persons whose countable income is under the federal poverty level do not have a deductible. However, other persons who meet all other eligibility factors but whose income exceeds the federal poverty level have a deductible. The individuals are responsible for their health care costs until they incur medical bills equal to the amount of their deductible. Once the person’s incurred medical bills equal the amount of his/her deductible, Medicaid will pay for covered services for the remainder of the eligibility period. Medicaid may not pay for any expenses used to meet the deductible.

Medical expenses that can usually be used to meet a deductible include but are not limited to the following:

- Hospital charges.

- Clinic and laboratory charges.
- Charges by dentists, physicians, and therapists.
- Prescription drug charges.
- Charges for “over-the-counter” medicines and medical supplies.
- Medically-related transportation costs.
- Charges for dentures, eyeglasses, hearing aids, walkers and other medical equipment.
- Dietary supplements such as “Ensure” if prescribed by a physician.
- Premiums paid by the individual for private health insurance.

The expense must be incurred by the beneficiary to apply to the deductible. Bills in advance of the delivery of a service may not be applied.

The beneficiary must be responsible for an expense for the expense to count towards the deductible. There is one exception involving expenses paid with local or State government funds – DSS will apply this exception when appropriate.

If an expense is partly paid by private insurance, Medicare, or another third party, only the portion that is the beneficiary’s responsibility counts towards the deductible.

If the beneficiary is billed based on a sliding fee schedule, only the amount for which the beneficiary is responsible applies to the deductible.

A person on a deductible uses bills and receipts to meet the deductible; therefore, it is important that these items are obtained and given to DSS as quickly as possible.

There are two provisions about deductibles that apply to CAP/C beneficiaries.

- The deductible for a CAP/C beneficiary is met monthly rather than on a six-month basis.

- In addition to the usual expenses allowed toward a deductible, a CAP/C beneficiary may use the cost of CAP/C services approved on the Plan of Care if they are provided during the deductible period.

If you have a beneficiary with a deductible, get with the Medicaid worker to learn what expenses may apply and the best method to get the information quickly to the worker. Some case managers collect the bills and receipts to help expedite getting the information to DSS and the person authorized for Medicaid.

CO-PAYMENTS

Some Medicaid coverage require a co-payment by the Medicaid beneficiary. Visits to physicians, chiropractors, dentists and optometrists, as well as prescriptions, are examples of services that may require a co-payment. CAP/C beneficiaries are exempt from the co-payment requirements. This helps beneficiaries with prescription drugs and physician services. Providers are periodically reminded of the exemption in the *Medicaid Bulletin* and the *Medicaid Pharmacy Newsletter*. If you encounter a provider who is not aware of the exemption, suggest that the provider contact the fiscal agent.

PRIOR APPROVAL

Some Medicaid services require prior approval before Medicaid will cover the service. Examples include nursing facility care, ICF/MR care, CAP participation and CAP/C services, some durable medical equipment, certain dental coverage and private duty nursing.

CAP/C beneficiaries must meet the same requirements as other Medicaid beneficiaries to get the regular Medicaid services. Approval of the CAP/C Plan of Care does not replace the prior approval requirements or other eligibility requirements for services such as DME and Home Health Services.

WHICH MEDICAID CATEGORIES ARE ELIGIBLE FOR CAP/C

Though there are a variety of categories in Medicaid, only Medicaid beneficiaries in the following coverage groups may receive CAP/C:

- Medicaid for the Blind (MAB)
- Medicaid for the Disabled (MAD)
- Medicaid for children receiving adoption assistance (I-AS)
- Medicaid for children receiving foster care assistance (H-SF)

Not everyone on Medicaid may participate in CAP/C. This is why it is important that a case manager contact DSS when a new beneficiary is being considered.

COORDINATING WITH DSS MEDICAID STAFF

For your client to get CAP/C benefits and for providers to get paid, you must coordinate activities with the local DSS Medicaid staff. You should establish a contact person at the county DSS. The key areas requiring communication and coordination include:

- Referring a potential CAP/C beneficiary to DSS is critical so that a Medicaid application can be promptly initiated if the client is not on Medicaid. For a client on Medicaid, it will assure the client is in the proper Medicaid category.
- Promptly processing your assessment and Plan of Care to get an approval as quickly as possible is important for the beneficiary as well as DSS. DSS has strict time limits to act on applications. If the Plan is not approved within the time limit, DSS may have to deny the Medicaid application. This means a beneficiary may have to reapply for Medicaid. Getting the Plan approved within 45 days benefits the beneficiary.

- Coordinating deductibles helps the beneficiary and providers. If your beneficiary has a deductible, work with the DSS Medicaid staff and the beneficiary to be sure that there is a clear understanding of what may be used to meet the deductible, what proof is required for expenses, and who will get the proof to DSS. If the beneficiary has a recurring medical expense each month, such as medications, you may be able to develop a plan with DSS for the beneficiary to regularly meet the deductible by incurring the expense at the beginning of each month.
- Notifying DSS about CAP/C changes is necessary to be sure that your beneficiary receives the proper benefits and is given the proper notices about changes in Medicaid eligibility. DMA sends copies of initial approval, denial, and disenrollment letters to the DSS, but you will need to follow-up with the DSS to ensure that they have received the notice and the change has been made.
- If your beneficiary has a deductible, DSS needs a copy of the current Cost Summary from the Plan of Care so it knows what expenses may be used for the deductible.
- If you are considering disenrolling a beneficiary, coordinate the timing of the disenrollment with DSS. DSS has advance notice requirements that it must meet. If the beneficiary is hospitalized, placed in a nursing facility, or will be absent for 30 days or more, notify DSS.

