

SECTION 2

CAP/C GENERAL INFORMATION

CHAPTER 7

Who May Have CAP/C

Children who meet all of the following criteria may be approved for CAP/C participation:

- Age under 21 years
- Medically Fragile
- At Risk for Institutionalization
- Lives in a private residence while on the program
- Requires one waiver service (excluding respite and waiver incontinence supplies) in addition to case management at least once per 90 days
- Requires the service to supplement, not replace, existing resources
- Requires the service to meet specific unmet needs of the child
- Is not requesting CAP/C solely to become eligible for Medicaid or other Medicaid services
- Meets the Medicaid eligibility criteria for CAP/C including approval for disability by the Social Security Administration if applicable
- Has an emergency back-up plan with adequate social support to meet the basic needs outlined in the CAP/C assessment to maintain their health, safety and well-being.
- Can have his or her healthcare needs met within the CAP/C cost limit for the selected services, and there is no other more conservative or less costly treatment available statewide

- Has family/caregivers that participate in the child's care and in the CAP/C program.

The remainder of this chapter describes these criteria in more detail.

In addition to these criteria for participation, each service and supply within the program has its own eligibility criteria, found in the chapter for that particular service or supply.



MORE
INFORMATION

AGE UNDER 21YEARS

A beneficiary is eligible for CAP/C from birth until the last date they are 20 years old. (Medicaid eligibility will continue until the end of that month.) Transition to adult services may occur at almost any time prior to that date. Transitioning off of CAP/C is one of the many transitions the case manager will be coordinating at this time. The child will also need transition to adult physicians and therapists, possibly college or employment versus school, possibly a different living arrangement. All of this should be settled before the beneficiary transitions off of CAP/C and possibly into a program with no case management. Some programs require transfer at the end of the month. In these cases, CAP/C will end on the last day of the month before the beneficiary's 21st birthday and the new service will start the first of the month of their birthday.

MF
Medically
Fragile

MEDICALLY FRAGILE

Medically fragile refers to children who have:

- A primary diagnosis or diagnoses that 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.)

- Care needs that are directly related to the medical diagnosis
 In addition to having a medical diagnosis, the service or supply that is provided in the home must relate directly to that diagnosis. For instance, a child may have a heart defect requiring physician appointments and surgeries, but no oxygen, monitoring, or other in-home care needs. All of her in-home care needs are related to the developmental delays related to her Down's syndrome. This child would not qualify for CAP/C.
- A serious, ongoing illness or chronic condition requiring prolonged hospitalization and ongoing medical treatments and monitoring
 The child must have an ongoing, chronic illness. 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.

AT RISK FOR INSTITUTIONALIZATION

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

Children considered at risk of institutionalization are those who:

- Are prior-approved through the fiscal agent for nursing facility 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

LOC
Level of
Care

Chapter 7 Who May Have CAP/C

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 HP) will approve the FL-2 for "nursing facility level of care" (formerly 'intermediate' level of care or 'skilled' level of care).

- Without CAP/C services, would need to be institutionalized in a nursing facility or hospital as determined by statement of the parents or responsible party

The parents attest to this by signing 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.

LIVES IN A PRIVATE RESIDENCE WHILE ON THE PROGRAM

A primary residence is defined as one belonging to a regular caregiver or one court-ordered (not a jail). A Level I residential child care facility/group foster home (meaning that the children do not require residential mental health treatment) is allowed. Residential child care facilities licensed as level 2 or higher are generally considered institutional, and would contain children who require residential mental health treatment, so this setting is usually not approved. Care may not be provided in the home of any paid caregiver.

REQUIRES CASE MANAGEMENT PLUS ONE OTHER WAIVER SERVICE

The beneficiary must require and accept CAP/C Case Management services to provide assessment, care planning, service authorization, care monitoring, and other case management activities.

MN
Medically
Necessary

In addition to the case management, the beneficiary must require at least one of the following waiver services, at least once within 90 consecutive days:

- In-home nurse care or in-home nurse aide care on a regularly scheduled basis (CAP/C Nursing, CAP/C Pediatric Nurse Aide, and CAP/C Personal Care services).
- Waiver Supplies: adaptive tricycle
- Home Modifications
- Vehicle Modifications
- Community Transition Funding
- Palliative Care services (Counseling, Bereavement Counseling, and Expressive Therapies)
- Caregiver Education and Training

In addition to the above, respite services, and waiver supplies including re-usable incontinence undergarments, and disposable liners for them may be provided. Only those beneficiaries getting case management plus at least one of the above services may receive respite.

MN
Medically
Necessary

'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 paid services, including those 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 or nurse aide hours that can be approved on the Plan of Care.

MN
Medically
Necessary

'SPECIFIC UNMET NEEDS'

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.

For in-home services such as nursing or nurse aide care, staffing issues cannot be a factor in planning care. We cannot approve a nurse instead of an aide because a nurse is available and an aide is not. There must be care provided during the time the CAP/C staff is there. A parent cannot change the approved hours to a time when no medically-related care is provided because of a need for childcare during that time.

MN
Medically
Necessary

'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.

FA
Financial
Accountability

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 in order to keep 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 a waiver service (excluding respite and waiver incontinence supplies) within 90 consecutive days. CAP/C will not be approved for any other reason.

MEETS CAP/C MEDICAID ELIGIBILITY CRITERIA

Eligibility for CAP/C involves two separate but related determinations:

- DMA's determination that the child meets the program and service criteria for CAP/C
- DSS's determination that the child is eligible for Medicaid.

For CAP/C children, DSS uses eligibility criteria like those that apply to Institutional care. This means that only the child's income counts toward financial eligibility, not the income of the parents or others in the household. (Be aware that a special needs trust may impact Medicaid eligibility.) However, there are other criteria that need to be met. CAP/C can not be provided if Medicaid is not approved.

HEALTH, SAFETY, AND WELL-BEING

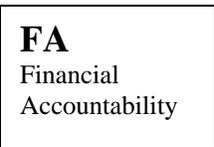
HW
Health and
Welfare

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, safety, and well-being of our beneficiaries. There must be ongoing monitoring of the beneficiary's well-being, health status, and the effectiveness of the waiver services in meeting the beneficiary's goals.

If the beneficiary is not medically stable enough to be cared for safely at home, or the home is for some other reason not a safe environment for

the provision of care, then CAP/C services can not be approved or the child must be disenrolled from CAP/C.



COST LIMIT

The cost of CAP/C care must be less than the cost of its alternative: nursing home or hospital placement. For this reason, there are limits on the amount of time or money that can be provided under each waiver service. If CAP/C care exceeds these limits, therefore exceeding the cost of institutionalization, then CAP/C can not be provided.

Additionally, for any Medicaid service to be approved, there must be no other as effective and less costly option available statewide. This means that for instance, if Medicaid In-Home Care Services can meet that beneficiary's needs as effectively as CAP/C, then that program (In-Home Care) is the program that must be provided.

PARTICIPATING CAREGIVERS

Family/caregivers must participate in the child's care and in the CAP/C program. Families attest to this when they sign the Letter of Understanding and Freedom of Choice. If a family does not participate in case management activities such as being available for phone calls and quarterly visits, or if the family refuses to adhere to the Plan of Care, that family is at risk of losing their CAP/C services.

CHAPTER REVIEW

🔑 Key Points

CAP/C children must

- Be under age 21
- Be medically fragile
- Be at risk for institutionalization
- Live in a private residence
- Require/use one waiver service (excluding respite and waiver incontinence supplies) in addition to case management at least once in a 90 day rolling period ~~per quarter~~
- Require the service to supplement, not replace, existing resources
- Require the service to meet specific unmet needs of the child
- Require CAP/C because of a need for the waiver services, not in order to get Medicaid
- Be Medicaid eligible using criteria for CAP/C
- Has an emergency back-up plan with adequate social support to meet the basic needs outlined in the CAP/C assessment to maintain their health, safety and well-being.
- Be able to have his or her healthcare needs met within the CAP/C cost limits, and there is no other more conservative or less costly treatment available statewide.
- Have family/caregivers that participate in the child's care and in the CAP/C program

 **Test Your Knowledge**

1. CAP/C service must end
 - a. when the child turns 18
 - b. through age 18/when the child turns 19
 - c. when the child turns 21
 - d. through age 21/when the child turns 22
2. True or False: CAP/C may be provided so that a child that does not qualify for Medicaid can receive Medicaid
3. True or False: DMA's determination that the child qualifies for CAP/C per program criteria is the only determination of eligibility.
4. A beneficiary must use case management plus one other waiver service at least once per _____ in order to be approved for and to remain on CAP/C.
5. Which CAP/C services can not be the only waiver services besides case management? _____

1. c, 2. False, 3. False, 4. 90 consecutive days, 5. respite and waiver incontinence supplies

SECTION 2

CAP/C GENERAL INFORMATION

CHAPTER 8

What They May Have

The following services are available to CAP/C beneficiaries.

MANDATORY WAIVER SERVICES

- Case Management
Case Management is a REQUIRED component of CAP/C participation. A beneficiary that does not want case management and/or is not cooperative with case management activities may not participate in CAP/C.
- At least one other waiver service from the list below, used at least every 90 days.

OPTIONAL WAIVER SERVICES

In addition to case management, each beneficiary must use at least one of these services at least every 90 days to be approved for and maintain participation in the CAP/C program.

- CAP/C In-Home Nursing Care
Provides the services of an RN or LPN in the home to assist the family in meeting the medically-related in-home care needs of the child.
- CAP/C Pediatric Nurse Aide Care
Provides the services of an NA I+ or NA II with additional pediatric training in the home to assist the family in meeting the medically-related in-home care needs of the child.

- CAP/C Personal Care
Provides the services of an NA I in the home to assist the family in meeting the medically-related in-home care needs of the child.
- CAP/C Waiver Supplies: adaptive tricycles.
- CAP/C Home Modifications
Selected adaptations to the family's home to allow access and to increase the functional independence of the disabled child in the home.
- CAP/C Vehicle Modifications
Selected adaptations to the family's vehicle to allow access and use by the disabled child.
- CAP/C Community Transition Funding
A one-time source of funding for home and vehicle modifications for certain children leaving institutional care.
- CAP/C Caregiver Training and Education
Provides the cost of registration or enrollment for a conference, seminar, or training session that will improve the care-giving ability of the child's informal support person(s).
- CAP/C Palliative Care
Provides counseling, expressive therapies, and bereavement counseling to medically fragile/disabled children and their families.

ADDITIONAL OPTIONAL WAIVER SERVICES

- CAP/C Respite Care
Provides in-home or institutional care for the relief of the informal caregivers.
- CAP/C Waiver Incontinence Supplies

Reusable incontinence undergarments and disposable liners for those undergarments.

These services are also available to beneficiaries of CAP/C, but they may not be the only waiver services besides case management. Respite care and waiver incontinence supplies may be approved after the beneficiary is approved for case management plus one other waiver service.

NON-WAIVER, MEDICAID SERVICES

Once a beneficiary is approved for CAP/C, that beneficiary has 'regular' (formerly blue card) Medicaid. This means that they may be eligible for 'regular' Medicaid services or supplies if they meet the program criteria for those services or supplies. Some of the services commonly used by CAP/C beneficiaries include:

- Durable Medical Equipment
- Orthotics and Prosthetics
- Home Health Services and Supplies
- Physical, Occupational, and Speech Therapy through Independent Practitioners

The beneficiary must follow all of the regulations and meet all of the qualifications for the particular service. CAP/C has no authority to approve, deny, or change any non-waiver service or supply.

CAP/C beneficiaries do not have a monthly limit or co-payment on doctor's visits or prescriptions.

EPSDT

As with all Medicaid beneficiaries under the age of 21, EPSDT allows for the provision of any medically-necessary supply or service contained in

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

Please see Chapter 6 of this CAP/C Manual for this list and for complete EPSDT information, or visit the website at

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



MORE
INFORMATION

CHAPTER REVIEW

Key Points

1. Case management is a required component of CAP/C participation.
2. In addition to case management, a beneficiary must use at least one other waiver service (excluding respite and waiver incontinence supplies) at least every 90 calendar days in order to maintain participation in the program.
3. Waiver services include CAP/C Nursing, CAP/C Pediatric Nurse Aide, CAP/C Personal Care, Waiver Supplies, Home Modifications, Vehicle Modifications, Community Transition Funding, Caregiver Training and Education, Palliative Care, and Respite Care.
4. In addition to the waiver services, the child may receive any other 'regular' Medicaid service or supply for which he or she is eligible according to that service's policies.
5. EPSDT is available to all Medicaid beneficiaries under the age of 21.

**Test Your Knowledge**

1. Which of the following services is required for all CAP/C beneficiaries?
 - a. Case Management
 - b. In-home Nursing, Pediatric Nurse Aide, or Personal Care services
 - c. both of the above
 - d. none of the above
2. True or False: CAP/C can NOT approve a child for physical therapy.
3. Which of the following is NOT a waiver service?
 - a. Caregiver Training and Education
 - b. Respite
 - c. disposable diapers
 - d. adaptive tricycles

1. a, 2. True, 3. c

SECTION 2 CAP/C GENERAL INFORMATION

CHAPTER 9 How Much They May Have

Chapter 9 How Much They May Have

FA
Financial
Accountability

This entire chapter relates to the waiver assurance of Financial Accountability.

Each individual service within the CAP/C program has a time and/or dollar limit for that particular service. However, a beneficiary may use as many of the services as he/she wants and for which he/she is eligible. CAP/C beneficiaries do not have an overall maximum budget limit. Keep in mind that in certain cases, EPSDT may override the individual service limits. Please see Chapter 6 for complete EPSDT information.