Also you may find it helpful to receive copies of the notices that DSS sends to beneficiaries. This will alert you to possible changes in Medicaid eligibility as well as any problems that DSS is having in processing applications and re-certifications. DSS requires permission from beneficiaries to send copies to the case manager. If you are interested in this possibility, discuss it with DSS.

Remember that beneficiaries now receive an annual Medicaid card, and that card is not considered proof of Medicaid eligibility.

CHAPTER REVIEW

Key Points

1. CAP/C beneficiaries must have one of the following four types of Medicaid: MAB, MAD, I-AS, H-SF.
2. CAP/C beneficiaries are counted as a 'family of one'. Income of parents and spouses does not count; only the child's income, if any, counts.
3. An applicant may apply for Medicaid services to be retroactive for up to three months prior to the approval date. CAP/C services can only be retroactive to the CAP effective date.
4. The CAP effective date is the latest of three dates:
 - a. the date of the Medicaid application
 - b. the date of the approved FL-2
 - c. the date of deinstitutionalization
5. If a child has a deductible, or spend-down, that child is not eligible for Medicaid until they have met the spend-down. For CAP/C beneficiaries, spend-downs are met on a monthly, rather than 6 month basis.
6. CAP/C beneficiaries are exempt from copay requirements.
7. CAP/C beneficiaries must meet the same requirements as other Medicaid beneficiaries to get the regular Medicaid services.
8. It is important for the Case Manager to coordinate with the DSS regarding applications, absences, changes, deductibles, and disenrollments.
9. Medicaid, especially Medicaid eligibility is very complicated. Please refer to your DSS for any questions you may have.

 **Test Your Knowledge**

1. Which of the following is not a category of Medicaid that a CAP/C beneficiary could have while on CAP/C?
 - a. MAD (disabled)
 - b. MIC (infants and children)
 - c. I-AS (adoption assistance)
 - d. H-SF (foster care assistance)
2. True or False: In order for a CAP/C beneficiary to receive physical therapy, the beneficiary has to go through the same prior approval process as any other Medicaid beneficiary.
3. True or False: A CAP/C beneficiary with a spend-down may receive Medicaid-reimbursed services and supplies during the time they are meeting their spend-down.
4. Pharmacies _____ charge a CAP/C beneficiary a copay for Medicaid-reimbursed medication.
 - a. may
 - b. may not
5. Fill in the blanks. The CAP effective date is the latest of these three dates:
 - a. _____
 - b. _____
 - c. _____

1. b; 2. True; 3. False; 4. b; 5. the date of the Medicaid application, the date of the FL-2 approval, or the date of deinstitutionalization.

SECTION 1

CAP/C CONCEPTS AND PRINCIPLES

CHAPTER 6

Early Periodic Screening, Diagnosis, and Treatment

EPSDT POLICY INSTRUCTIONS UPDATE

Background

Federal Medicaid law at 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act] requires state Medicaid programs to provide Early and Periodic Screening, Diagnostics, and Treatment (EPSDT) for recipients under 21 years of age. Within the scope of EPSDT benefits under the federal Medicaid law, states are required to cover any service that is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening,” whether or not the service is covered under the North Carolina State Medicaid Plan. The services covered under EPSDT are limited to those within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. The listing of EPSDT/Medicaid services is appended to this instruction.

EPSDT services include any medical or remedial care that is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This means that EPSDT covers most of the treatments a recipient under 21 years of age needs to stay as healthy as possible, and North Carolina Medicaid must provide for arranging for (directly or through referral to appropriate agencies, organizations, or individuals) corrective treatment the need for which is disclosed by such child health screening services. “**Ameliorate**” means to improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Even if the service will not cure the recipient’s condition, it must be covered if the service is medically necessary to improve or maintain the recipient’s overall health.

EPSDT makes short-term and long-term services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients 21 years of age and over). For example, a service must be covered under EPSDT if it is necessary for immediate relief (e.g., pain medication). It is also important to note that treatment need not ameliorate the recipient’s condition taken as a whole, but need only be medically necessary to ameliorate one of the recipient’s conditions. The services must be prescribed by the recipient’s physician, therapist, or other licensed practitioner and often must be approved in advance by Medicaid. See the *Basic Medicaid Billing Guide, Section 6* (on the Web at <http://www.ncdhhs.gov/dma/basicmed/>), for further information about EPSDT and prior approval requirements.

EPSDT Features

Under EPSDT, there is:

1. No Waiting List for EPSDT Services

EPSDT does not mean or assure that physicians and other licensed practitioners or hospitals/clinics chosen by the recipient and/or his/her legal representative will not have waiting

EPSDT Policy Instructions Update

07/31/07

REV. 03/23/09

REV. 01/11/10

lists to schedule appointments or medical procedures. However, Medicaid cannot impose any waiting list and must provide coverage for corrective treatment for recipients under 21 years of age.

2. No Monetary Cap on the Total Cost of EPSDT Services*

A child under 21 years of age financially eligible for Medicaid is entitled to receive EPSDT services without any monetary cap provided the service meets all EPSDT criteria specified in this policy instruction. If enrolled in a Community Alternatives Program (CAP), the recipient under 21 years of age may receive **BOTH** waiver and EPSDT services. However, it is important to remember that the conditions set forth in the waiver concerning the recipient's budget and continued participation in the waiver apply. That is, the cost of the recipient's care must not exceed the waiver cost limits specified in the CAP waivers for Children (CAP/C) or Disabled Adults (CAP/DA). Should a recipient enrolled in the CAP waiver for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD) need to exceed the waiver cost limit, prior approval must be obtained from ValueOptions.