MORE
INFORMATION

CASE MANAGEMENT

Code	Service	Units	Hour Limit	Unit Limit
T1016	all case management activities	15 minutes	72 hours per year.	288 units per year.

'Year', in this case, refers to the reassessment year, which generally runs from the first of the month following the child's birth month to the end of the child's birth month the following year.


MORE
INFORMATION

Please see Chapter 13 for complete information regarding CAP/C Case Management.

HOME MODIFICATIONS

The amount of home modifications a beneficiary may have is based upon the length of time they participate in the current waiver cycle.

If the child is in or enters the waiver...	he/she can have a maximum amount of ...	to be spent during the period of time from
Year 1: 7/1/10-6/30/11	\$10,000	7/1/10-6/30/15
Year 2: 7/1/11-6/30/12	\$ 8, 000	7/1/11-6/30/15
Year 3: 7/1/12-6/30/13	\$ 6,000	7/1/12-6/30/15
Year 4: 7/1/13-6/30/14	\$ 4,000	7/1/13-6/30/15
Year 5: 7/1/14-6/30/15	\$ 2,000	7/1/14-6/30/15

The beneficiary does not have to limit their spending to \$2000 per year. The beneficiary may distribute the funds any way they want to over their allotted period of time. For example, if the beneficiary is eligible for \$10,000 they may spend \$5000 the first year, \$0 the second year, \$1500 the third year, \$500 the fourth year, and \$3000 the final year.

A beneficiary that exits and then returns to the waiver within the same waiver cycle will have only the amount remaining that he/she had left when he/she exited the waiver. For example, if the beneficiary was eligible for \$10,000 and in the first year spent \$6000 and then exited the waiver, if that beneficiary returned to the waiver in year 3, he/she would not have a new allotment of \$6000 – he/she would have only the \$4000 that was remaining when he/she left.

Please see Chapter 19 for complete information regarding Home Modifications.



MORE
INFORMATION

VEHICLE MODIFICATIONS

The amount of home modifications a beneficiary may have is based upon the length of time they participate in the current waiver cycle.

If the child is in or enters the waiver...	he/she can have a maximum amount of ...	to be spent during the period of time from
Year 1: 7/1/10-6/30/11	\$ 15,000	7/1/10-6/30/15
Year 2: 7/1/11-6/30/12	\$ 12,000	7/1/11-6/30/15
Year 3: 7/1/12-6/30/13	\$ 9,000	7/1/12-6/30/15
Year 4: 7/1/13-6/30/14	\$ 6,000	7/1/13-6/30/15
Year 5: 7/1/14-6/30/15	\$ 3,000	7/1/14-6/30/15

The beneficiary does not have to limit their spending to \$3000 per year. The beneficiary may distribute the funds any way they want to over their allotted period of time. For example, if the beneficiary is eligible for \$15,000 they may spend \$6000 the first year, \$3500 the second year, \$2000 the third year, \$1500 the fourth year, and \$2,000 the final year.

A beneficiary that exits and then returns to the waiver within the same waiver cycle will have only the amount remaining that he/she had left when he/she exited the waiver. For example, if the beneficiary was eligible for \$15000 and in the first year spent \$10000 and then exited the waiver, if that beneficiary returned to the waiver in year 3, he/she would not have a new allotment of \$9000 – he/she would have only the \$5000 that was remaining when he/she left.

Please see Chapter 20 for complete information regarding Vehicle Modifications.



COMMUNITY TRANSITION FUNDING

For children becoming deinstitutionalized, Community Transition Funding makes up the difference between the maximum budget possible for home and vehicle modifications (\$10,000 for home and \$15,000 for vehicle modifications) and the prorated amount for home and vehicle modifications for which the beneficiary is eligible if he/she enters after the first waiver year. It is intended for people who need extensive modifications to their home or vehicle in order to be able to return to their home setting. For example, a beneficiary was in a motor vehicle

accident and is now a new quadriplegic getting ready to be discharged from hospital and rehab care. If he enters the waiver in year 4, he is eligible for only \$4000 in home modifications. Community transition funding provides up to \$6000 so that the child/family has \$10,000, if needed, to modify their home. This is not available to all beneficiaries. It is available only to those with a new condition requiring extensive modifications in order to become de-institutionalized.

If the child is in or enters the waiver...	he or she can have a maximum amount of CTF for home modifications of	and a maximum amount of CTF for vehicle modifications of	to be spent during the period of time from
Year 1: 7/1/10-6/30/11	\$0	\$0	7/1/10-6/30/15
Year 2: 7/1/11-6/30/12	\$2000	\$3000	7/1/11-6/30/15
Year 3: 7/1/12-6/30/13	\$4000	\$6000	7/1/12-6/30/15
Year 4: 7/1/13-6/30/14	\$6000	\$9000	7/1/13-6/30/15
Year 5: 7/1/14-6/30/15	\$8000	\$12000	7/1/14-6/30/15

The beneficiary does not have to limit their spending per year. The beneficiary may distribute the funds any way they want to over their allotted period of time.

A beneficiary that exits and then returns to the waiver within the same waiver cycle will have only the amount remaining that he/she had left when he/she exited the waiver. However, this amount would only apply if the child was being deinstitutionalized with the return to CAP/C and needed these services to return home.

Please see Chapter 21 for complete information regarding Community Transition Funding.



MORE
INFORMATION

CAREGIVER TRAINING AND EDUCATION

Caregiver Training and Education pays only the cost of registration or enrollment for the event being attended. However, it is billed in 15 minute units.

Code	Unit	Maximum
S5110	15 minutes	\$500 per waiver year

For example, the registration for an all-day (8 hour) event costs \$75. At the (current at the time of publication) rate of \$8.36 per 15 minutes, you would bill 8.97 units of S5110. ($\$75.00 \div \$8.36 = 8.97$). Remember, you are billing the actual cost of tuition, NOT the amount of time. You are not billing 8 hours = 32 units = \$267.52.

The waiver year begins each July 1 and ends each June 30.

Please see Chapter 22 for complete information regarding Caregiver Training and Education.

PALLIATIVE CARE

Code	Service	Units	Hours	Unit Limit
99510	counseling	each visit		98 visits per waiver year
S5111	bereavement counseling	each visit		1 visit
S5108	expressive therapies	15 minutes	39 hours per waiver year	156 units per waiver year

The waiver year begins each July 1 and ends each June 30.

Please see Chapter 23 for complete information regarding Palliative Care services.



MORE
INFORMATION

WAIVER SUPPLIES

Code	Supply	Unit	Limit
T4539	Reusable incontinence undergarments	each	\$500 per waiver year
T4535	Disposable liners for the reusable incontinence undergarments	each	\$1000 per waiver year
T2029	Adaptive tricycle	each	one tricycle per waiver year max \$600 per waiver year

Reusable incontinence undergarments and disposable liners are only available to beneficiaries using case management plus at least one other waiver service at least every 90 consecutive days.

A waiver year begins each July 1 and ends each June 30.

Please see Chapter 18 for complete information regarding waiver supplies.



MORE
INFORMATION

RESPIRE CARE

Respite services are only available to beneficiaries using case management plus at least one other waiver service at least every 90 consecutive days.

Code	Service	Unit	Limit										
T1005	In-home nurse	15 minutes	Any combination of these three services up to a maximum number of hours based on amount of formal support.										
S5150	Personal Care Aide	15 minutes											
T1004	Pediatric Nurse Aide	15 minutes											
H0045	institutional	1 day	<table> <thead> <tr> <th>Hrs Per Week Formal Support</th> <th>Hrs Per Year Respite</th> </tr> </thead> <tbody> <tr> <td>0-30</td> <td>720</td> </tr> <tr> <td>31-60</td> <td>540</td> </tr> <tr> <td>61-90</td> <td>360</td> </tr> <tr> <td>91 or more</td> <td>180</td> </tr> </tbody> </table>	Hrs Per Week Formal Support	Hrs Per Year Respite	0-30	720	31-60	540	61-90	360	91 or more	180
Hrs Per Week Formal Support	Hrs Per Year Respite												
0-30	720												
31-60	540												
61-90	360												
91 or more	180												

A 'year' is a waiver year, which begins each July 1 and ends each June 30.

A 'day' is whatever that particular institution considers a day.

'Formal support' is paid support, regardless of the payer source or place of service. For example, daycare, school, CAP/C services, and services provided through private insurance are all formal support.

Unused respite hours do not roll over into the next year. Additional hours are not available if the beneficiary runs out prior to the end of the year.

If a beneficiary changes hours of formal support mid-year, the respite hours may be increased, but not decreased. In the event of a plan of care change in which a child receives more formal support and therefore less respite, the current respite allotment will remain in effect for the remainder of the current waiver year. The new amount will take effect beginning the first day of the next waiver year.

Please see Chapter 17 for complete information regarding respite care.

NURSING SERVICES

Code	Service	Unit	Weekly Limit	Annual Limit
T1000 TD	RN	15 minutes	Max 20 hours per week personal time Max 50 hours per week work time Max 56 hours per week sleep time Max 126 hours per week formal support – may or may not be all	\$265,000 per waiver year for any combination of these services
T1000 TE	LPN	15 minutes		
G0154 TD	Congregate RN	15 minutes		
G0154 TE	Congregate LPN	15 minutes		

			CAP/C	
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As with all CAP/C services, the maximum is not an entitlement. Only those hours that are necessary will be approved.

Additional hours are available for short-term increases in need due to acute illness or exacerbation or family/caregiver illness or crisis. These hours are referred to as short-term-intensive (STI) hours. Documentation of need for the additional services may be requested prior to approval. All STI hours must be approved by DMA. The cost of STI hours are included in the \$265,000 annual limit.

Requests for STI care for 24 hours per day will be approved only for a two-week period. If the need for 24 hour care is expected to last beyond that time, an additional two weeks may be approved to allow the family and case manager time to get other supports and training into place.

Absolutely no more than four weeks of 24 hour care may be approved for each significant change in condition. 24 hour care for an extended length of time becomes institutional care rather than an alternative to institutionalization.

Please see Chapter 17 for more information regarding short-term-intensive services.

The hours approved for a beneficiary take into consideration the hours paid by private insurance or another funding source. For example, if CAP/C would approve a beneficiary for 18 hours per day, and private insurance pays 6 hours per day, the beneficiary would not be approved for 24 hours per day. The beneficiary would receive 18 hours per day, with 12 of those hours paid by CAP/C and 6 of those hours paid by private insurance.

The hours approved for the beneficiary are also based on no beneficiary receiving more than 126 hours of formal support services per week. These



MORE
INFORMATION

MN
Medically
Necessary

formal support services include hours paid by CAP/C and by private insurance, and also school or daycare services whether or not nursing care is provided during that time. Each parent on the CAP/C program must maintain some responsibility for their child.

Please be aware of the number of nursing hours being staffed by each individual nurse. A nurse that works with a client more than 12 hours per day or more than 60 hours per week should cause concern about that nurse’s ability to provide safe care. Discuss these concerns with the agency and your CAP/C Nurse Consultant.

Please see Chapter 14 for complete information regarding CAP/C Nursing services.



NURSE AIDE SERVICES

Code	Service	Unit	Weekly Limit	Annual Limit
T1019	Pediatric Nurse Aide	15 minutes	Max 20 hours per week personal time Max 50 hours per week work time Max 126 hours per week formal support – a maximum of 70 hours of those 126 may be CAP/C	\$75,000 per waiver year for any combination of these two services. \$60,000 per waiver year if only personal care aid services are used.
S5125	Personal Care	15 minutes		
G0156 TG	Congregate Pediatric Nurse Aide Care	15 minutes		
G0156 TF	Congregate CAP/C Personal Care	15 minutes		

As with all CAP/C services, the maximum is not an entitlement. Only those hours that are necessary will be approved.

Additional hours are available for short-term increases in need due to acute illness or exacerbation or family/caregiver illness or crisis. These hours are referred to as short-term-intensive (STI) hours. Documentation of need for the additional services may be requested prior to approval. All STI hours must be approved by DMA. The cost of STI hours are included in the \$75,000 (or \$60,000 for PCS services) annual limit.

Requests for STI care for 24 hours per day will be approved only for a two-week period. If the need for 24 hour care is expected to last beyond that time, an additional two weeks may be approved to allow the family and case manager time to get other supports and training into place.

Absolutely no more than four weeks of 24 hour care may be approved. 24 hour care for an extended length of time becomes institutional care rather than an alternative to institutionalization.

Please see Chapter 17 for more information regarding short-term-intensive services.



MORE
INFORMATION

The hours approved for a beneficiary account for hours paid by private insurance or another funding source. For example, if CAP/C would approve a beneficiary for 10 hours per day, and private insurance pays 6 hours per day, the beneficiary does not have 16 hours per day. The beneficiary receives 10 hours per day, with 4 of those hours paid by CAP/C and 6 of those hours paid by private insurance. (Private insurance generally does not pay for Nurse Aide care.)

The hours approved for the beneficiary are also based on no beneficiary receiving more than 126 hours of formal support services per week, with no more than 70 of those hours being provided by CAP/C. These formal support services include the hours paid by CAP/C and by private insurance, and also school or daycare services whether or not nurse aide care is provided during that time. Each parent on the CAP/C program must maintain some responsibility for their child.

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Please be aware of the number of hours being staffed by each individual aide. An aide who works with a client more than 12 hours per day or more than 60 hours per week should cause concern about that aide's ability to provide safe care. Discuss these concerns with the agency and your CAP/C Nurse Consultant.