***EPSDT services are defined as Medicaid services within the scope of the category of services listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. See attached listing.**

3. No Upper Limit on the Number of Hours or Units under EPSDT

For clinical coverage policy limits to be exceeded, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

4. No Limit on the Number of EPSDT Visits to a Physician, Therapist, Dentist, or Other Licensed Clinician

To exceed such limits, the provider's documentation must address why it is medically necessary to exceed the limits in order to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

5. No Set List that Specifies When or What EPSDT Services or Equipment May Be Covered

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. However, specific limitations in service definitions, clinical policies, or DMA billing codes **MAY NOT APPLY** to requests for services for children under 21 years of age.

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

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing. Provider documentation must address why the service is medically necessary to correct or ameliorate a defect, physical and mental illness, or condition [health problem].

8. Coverage for Services Not Listed in the N.C. State Medicaid Plan

Only those services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act] can be covered under EPSDT. See attached listing.

EPSDT Criteria

It is important to note that the service can only be covered under EPSDT if all criteria specified below are met.

1. EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. For example, "rehabilitative services" are a covered EPSDT service, even if the particular rehabilitative service requested is not listed in DMA clinical policies or service definitions.

2. The service must be medically necessary to correct or ameliorate a defect, physical or mental

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illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner. By requiring coverage of services needed to correct or ameliorate a defect, physical or mental illness, or a condition [health problem], EPSDT requires payment of services that are medically necessary to sustain or support rather than cure or eliminate health problems to the extent that the service is needed to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

3. The requested service must be determined to be medical in nature.
4. The service must be safe.
5. The service must be effective.
6. The service must be generally recognized as an accepted method of medical practice or treatment.
7. The service must not be experimental/investigational.

Additionally, services can only be covered if they are provided by a North Carolina Medicaid enrolled provider for the specific service type. This may include an out-of-state provider who is willing to enroll if an in-state provider is not available.

IMPORTANT POINTS ABOUT EPSDT COVERAGE

General

1. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. EPSDT services must be coverable within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]. EPSDT requires Medicaid to cover these services if they are medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. "**Ameliorate**" means to improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.
3. Recipients under 21 must be afforded access to the full panoply of EPSDT services, including case management. Case management must be provided to a Medicaid eligible child if medically necessary to correct or ameliorate the child's condition regardless of eligibility for CAP waiver services.
4. EPSDT services need not be services that are covered under the North Carolina State Medicaid Plan or under any of the Division of Medical Assistance's (DMA) clinical coverage policies or service definitions or billing codes.
5. Under EPSDT, North Carolina Medicaid must make available a variety of individual and group providers qualified and willing to provide EPSDT services.
6. EPSDT operational principles include those specified below.
 - a. When state staff or vendors review a covered state Medicaid plan services request for prior approval or continuing authorization (UR) for an individual under 21 years of age, the reviewer will apply the EPSDT criteria to the review. This means that:
 - (1) Requests for EPSDT services do **NOT** have to be labeled as such. Any proper request for services for a recipient under 21 years of age is a request for EPSDT services. For recipients under 21 years of age enrolled in a CAP waiver, a request for services must be considered under EPSDT as well as under the waiver.
 - (2) The decision to approve or deny the request will be based on the recipient's medical need for the service to correct or ameliorate a defect, physical [or] mental illness, or condition [health condition].
 - b. The specific coverage criteria (e.g., particular diagnoses, signs, or symptoms) in the DMA clinical coverage policies or service definitions do **NOT** have to be met for recipients under

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21 years if the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems].

c. The specific numerical limits (number of hours, number of visits, or other limitations on scope, amount or frequency) in DMA clinical coverage policies, service definitions, or billing codes do NOT apply to recipients under 21 years of age if more hours or visits of the requested service are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem]. This includes the hourly limits and location limits on Medicaid Personal Care Services (PCS) and Community Support Services (CSS).

d. Other restrictions in the clinical coverage policies, such as the location of the service (e.g., PCS only in the home), prohibitions on multiple services on the same day or at the same time (e.g., day treatment and residential treatment) must also be waived under EPSDT as long as the services are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem].

Out-of-state services are NOT covered if similarly efficacious services that are medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problems] are available anywhere in the state of North Carolina. Services delivered without prior approval will be denied. There is no retroactive prior approval for services that require prior approval, unless there is retroactive Medicaid eligibility. See DMA's *Basic Medicaid Billing Guide*, **Section 6** (on the Web at <http://www.ncdhhs.gov/dma/basicmed/>), for further information regarding the provision of out-of-state services.

e. Providers or family members may write directly to the Assistant Director for Clinical Policy and Programs, Division of Medical Assistance, requesting a review for a specific service.