Please see Chapters 14 and 15 for complete information regarding CAP/C nurse aide services.

Summary of Limits to CAP/C Waiver Services and Supplies

Code	Service	Unit	Limit
T1016	Case Management	15 minutes	72 hours = 288 units per CNR/reassessment year
S5165	Home Modifications	as billed	\$10,000 over the five year waiver cycle, decreased by \$2000 for every year not in waiver cycle
T2039	Vehicle Modifications	as billed	\$15,000 over the five year waiver cycle, decreased by \$3000 for every year not in waiver cycle
T2038	Community Transition Funding	as billed	The difference between the full and the prorated amounts for home and vehicle modifications
S5110	Caregiver Training and Education	15 minutes	\$500 per waiver year
99510	Palliative Care: Counseling	per visit	98 visits per waiver year
S5111	Palliative Care: Bereavement Counseling	per visit	one visit maximum
S5108	Palliative Care: Expressive Therapies	15 minutes	39 hours = 156 units per waiver year
T4539	Waiver Supply: reusable incontinence undergarment	each	\$500 per waiver year
T4535	Waiver supply:	each	\$1000 per waiver year

	disposable liner for reusable incontinence undergarment		
T2029	Waiver supply: adaptive tricycle	as billed	one tricycle per waiver year \$600 per waiver year
T1005 S5150 T1004 H0045	Respite: In home nurse Personal Care Aide Pediatric Nurse Aide institutional	15 minutes 15 minutes 15 minutes day	720 hours per waiver year of any combination of the three types of respite, prorated according to amount of formal support
T1000 TD T1000 TE G 0154 TD G0154 TE	Nursing RN Nursing LPN Congregate RN Congregate LPN	15 minutes 15 minutes 15 minutes 15 minutes	20 hours = 80 units per week personal time, plus 50 hours = 200 units per week work time, plus 56 hours = 224 units per week sleep time Max 126 hours per week of combination of all formal supports Max \$265,000 for waiver year
S5125 T1019 G0156 TF G0156 TG	Personal Care Nurse Aide Pediatric Nurse Aide Congregate Personal Care Congregate Pediatric Nurse Aide	15 minutes 15 minutes 15 minutes 15 minutes	20 hours = 80 units per week personal time, plus 50 hours = 200 units per week work time Max 126 hours per week of combination of all formal supports; a max of 70 of these 126 may be CAP/C Max \$75,000 for waiver year (or \$60,000 for PCS services only)

CHAPTER REVIEW

Key Points

1. There is a limit of amount of time or number of dollars for each waiver service.
2. There is not a limit on the number of services that an eligible beneficiary can receive.
3. The limits are subject to consideration under EPSDT.
4. Refer to the chart on the previous two pages for a summary of the limits for each service.



Test Your Knowledge

1. A waiver year begins _____ and ends _____.
2. True or False: More than \$2000 may be spent on home modifications in one waiver year.
3. \$75,000 is the maximum allowed amount for Personal Care and Pediatric Nurse Aide care
 - a. each
 - b. combined
4. Because CAP/C exists to supplement, not replace, a maximum of _____ hours per week of care may be provided through formal support systems.
5. True or False: CAP/C beneficiaries have a limit on the number of services they may receive per waiver year.

1. July 1 and June 30, 2. True, 3. b, 4. 126, 5. False

SECTION 2

CAP/C GENERAL INFORMATION

CHAPTER 10

Where They Can Have It

THE CHILD'S HOME

Most CAP/C services are provided in the child's home, or primary residence. This is usually a private home, but can be a hotel or a shelter if that is the child's primary residence and care can be provided safely in that environment. The safety of the environment is determined according to the criteria in the 'Housing' section of the CAP/C Case Manager Assessment. Please see Chapter 33 for complete information regarding this assessment.

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INFORMATION

OTHER HOMES

Care is sometimes provided in the home of another relative or informal support person. If care is routinely provided in this environment, it must also be assessed according to the criteria in the 'Housing' section of the CAP/C Case Manager Assessment. Please see Chapter 33 for complete information regarding this assessment.



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Occasional one-time occurrences of care in a different home do not require the environmental assessment of the Case Manager. However, the staff should use their professional judgment regarding the provision of care in that environment and should notify the Case Manager of any problems. CAP/C services cannot be provided in the home of the paid nurse or nurse aide. This means that the nurse or nurse aide may not take the child to their own home to provide care. This also means that no one residing in

the same household as the client can act as the paid nurse, nurse aide, or attendant for that child.

FOSTER HOMES

A Level I residential child care facility/group foster home (meaning that the children do not require residential mental health treatment) is allowed.

Residential child care facilities licensed as level 2 or higher would contain children who require residential mental health treatment, so this would need to be considered on a case-by-case basis, ensuring that the child had sufficient medical needs, in addition to the mental health needs, to warrant CAP/C.

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SCHOOLS

CAP/C Nursing, Pediatric Nurse Aide, and Personal Care services may be provided in the school setting within the following parameters:

- The school is a private school.
- Services are not provided exclusively in the school; services in the home are provided as well.
- The CAP/C case manager is not required to conduct an environmental assessment of the school.
- The nurse or nurse aide may not transport the child independently to or from the school. The nurse or nurse aide may accompany the child during transport provided by the parent or school.
- The hours of care provided are within the hourly and financial limitations set forth in Chapters 14, 15, and 16

PRESCHOOLS AND DAYCARES

CAP/C Nursing, Pediatric Nurse Aide, and Personal Care services may be provided in the school setting within the following parameters:

- The nurse or nurse aide may not transport the child independently to or from the preschool or daycare. The nurse or nurse aide may accompany the child during transport provided by the parent or preschool/daycare.
- The preschool or daycare must be:
 - a. A child care center with a 1 star or greater license issued by the Division of Child Development (DCD), or
 - b. a family child care home with a 1 star or greater license issued by the DCD, or
 - c. a church sponsored program with a letter of compliance issued by the DCD.

This information is available at

<http://ncchildcaresearch.dhhs.state.nc.us/search.asp>.

- The CAP/C case manager is not required to conduct an environmental assessment of preschool or daycare, as the license or letter of compliance issued by the DCD assures that the minimal safety requirements are met.
- The child must be able to be safely cared for within the daycare/preschool setting. In particular, the risk to the child of being exposed to other children with known or unknown infectious illnesses should be considered.
- The daycare or preschool setting must be part of the plan of care to maximize the child's potential. Attendance at a daycare or preschool is intended for those children who can benefit from the socialization and learning that takes place in that setting. For example, a child who is developmentally age-appropriate and has

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INFORMATION

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a tracheostomy would be an ideal candidate as he/she could benefit from the socialization and school-readiness provided.

- The Medicaid reimbursement rate for the nurse or nurse aide care shall be the same as that for in-home care. CAP/C will pay only for the nurse or nurse aide; it will not pay for the preschool or daycare tuition.
- Nurse or nurse aide care shall not duplicate those services provided by the preschool or daycare, particularly when the preschool/daycare is designed to accommodate the care of special needs children (e.g., developmental daycare centers).
- Duplicate durable medical equipment and home health supplies will not be authorized. For example, if the preschool/daycare does not have a feeding pump on site, the feeding pump will need to be transported back and forth between the home and the preschool/daycare.

<p>MN Medically Necessary</p>
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THE COMMUNITY

CAP/C services may be provided in other environments where social/leisure activities are taking place, if within the following parameters:

- there is nurse/nurse aide care to be performed during the activity
- there is readily available access to 911
- the nurse or nurse aide does not independently transport the client to and from the activity, although she may accompany the client during transport by someone else. Clarification: walking is not included as a form of transport; the Nurse/Nurse Aide is able to be completely attentive to the client while walking – she cannot be while driving.

<p>HW Health and Welfare</p>

VACATIONS

Out-of-state providers who are within 40 miles of the North Carolina border may enroll with Medicaid as in-state providers. They may provide the



MORE
INFORMATION

same services, including CAP/C services as other in-state providers. The Basic Medicaid Billing Guide contains a list of zip codes considered to be within 40 miles of the North Carolina border.

Other out-of state providers may not provide services unless the service is not available in North Carolina and has been prior-approved. This means that out-of-state providers may not provide staff to serve a family on vacation, because they are not providing a service unavailable in North Carolina. This includes agencies that have offices in other states. For example, if a beneficiary uses ABC Agency, and ABC Agency has offices in North Carolina and South Carolina, the family can not vacation in South Carolina and receive services from a local ABC Agency. It must be their North Carolina provider.

The request for a nurse or nurse aide to accompany a family on a vacation will be considered on a case-by-case basis in accordance with the following:

- The nurse/nurse aide must obtain appropriate licensure/listing in the vacation area. A North Carolina nursing license or nurse aide registry listing may not allow the nurse or nurse aide to practice in the state where the beneficiary is vacationing. Prior to the vacation, the nurse, nurse aide, and/or the employing home care agency must contact the Board of Nursing in the state where the patient is vacationing to review the requirements for practicing in that state. Those requirements must be followed.
- The nurse/nurse aide agency must meet their North Carolina licensure and agency requirements regarding supervision of the nurse or nurse aide.
- The length and location of the vacation must be such that case management can be provided if needed.

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Chapter 10 Where They Can Have It

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and
Welfare

- The case manager must be reasonably sure that the environment meets the CAP/C requirements for safety.
- The nurse or aide will be paid only for their regularly approved hours. They will not be paid for additional hours unless the family chooses to use their respite for this purpose. The nurse or nurse aide may not be paid while sleeping. No single staff member may work more than 16 hours per day.

WHERE CAP/C SERVICES MAY NOT BE PROVIDED

CAP/C services cannot be provided:

- In the home of the paid nurse or nurse aide. This means that the nurse or nurse aide may not take the child to their own home to provide care. This also means that no one residing in the same household as the client can act as the paid nurse or nurse aide for that client.
- In a State or Federal prison, jail, detention facility, or other penal facility when the client is in the secure custody of that facility for a criminal offense or is confined involuntarily.
- In a hospital or in a nursing facility, rehab facility, ICF-MR facility, or other type of long-term care facility (except for Case Management as needed for discharge planning for transition out of the facility to home CAP/C services).
- Usually, in a Level 2 or higher Residential Child Care facility. By definition, the children in these facilities have a need for residential mental health treatment. In order to receive care in such a facility the child would also have to have medical needs related to a medical diagnosis that would warrant CAP/C participation. This would need to be determined on a case-by-case basis.
- Any environment which does not meet safety requirements as determined by the 'Housing' section of the assessment form, or is a threat to the client's health, safety, or well-being. This is not to say that

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a rating of 'needs attention' on that assessment means that services must be withheld. It does mean that a plan needs to be put in place to correct the inadequacy, and the child's safety must be assured during the process.

Chapter 10 Where They Can Have It

CHAPTER REVIEW

🔑 Key Points

1. CAP/C services may be provided in homes, private schools, preschools, daycares and in the community, as long as safety considerations and Medicaid policy regulations are met.
2. CAP/C services can sometimes be provided in foster homes and during the beneficiary's vacation trips.
3. CAP/C services can not be provided in jails/detention centers, long-term care facilities, in the homes of paid staff, or in any environment in which care can not be safely provided.

 **Test Your Knowledge**

Match the place of service with the type of environmental safety assurance required.

- | | |
|----------------------------|----------------------------------|
| 1. _____ home | a. letter of compliance from DCD |
| 2. _____ church daycare | b. none |
| 3. _____ child care center | c. case manager assessment |
| 4. _____ school | d. one star license from DCD |
-
5. CAP/C care may NOT be provided in
- a. a physician's office
 - b. a jail
 - c. the nurse's home
 - d. all of the above
 - e. none of the above

1. c, 2. a, 3. d, 4. b, 5. d

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SECTION 2

CAP/C GENERAL INFORMATION

CHAPTER 11

Who May Provide CAP/C

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This entire chapter relates to the waiver assurance of Qualified Providers.

GENERAL MEDICAID QUALIFICATIONS

Provider enrollment is part of the effort to assure that services are provided to CAP/C clients by qualified agencies. A provider must be enrolled with Medicaid to be entitled to Medicaid reimbursement. For certain services where non-Medicaid enrolled providers are used, the enrolled case management agency bills Medicaid on behalf of the provider, and reimburses that provider.

The Purpose of Enrollment

An agency's enrollment with DMA does two things:

- It documents that the agency agrees to provide services to Medicaid beneficiaries under the conditions of enrollment; and
- Allows the agency to be paid according to Medicaid policies and procedures for the services that it provides to Medicaid beneficiaries.

Who May Be Enrolled

An agency's enrollment depends on three factors:

- It must meet the qualifications to provide the service(s) for which it wishes to be enrolled.
- It must agree to all of the conditions of participation.

- It must complete and submit the appropriate enrollment forms to CSC. Forms and additional information can be found at <http://www.ncdhhs.gov/dma/provenroll/index.htm>

Responsibilities of an Enrolled Provider

The provider agency is responsible for meeting the terms of the provider participation agreement. The conditions of participation are included in the agreement. In addition to the responsibilities listed there for all Medicaid providers, there are additional responsibilities specific to CAP/C. Responsibilities specific to CAP/C include:

- Rendering the services as authorized by the CAP/C case manager.
- Making documentation of the provision of CAP/C services available to the CAP/C case manager as well as the other parties required by Medicaid policies and the participation agreement.
- Promptly notifying the CAP/C case manager of changes in the client's situation and needs.
- Promptly notifying the CAP/C case manager and other appropriate parties of any difficulties with the delivery of the service.