However, DMA vendors and contractors must consider any request for state Medicaid plan services for a recipient under 21 years of age under EPSDT criteria when the request is made by the recipient's physician, therapist, or other licensed practitioner in accordance with the Division's published policies. If necessary, such requests will be forwarded to DMA or the appropriate vendor.

f. Requests for prior approval for services must be fully documented to show medical necessity. This requires current information from the recipient's physician, other licensed clinicians, the requesting qualified provider, and/or family members or legal representative. If this information is not provided, Medicaid or its vendor will have to obtain the needed information, and this will delay the prior approval decision. See procedure below for requesting EPSDT services regarding further detail about information to be submitted.

g. North Carolina Medicaid retains the authority to determine how an identified type of equipment, therapy, or service will be met, subject to compliance with federal law, including consideration of the opinion of the treating physician and sufficient access to alternative services. Services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner, the determination process does not delay the delivery of the needed service, and the determination does not limit the recipient's right to free choice of North Carolina Medicaid enrolled providers who provide the approved service. It is not sufficient to cover a standard, lower cost service instead of a requested specialized service if the lower cost service is not equally effective in that individual case.

h. Restrictions in CAP waivers such as no skilled nursing for the purpose of monitoring do not apply to EPSDT services if skilled monitoring is medically necessary. Nursing services will be provided in accordance with 21 NCAC 36.0221 (adopted by reference).

i. Durable medical equipment (DME), assistive technology, orthotics, and prosthetics do NOT have to be included on DMA's approved lists or be covered under a CAP waiver program in

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order to be covered under EPSDT subject to meeting the criteria specified in this policy.
 j. Medicaid will cover treatment that the recipient under 21 years of age needs under this EPSDT policy. DMA will enroll providers, set reimbursement rates, set provider qualifications, and assure the means for claims processing when the service is not already established in the North Carolina State Medicaid Plan. k. Requests for prior approval of services are to be decided with reasonable promptness, usually within 15 business days. No request for services for a recipient under 21 years of age will be denied, formally or informally, until it is evaluated under EPSDT.

l. If services are denied, reduced, or terminated, proper written notice with appeal rights must be provided to the recipient and copied to the provider. The notice must include reasons for the intended action, citation that supports the intended action, and notice of the right to appeal. Such a denial can be appealed in the same manner as any Medicaid service denial, reduction, or termination.

m. The recipient has the right to continued Medicaid payment for services currently provided pending an informal and/or formal appeal. This includes the right to reinstatement of services pending appeal if there was less than a 30 day interruption before submitting a reauthorization request.

EPSDT Coverage and CAP Waivers

1. Waiver services are available only to participants in the CAP waiver program and are not a part of the EPSDT benefit unless the waiver service is ALSO an EPSDT service (e.g. durable medical equipment).
2. Any request for services for a CAP recipient under age 21 must be evaluated under BOTH the waiver and EPSDT.
3. Additionally, a child financially eligible for Medicaid outside of the waiver is entitled to elect EPSDT services without any monetary cap instead of waiver services.
4. ANY child enrolled in a CAP program can receive BOTH waiver services and EPSDT services. However, if enrolled in CAP/C or CAP/DA, the cost of the recipient's care must not exceed the waiver cost limit. Should the recipient be enrolled in the Community Alternatives Program for Persons with Mental Retardation and Developmental Disabilities (CAP/MR-DD), prior approval must be obtained to exceed the waiver cost limit.
5. A recipient under 21 years of age on a waiting list for CAP services, who is an authorized Medicaid recipient without regard to approval under a waiver, is eligible for necessary EPSDT services without any waiting list being imposed by Medicaid. For further information, see "No Waiting List for EPSDT" on page 2 of this instruction.
6. EPSDT services must be provided to recipients under 21 years of age in a CAP program under the same standards as other children receiving Medicaid services. For example, some CAP recipients under 21 years of age may need daily in-school assistance supervised by a licensed clinician through community intervention services (CIS) or personal care services (PCS). It is important to note that Medicaid services coverable under EPSDT may be provided in the school setting, including to CAP/MR-DD recipients. Services provided in the school and covered by Medicaid must be included in the recipient's budget.
7. Case managers in the Community Alternatives Program for Disabled Adults (CAP/DA) can deny a request for CAP/DA waiver services. If a CAP/DA case manager denies, reduces, or terminates a CAP/DA waiver service, it is handled in accordance with DMA's recipient notices procedure. **No other case manager can deny a service request supported by a licensed clinician, either formally or informally.**
8. When a recipient under 21 years of age is receiving CAP services, case managers must request

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covered state Medicaid plan services as indicated below. Covered state Medicaid plan services are defined as requests for services, products, or procedures covered by the North Carolina State Medicaid Plan.

a. **CAP/C:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor and a plan of care revision submitted to the CAP/C Consultant in accordance with the CAP/C policy. A plan of care revision for waiver services must be submitted to the CAP/C consultant as well.

b. **CAP/DA:** Requests for medical, dental, and behavioral health services covered under the North Carolina State Medicaid Plan that require prior approval must be forwarded to the appropriate vendor and a plan of care revision submitted to the CAP/DA case manager in accordance with the CAP/DA policy. A plan of care revision for waiver services must be submitted to the CAP/DA case manager as well. **All EPSDT requests must be forwarded to the CAP/DA consultant at DMA.**

c. **CAP/MR-DD:** All EPSDT and covered state Medicaid plan requests for behavioral health services must be forwarded to ValueOptions. This includes requests for children not in a waiver who have a case manager. Requests for medical and dental services covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do **NOT** submit such requests to ValueOptions. Plan of care revisions must be submitted in accordance with the CAP/MR-DD policy.

EXCEPTION: Behavioral health services requested for individuals residing in the Piedmont Cardinal Health Plan (PCHP) catchment area. See item d below.

d. All EPSDT and covered state Medicaid plan requests for *behavioral health services* for Medicaid recipients in the Piedmont Cardinal Health Plan (PCHP) catchment area must be forwarded to PCHP. The PCHP catchment area includes Cabarrus, Davidson, Rowan, Stanly, and Union counties. Requests for *medical and dental services* covered under the North Carolina State Medicaid Plan must be forwarded to the appropriate vendor (medical or dental) for review and approval. Do *not* submit such requests to PCHP. Plan of care revisions must be submitted in accordance with the Piedmont Innovations waiver policy.

9. An appeal under CAP must also be considered under EPSDT criteria as well as under CAP provisions if the appeal is for a Medicaid recipient under 21 years of age.

EPSDT Coverage and Mental Health/Developmental Disability/Substance Abuse (MH/DD/SA) Services

1. Staff employed by local management entities (LMEs) CANNOT deny requests for services, formally or informally. Requests must be forwarded to ValueOptions or the other appropriate DMA vendor if supported by a licensed clinician.
2. LMEs may NOT use the Screening, Triage, and Referral (STR) process or DD eligibility process as a means of denying access to Medicaid services. Even if the LME STR screener does not believe the child needs enhanced services, the family must be referred to an appropriate Medicaid provider to perform a clinical evaluation of the child for any medically necessary service.
3. Requests for prior approval of MH/DD/SA services for recipients under 21 must be sent to ValueOptions or LME if providing utilization review for their catchment area. If the request needs to be reviewed by DMA clinical staff, ValueOptions will forward the request to the Assistant Director for Clinical Policy and Programs.
4. If a recipient under 21 years of age has a developmental disability diagnosis, this does not necessarily mean that the requested service is habilitative and may not be covered under EPSDT. The EPSDT criteria of whether the service is medically necessary to correct or ameliorate a defect, physical or mental illness, or condition [health problem] apply. Examples include dual

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diagnoses and behavioral disorders. All individual facts must be considered.

5. All EPSDT requirements (except for the procedure for obtaining services) fully apply to the Piedmont waiver.

PROCEDURE FOR REQUESTING EPSDT SERVICES

Covered State Medicaid Plan Services

Should the service, product, or procedure require prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval. **If prior approval is required** and if the recipient does not meet the clinical coverage criteria or needs to exceed clinical coverage policy limits, submit documentation with the prior approval request that shows how the service at the requested frequency and amount is medically necessary and meets all EPSDT criteria, including to correct or ameliorate a defect, physical or mental illness, or condition [health problem], to the appropriate vendor or DMA staff. When requesting prior approval for a covered service, refer to the *Basic Medicaid Billing Guide*, section 6. If the request for service needs to be reviewed by DMA clinical staff, the vendor will forward the request to the Assistant Director for Clinical Policy and Programs. Should further information be required, the provider will be contacted. See the Provider Documentation section of these instructions for information regarding documentation requirements.

In the event **prior approval is not required** for a service and the recipient needs to exceed the clinical coverage policy limitations, prior approval from a vendor or DMA staff is required. See the Provider Documentation section of these instructions for information regarding documentation requirements.

Services Formerly Covered by Children's Special Health Services (CSHS)

Previously, requests for pediatric mobility systems, cochlear implants and accessories, ramps, tie-downs, car seats, vests, DME, orthotics and prosthetics, home health supplies, not listed on DME fee schedules for recipients under 21 years of age, oral nutrition, augmentative and alternative communication devices, and over-the counter medications were approved and processed by CSHS. These services have been transferred from CSHS to Medicaid as specified below.

- **Pediatric Mobility Systems**, including non-listed components—Send to HP Enterprise Services using the Certificate of Medical Necessity/Prior Approval (CMN/PA form). Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, for details (on DMA's website at <http://www.ncdhhs.gov/dma/mp/>).
- **Cochlear/Auditory Brainstem Implants and Accessories**—Fax all requests for external parts replacement and repair, in letter format, to the appropriate cochlear or auditory brainstem implant manufacturer. The manufacturer will process requests, obtain prior approval for external speech processors, and file claims. Guidelines for the letter requesting external parts replacement or repair can be obtained from the cochlear or auditory brainstem manufacturer.
- **Oral Nutrition Formula on DMA Fee Schedules**—Send requests except those for metabolic formula to HP Enterprise Services. Refer to Clinical Coverage Policy 5A, *Durable Medical Equipment*, for details (on DMA's website at <http://www.ncdhhs.gov/dma/mp/>). Metabolic formula requests should be sent to the Division of Public Health.
- **Augmentative and Alternative Communication Devices on DMA Fee Schedules**—Send requests to HP Enterprise Services.
- **Ramps, Tie Downs, Car Seats, and Vests**—Effective with date of request September 1, 2008, CSHS no longer authorizes payment for ramps, tie-downs, car seats, and vests. These items are not included in the DME covered by Medicaid, nor are they covered under EPSDT services, which cover medical equipment and supplies suitable for use in the home for Medicaid recipients under the age of 21. However, if the recipient is covered under a Medicaid waiver, these items

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may be considered **if covered under the waiver**.