How To Enroll

To submit an application for enrollment, refer to the following website:

<http://www.ncdhhs.gov/dma/provenroll/index.htm>.

A provider of a waiver service or supply needs to specify that service or supply on their provider agreement. If the provider wishes to add or delete a service or supply, they need to change their provider agreement.

An enrolled provider of non-waiver services does not need to enroll as a CAP provider, even if they provide services to CAP/C beneficiaries.

Disenrollment

If a provider no longer wishes to be enrolled, it notifies DMA's Provider

Services Unit in writing. The provider may be disenrolled without cause by either party with written advance notification to the other party at least 30 days before the disenrollment date. In addition, a provider may be disenrolled as a qualified provider as outlined in the agreement and in Medicaid policies.

Also send a notice in writing to the HCI Unit Supervisor at least 30 days before the disenrollment date. A notice of 120 days is preferred so that there is adequate time to find another provider.

If your agency's Medicaid enrollment is ending, remember to contact the CAP/C case manager to coordinate the transfer of or disenrollment from any services that your agency is providing to CAP/C clients.

CAP/C QUALIFICATIONS

Case Management

Provider agencies are endorsed by the DMA CAP/C Supervisor prior to being approved by CSC Provider Enrollment. Endorsement is based on the ability of the agency to meet the conditions contained in this policy, as well as its ability to meet the CMS waiver assurances and case management standards of practice. Any information available to the CAP/C Supervisor, including information requested by her, or information available from entities such as DHSR and Program Integrity will be factored into a decision regarding endorsement.

Agency Qualifications

- The agency is capable of providing case management by both nursing and social work.
- The agency complies with policy development.
- The agency completes all required application and enrollment documentation and provides required certifications and tax information

as defined in the DMA Provider Enrollment guidelines. Eligible providers may include health departments, departments of social services, home care agencies licensed by DHSR under 10A NCAC 13J, aging agencies, and private providers.

- Providers demonstrate experience with pediatric case management.
- The agency has capability of Web-based automation.
- The agency providing case management services, including their subsidiary corporations, related partners, or closely allied entities may not also provide direct care services to the same beneficiary. Exceptions to this criterion may be approved on a case-by-case basis when:
 - There is a lack of available providers such that the beneficiary would be unable to access services, or
 - There is a written statement, signed by the beneficiary, that the individual has been offered choice among all qualified providers and that he or she has freely chosen the same agency for both purposes, and
 - There is an individual capable of and willing to advocate for the beneficiary, and that advocate can be present in planning meeting, and
 - All of the normal administrative requirements for both services are met independently; i.e., there is one beneficiary file for the case management services, which meets all of the CAP/C case management criteria, and a second beneficiary file for home health services which meets all of the home health criteria, and
 - The advocate is informed verbally and in writing about how to make a complaint to the State or request assistance with concerns about choice, quality, and outcomes.
- An agency employing or contracting a case manager who is the parent or family of a CAP/C beneficiary shall not provide case management to that

beneficiary. Exceptions to this criterion may be approved on a case-by-case basis when there is no alternate agency or when free choice of that agency is documented as above.

- The agency must provide Care Advisement to beneficiaries in the CAP/C-Choice option.

Individual Qualifications for Case Managers

The individual case manager must meet the following qualifications:

- Bachelor's degree in social work from an accredited school of social work and one year directly related experience, or
- Bachelor's degree in a human services field (as set forth in "Guidelines for Evaluating Human Services Degrees, Prepared by Office of State Personnel Local Government Services, October 2003" , located at http://www.osp.state.nc.us/Guide/LocalGovmt/HRManual/vi_humansrvc_degrees.pdf from an accredited college or university and one year directly related experience, or
- Bachelor's degree from an accredited college or university and two years directly related experience, or
- Registered nurses who hold a current North Carolina license, regardless of whether they have completed a two or four year educational program, must have one year directly related experience.

Directly related experience is defined as human services experience in the areas of pediatrics, nursing, medical social work, case management, assessment and referral, intervention, and treatment planning. No trainee appointments are eligible.

New hires must meet qualifications at time of hire.

Training

Case Manager Training Requirements

The agency is responsible for ensuring and documenting that each individual case manager has the following:

1. Bloodborne pathogen/infection control training
2. HIPAA training
3. Completion of the DMA-sponsored CAP/C training within 90 calendar days of employment and prior to billing any case management services.
4. Completion of the "Training for Case Managers – Improving the Quality of Home and Community Based Waiver Services", within 90 calendar days of employment, located at <http://www.hcbsassurances.org>.
5. One year of experience in pediatrics or completion of DMA-approved pediatric training curriculum.

Competencies

In addition to meeting the minimum staff qualifications, provider agencies are responsible for ensuring that staff is competent in the following areas:

1. Assessment

Knowledge of:

- a. Formal and informal assessment practices.
- b. The population/disability/culture of the beneficiary being served

Skills and Abilities to:

- a. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and giving options.
- b. Develop a trusting relationship to engage beneficiary and natural supports
- c. Engage beneficiaries and families to elicit, gather, evaluate, analyze and integrate pertinent information, and form assessment conclusions.
- d. Recognize indicators of risk (health, safety, mental health/substance abuse).

- e. Gather and review information through a holistic approach, giving balanced attention to individual, family, community, educational, work, leisure, cultural, contextual factors, and beneficiary preferences.
- f. Consult other professionals and formal and natural supports in the assessment process.
- g. Discuss findings and recommendations with the beneficiary in a clear and understandable manner.

2. Care Planning

Knowledge of:

- a. The values that underlie a person-centered approach to providing service to improve beneficiary functioning within the context of the beneficiary's culture and community.
- b. Models of wellness-management and recovery
- c. Biopsychosocial theories of practice, evidenced-based standards of care, and practice guidelines.
- d. Processes used in a variety of models for group meetings to promote beneficiary and family involvement in case planning and decision-making.
- e. Services and interventions appropriate for assessed needs.

Skills and Abilities to:

- a. Identify and evaluate a beneficiary's existing and accessible resources and support systems.
- b. Develop an individualized care plan with a beneficiary and his or her supports based on assessment findings that include measurable goals and outcomes.

3. Linkage/Referral

Knowledge of:

- a. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, recreation, and housing resources.
- b. Current laws, regulations, and policies surrounding medical and behavioral healthcare.

Skills and Abilities to:

- a. Research, develop, maintain, and share information on community and other resources relevant to the needs of beneficiaries.
- b. Maintain consistent, collaborative contact with other health care providers and community resources
- c. Initiate services in the care plan in order to achieve the outcomes derived for the beneficiary's goals.
- d. Assist the beneficiary in accessing a variety of community resources.