Non-Covered State Medicaid Plan Services

Requests for non-covered state Medicaid plan services are requests for services, products, or procedures that are not included at all in the North Carolina State Medicaid Plan **but are coverable** under federal Medicaid law, 1905(r) of the Social Security Act, for recipients under 21 years of age. See attached listing. **Medical and dental** service requests for non-covered state Medicaid plan services, and requests for a review when there is no established review process for a requested service, should be submitted to the Division of Medical Assistance, Assistant Director for Clinical Policy and Programs, at the address or facsimile (fax) number specified on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age. Requests for non-covered state Medicaid plan **mental health services** should be submitted to ValueOptions. The Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age is available on the DMA Web site <http://www.ncdhhs.gov/dma/provider/forms.htm>. To decrease delays in reviewing non-covered state Medicaid plan requests, providers are asked to complete this form. A review of a request for a noncovered state Medicaid plan service includes a determination that **ALL** EPSDT criteria specified in these instructions are met.

Requests for the services listed below should be sent to the Assistant Director, Clinical Policy and Programs, DMA and should be submitted on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age as specified at the end of this section and unless otherwise specified.

- **Any other service not listed on the DMA fee schedules for recipients under 21 years of age that appears at 1905(a) of the Social Security Act**

- **Over-the-Counter (OTC) Medications**—If the OTC has a National Drug Code (NDC) number and the manufacturer has a valid rebate agreement with the Centers for Medicare and Medicaid Services (CMS), but the drug does not appear on DMA's approved coverage listing of OTC medications.

Send requests for the services immediately above, any other non-covered state Medicaid plan services that are coverable under 1905(a) of the Social Security Act, or requests for a review when there is no established review process for a requested service on the Non-Covered State Medicaid Plan Services Request Form for Recipients under 21 Years of Age and mail or fax to

Assistant Director for Clinical Policy and Programs

Division of Medical Assistance

2501 Mail Service Center

Raleigh NC 27699-2501

FAX: 919-715-7679

Provider Documentation

Documentation for either covered or non-covered state Medicaid plan services should show how the service will correct or ameliorate a defect, physical or mental illness, or a condition [health problem].

This includes

1. documentation showing that medical necessity and policy criteria are met;
2. documentation to support that all EPSDT criteria are met; and
3. evidence-based literature to support the request, if available.

Should additional information be required, the provider will be contacted.

Instructions to Vendors Who Receive Prior Approval Requests Inappropriately from Providers

Vendors (HP Enterprise Services, ACS Pharmacy, CCME, and ValueOptions, etc.) may receive service

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requests from providers for which the vendor is not responsible for conducting the prior approval reviews. As vendors can only authorize specific services in accordance with DMA-vendor contracts, those requests should be forwarded to the appropriate vendor for review. For example:

1. If ValueOptions receives a request for breast surgery, the request should be forwarded to the prior approval section at HP Enterprises Services.
2. Should HP Enterprise Services receive a request for physical therapy, the request should be forwarded to CCME.
3. Should a vendor receive a request for Medicaid Personal Care Services (PCS) for a recipient **under 21 years of age**, the request should be forwarded to DMA, PCS Nurse Consultant, if the PCS clinical policy requires prior approval for the service requested in that case.

It should be noted that there may be a delay in making a decision when a provider sends a prior approval request to a vendor for which the vendor is not responsible for conducting the prior approval review. Once the request is received by the appropriate vendor, a decision will be reached promptly, usually within 15 business days of receipt of the request by the appropriate vendor.

Outreach

A special mailing publicizing Medicaid's EPSDT Policy instructions will be distributed to recipients and their legal representatives in the near future. The document will address general information about EPSDT, the Division's EPSDT Policy Instructions, and procedures for requesting services under EPSDT. This policy instruction shall remain posted at both DMA and DMH websites. DMA and DMH will regularly inform their staff, related DHHS Divisions, vendors, agents, Medicaid providers, families, and other agencies working with children on Medicaid (e.g. schools, Headstart, WIC, Smart Start, etc.) about this EPSDT policy and its procedures for EPSDT services. A summary of this policy and procedure, and a reference to the website address where it is posted, will be included in the Medicaid Consumer Guide for Families, in annual inserts with Medicaid cards, and in Medicaid provider bulletin articles at least annually. All affected staff, vendors, and providers will receive training on EPSDT policy and procedures. DHHS Division Directors will transmit these instructions to staff and vendors/ contractors.

For Further Information about EPSDT

- Important additional information about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the DMA EPSDT provider page. The web addresses are specified below.

Basic Medicaid Billing Guide

<http://www.ncdhhs.gov/dma/basicmed/>

Health Check Billing Guide

<http://www.ncdhhs.gov/dma/healthcheck/>

EPSDT Provider Page

<http://www.ncdhhs.gov/dma/epsdt/>

- DMA and its vendors will conduct trainings beginning fall 2007 for employees, agents, and providers on this instruction. Details will be published as soon as available.

ATTACHMENTS:

- Listing of Medicaid (EPSDT) Services Found in the Social Security Act at 1905(a) [42 U.S.C. § 1396d(a)]
- Non-Covered State Medicaid Plan Services Request Form

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LISTING OF EPSDT SERVICES FOUND AT 42 U.S.C. § 1396d(a) [1905(a) OF THE SOCIAL SECURITY ACT]

- Inpatient hospital services (other than services in an institution for mental disease)
- Outpatient hospital services
- Rural health clinic services (including home visits for homebound individuals)
- Federally-qualified health center services
- Other laboratory and X-ray services (in an office or similar facility)
- EPSDT (*Note: EPSDT offers periodic screening services for recipients under age 21 and Medicaid covered services necessary to correct or ameliorate a diagnosed physical or mental condition*)
- Family planning services and supplies
- Physician services (in office, recipient's home, hospital, nursing facility, or elsewhere)
- Medical and surgical services furnished by a dentist
- Home health care services (nursing services; home health aides; medical supplies, equipment, and appliances suitable for use in the home; physical therapy, occupation therapy, speech pathology, audiology services provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services)
- Private duty nursing services
- Clinic services (including services outside of clinic for eligible homeless individuals)
- Dental services
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- Prescribed drugs
- Dentures
- Prosthetic devices
- Eyeglasses
- Services in an intermediate care facility for the mentally retarded
- Medical care, or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law, specified by the Secretary (also includes transportation by a provider to whom a direct vendor payment can appropriately be made)
- Other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level
- Inpatient psychiatric hospital services for individuals under age 21
- Services furnished by a midwife, which the nurse-midwife is legally authorized to perform under state law, without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider throughout the maternity cycle
- Hospice care
- Case-management services
- TB-related services
- Respiratory care services
- Services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner, which the practitioner is legally authorized to perform under state law
- Personal care services (in a home or other location) furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease
- Primary care case management services

Definitions of the above federal Medicaid services can be found in the Code of Federal Regulations 42 CFR 440.1-440.170 at http://www.access.gpo.gov/nara/cfr/waisidx_06/42cfr440_06.html.

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Name _____ MID _____ DOB _____

**Non-Covered State Medicaid Plan Services Request Form
for Recipients *under 21 Years Old***

This form is available on DMA's Web site at <http://www.ncdhhs.gov/dma/provider/forms.htm>.
Mail the completed, signed form to the Assistant Director of Clinical Policy and Programs, Division of Medical Assistance, 2501 Mail
Service Center, Raleigh, N.C. 27699-2501 or fax it to (919) 715-7679. You may use additional sheets to supply any other information
you think would be helpful. **Include evidence-based literature, if available.**

I. Recipient Information. This must be completed by a physician, licensed clinician, or other provider.

Name _____
Date of Birth ____/____/____ (mm/dd/yyyy) Medicaid Number _____
Address _____

II. Medical Necessity. All requested information, including CPT and HCPCS codes, if applicable, as well as
provider information, must be completed. Please submit medical records that support medical necessity.

Requestor Name _____	Provider Name _____
Medicaid Provider # _____	Medicaid Provider # _____
Address _____	Address _____
Telephone _____	Telephone _____
Fax _____	Fax _____

In what capacity have you treated the recipient? (Include how long you have cared for the recipient and the
nature of the care.) _____

What is the recipient's health history? (Include chronic illness.) _____

What is/are the recent diagnosis(es) related to this request? (Include the onset and course of the disease and
the recipient's current status.) _____

What treatment has been given for the diagnosis(es) above? [Include previous and current treatment
regimens, duration, treatment goals, and the recipient's response to treatment(s).] _____

**On the next page, identify the requested procedure, product, or service (if applicable, please include CPT and
HCPCS codes). Provide a description of how the requested item will correct or ameliorate the recipient's defect,
physical or mental illness, or condition [the problem]. This description *must* include a detailed**

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discussion about how the service, product, or procedure will improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Is this request for an experimental or investigational treatment? _____ Yes _____ No

If yes, provide name and protocol # _____

Is the requested product, service, or procedure considered to be safe? _____ Yes _____ No

If no, please explain. _____

Is the requested product, service or procedure effective? _____ Yes _____ No

If no, please explain. _____

Are there alternatives to the product, procedure, or service requested that would be more cost effective but similarly medically effective? _____ Yes _____ No

If yes, specify what alternatives are appropriate for the recipient and provide evidence base with this request, if available.

What is the expected duration of treatment? _____

Requestor's Signature & Credentials _____ Date _____

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CHAPTER REVIEW

Key Points

- EPSDT applies to any Medicaid beneficiary under 21 years of age.
- EPSDT services are listed on the tenth page of this chapter.
- EPSDT says that the services on this list must be provided to beneficiaries under the age of 21 when the service or supply is
 - medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by screening
 - medical in nature
 - safe
 - effective
 - a generally accepted method of medical practice or treatment
 - not experimental or investigational
 - provided by a North Carolina Medicaid enrolled provider for the specific service
- EPSDT requires coverage of qualifying services and supplies to qualifying beneficiaries without regard to
 - Specific clinical coverage criteria
 - Numerical limits (number of hours, number of visits, dollar limit)
 - The location of service
 - Wait lists imposed by the state
 - Whether or not North Carolina Medicaid normally covers that service or supply
- If a service or supply normally requires prior approval, prior approval must still be obtained under EPSDT.
- EPSDT services and supplies will be provided in the most economic mode, as long as
 - the treatment made available is similarly efficacious to the one

requested

- the determination process does not delay the delivery of the needed service
 - the determination does not limit the beneficiary's right to free choice of North Carolina Medicaid enrolled providers who provide the approved service.
- All requests for services for a CAP beneficiary are evaluated under both the waiver and EPSDT.
 - Exceeding limitations on a covered service requires a written request including letter of medical necessity.
 - Requests for a supply or service not usually covered by Medicaid requires completion of the 'Non-Covered State Medicaid Plan Services Request Form for Recipients *under 21 Years Old*'.

**Test Your Knowledge**

1. EPSDT applies to
 - a. everyone under the age of 21
 - b. everyone under the age of 18
 - c. Medicaid beneficiaries under the age of 21
 - d. Medicaid beneficiaries under the age of 18
2. EPSDT covers
 - a. anything requested as long as it is medically necessary
 - b. items listed in the Social Security Act as long as they are medically necessary
 - c. items covered by Medicare but not Medicaid
3. You are requesting more than the usual limit on a particular supply that does not normally require prior approval. Do you need to obtain prior approval for the additional amount?
 - a. yes
 - b. no
4. For a CAP/C service that is also an EPSDT service (for example, in-home nursing), the CAP/C limit
 - a. may be exceeded if it meets EPSDT criteria.
 - b. is absolute; may not be exceeded even by EPSDT.

1. c; 2.b; 3. a; 4.a

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SECTION 1

CAP/C CONCEPTS AND PRINCIPLES

SECTION REVIEW

1. Mary is almost three years old. She is about to transition out of the Infant and Toddler Program and to begin public preschool. Her Early Intervention (Infant and Toddler) worker has referred Mary to the CAP/C program. You have completed the assessment. As you work to develop Mary's person-centered plan of care, you would
 - a. Not include Early Intervention in the discussion; she is aging out of that program
 - b. Include Early Intervention in the discussion
 - c. Suggest to the family that they include their Early Intervention worker, and include that person only if the family agrees
2. As you discuss what type of services and support Mary will need, the last type of support you consider is
 - a. Formal support systems
 - b. Mary's family and neighbors
 - c. Personal strengths
3. During the course of the assessment, Mary told you that it is important to her that she learn to ride a tricycle. However, Mary has problems keeping her balance and Mary's mother is concerned that riding a tricycle would not be safe. Mary's person-centered plan of care would
 - a. Include a goal for learning to ride a tricycle; it is important to Mary.

- b. Not include a goal for learning how to ride a tricycle; as the parent it is Mary's mother's decision.
 - c. Not include a goal for learning how to ride a tricycle; the plan of care should include only medical goals and interventions.
 - d. Include a goal for Mary to learn how to ride an adaptive tricycle while under close supervision – both Mary and her mother agreed to this.
4. As a Case Manger, which of the following activities would you not perform?
- a. Call the agency providing Mary's pediatric personal care services to assess the provision of services.
 - b. Drive Mary and her mother to the drugstore to pick up Mary's prescriptions.
 - c. Arrange a consult with a physical therapist to determine the type of adaptive tricycle that would meet Mary's needs.
5. Once you have developed the plan of care, you
- a. Implement it; as the Case Manager you approve the plan of care.
 - b. Submit it to DMA for review; DMA, as the administrative authority over the waiver, must approve the plan of care before you implement it.
6. Mary's mother is not happy with the agency providing Mary's speech therapy services. You advise her that
- a. The agency was appointed by Medicaid and she must use them, but you will try to help resolve the problem.
 - b. She cannot change agencies until her annual Continued Needs Review.
 - c. She may use any Medicaid enrolled agency she prefers.

7. Mary's mother has a friend whose child has autism. She inquires about getting the child CAP/C services. You advise her that
 - a. The child is probably not eligible for CAP/C because autism does not meet the criteria for medically fragile; however, she may submit a referral.
 - b. The child is eligible for CAP/C because she needs help with her personal care; she should submit a referral.
8. After review by DMA, the child is denied CAP/C services. The family
 - a. Can not do anything about it.
 - b. May appeal the denial.
9. Mary's mother asks you why she is only allowed 720 hours of respite per year. You tell her
 - a. She can have as much respite as she wants.
 - b. There are limits placed on all services, so that the cost of Mary's care at home can be kept below the cost of what Mary's care would be in an institution.
 - c. Services can only be approved in an amount that does not exceed the program's health and welfare requirements, and does not replace other sources of support.
 - d. Both b and c.
10. Mary's mother then asks you why she can't have additional respite hours under EPSDT. You tell her
 - a. Respite hours are not considered medically necessary.
 - b. The waiver overrules EPSDT, so she can only receive services and supplies through EPSDT for regular Medicaid items, not waiver items.
 - c. She can not have additional respite hours under EPSDT because respite is not one of the qualifying services listed in the federal law.

11. Your agency has been receiving a lot of CAP/C referrals. A new Case Manger asks you how many slots your county has. You tell him that
- CAP/C does not have 'slots' per county, although the waiver does determine how many children can be served statewide each year.
 - The number of children that can be served by the waiver in a given year is divided equally among all 100 counties.
12. All of the case managers in your county have as many clients as they can handle. At the present time, there are no funds available to hire another case manager, and your agency/DMA has not been able to find anyone to help you. EPSDT regulations concerning wait lists state that
- You may not have a wait list.
 - You may have a wait list, but if the child has Medicaid they are entitled to other Medicaid and EPSDT services while they are waiting.
 - You may have a wait list, but no child can receive any services while waiting.
13. Joey's parents are applying for CAP/C. Joey is at home – not in a hospital or nursing facility. The parents applied for Medicaid on July 8th. HP approved the FL-2 on July 17th. Joey's CAP effective date is _____.
14. Jimmy is already covered by Medicaid, and he is applying for CAP/C. The family questions why they need to contact the DSS. Your response is:
- You were incorrect; they do not need to go to the DSS.
 - CAP only takes certain categories of Medicaid, and Jimmy's Medicaid is in a different category.

1. c, 2. a, 3. c, 4. b, 5. b, 6. c, 7. a, 8. b, 9. d, 10. c, 11. a, 12. b, 13 July 17, 14.b

Section 1 Review

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