4. Monitoring & Follow-Up

Knowledge of:

- a. Outcome monitoring and quality management
- b. Wellness-management, recovery, and self-management
- c. Community beneficiary-advocacy and peer support groups

Skills and Abilities to:

- a. Collect, compile and evaluate data from multiple sources
- b. Modify care plans as needed with the input of beneficiaries, professionals, and natural supports
- c. Discuss quality-of-care and treatment concerns with the beneficiary, professionals, formal and natural supports.
- d. Assess the motivation and engagement of the beneficiary and his or her supports.
- e. Encourage and assist a beneficiary to be a self-advocate for quality care.

5. Professional Responsibility

Knowledge of:

- a. Importance of professional ethical standards and the consequences of violating ethical standards.
- b. Quality assurance practices and standards.
- c. Confidentiality regulations.
- d. Required performance standards and case management best practices
- e. Definitions and fundamental concepts of culture and diversity.
- f. Origins and tenets of one's personal value system, cultural background, and beliefs; and understanding of how this may influence actions and decisions in practice.
- g. Beneficiary differences in culture and ethnicity.

Skills and Abilities to:

- a. Use critical thinking skills and consultation with other professionals to make ethical decisions and conduct ethical case management.
- b. Use initiative and creative problem solving to support people in accessing the community and developing socially valued roles.
- c. Form constructive, collaborative relationships with beneficiaries of various cultures and use effective strategies for conducting culturally-competent case management.
- d. Form constructive, collaborative relationships with medical and other service providers.
- e. Discern with whom protected health information can be shared.
- f. Communicate clearly, both verbally and in writing.
- g. Discern when the severities of family problems are beyond the case manager's skill or responsibility, and when referrals to other professionals are necessary.
- h. Identify areas for self improvement, pursue necessary education and training, and seeks appropriate supervision.

In accordance with conflict free case management, case managers cannot be related by blood or marriage to the beneficiary or any of the beneficiary's paid caregivers, anyone financially responsible for the beneficiary, or anyone empowered to make financial or health-related decisions on behalf of the beneficiary.

For beneficiaries of CAP/C Nursing, it is recommended that the CAP/C case manager is an RN who meets the minimum standards set forth above.

A nurse or an agency who provides direct care to a CAP/C beneficiary may not also be the RN Case Manager or person contracted to perform nursing functions of case management (for example, the annual assessment) for that beneficiary.

Case Manager Supervisor Qualifications

The individual CAP/C Case Manager Supervisor shall meet the following qualifications:

All of the qualifications of the individual case manager, and

A. Designation as one of the following:

1. Certified Case Manager (CCM) by the Commission for Case Manager Certification.
2. Certified Social Work Case Manager (CSWCM) by the National Association of Social Workers.
3. Certified Advanced Social Work Case Manager (CASWCM) by the National Association of Social Workers.
4. Case Management Administrator Certification (CMAC) by the Center for Case Management.
5. Licensed Medical Social Worker.
6. Registered Nurse - Board Certified (RN-BC) in case management nursing by the American Nurses Credentialing Center.

OR

B. Having the following *additional* experience (above what is required for the individual case manager)

1. Bachelor of Social Work (BSW), Bachelor of Science (BS) in a human services field, or RN with two years of directly related experience, one of those years to have been case management experience.
2. BS in a non-human services field and three years directly related experience, one of those years to have been case management experience.

CAP/C Nursing, Nurse Aide, and In-Home Respite

Agency Qualifications

Providers licensed by the DHSR under 10A NCAC 13J as a home care agency and enrolled with N.C. Medicaid to provide in-home aide and nursing services may provide CAP/C Nursing , CAP/C Pediatric Nurse Aide Services, and CAP/C Personal Care Services.

Individual Nurse Qualifications

Nurses are qualified and supervised according to the N.C. Home Care Licensure Rules (10A NCAC 13J), the N.C. Nurse Practice Act (NCGS 90-171), and N.C. Board of Nursing rules and regulations (21 NCAC 36).

The provider agency is responsible for verifying the nurses' qualifications as follows:

- Verification of current licensure as a LPN or RN by the North Carolina Board of Nursing or a compact state. Verification is completed at hire and with each renewal date (every two years).
- Criminal background checks in accordance with GS 131E-265 and 10 NCAC 27G.0202. It is recommended that the nurse not begin providing services until the check has come back satisfactorily. It is further recommended that state criminal background checks be repeated every two years at time of licensure renewal.
- Verification of CPR certification at hire and every two years coinciding with expiration dates.

- Review of trainings and beneficiary-specific competencies upon hire and at each job performance review as per agency policy.
- Pediatric nursing experience or completion of DMA pediatric training.
- Supervision of the LPN or RN minimally every 60 calendar days, in the home, by the RN Supervisor.

Individual Nurse Aide Qualifications

The provider agency is responsible for verifying the aide's qualifications as follows:

- Check of Health Care Personnel Registry (10NCAC27G.0202) at hire and with each renewal date (every two years)
- Criminal background check in accordance with GS 131E-265. It is recommended that the nurse aide not begin providing services until the check has come back satisfactorily. It is further recommended that state criminal background checks be repeated every two years at time of registry renewal.
- Verification of CPR certification at hire and every two years coinciding with expiration dates. It is recommended that First Aid certification also be maintained and verified.
- Review of trainings and beneficiary-specific competencies upon hire at each job performance review as per agency policy.

For NA I+'s and NA II'S, completion of the DME pediatric/home care training curriculum. Nurse Aides currently functioning as NA I+ or NA II must complete the curriculum by March 31, 2011. Nurse Aide I+'s must have additional training in up to four NA II tasks.

- The Nurse Aide providing Pediatric Nurse Aide services completes DMA approved training regarding pediatric growth and development, pediatric client interactions, and home care of pediatric clients.
- The RN supervises the nurse aide in the beneficiary's home at least every three months, as specified in 10A NCAC 13J .1110.

Institutional Respite Services

Agency Qualifications

A Medicaid-certified nursing facility or a hospital with swing beds provides and bills for institutional respite. The facility or hospital is licensed under 10A NCAC 13 and certified by DHSR.

Individual Qualifications

Not Applicable

Waiver Supplies

Agency Qualifications

For incontinence supplies, the agency must meet the criteria above for case management providers or be a Medicaid-enrolled DME and CAP provider.

Adaptive tricycles are provided by a specialized vendor with the appropriate state/local business license.

Individual Qualifications

Adaptive Tricycles are requested by a licensed physical or occupational therapist and ordered in writing/signed by the physician.

Palliative Care

Agency Qualifications

Services are provided by a certified Hospice agency as according to 10A NCAC 13J .1005, a Home Health Agency, who must be a Medicaid-enrolled provider, or an independent provider.

Individual Counselor Qualifications

Counseling is provided by Clinical Social Worker, Licensed Professional Counselor (LPC), or Licensed Psychologist with experience working with clients with life-limiting illnesses and their families.

Individual Art Therapist Qualifications

Master's degree in art therapy or art education or psychology with major coursework in art, art therapy, including an approved clinical internship in art therapy. Registered or eligible for registration with the American Art Therapy Association.

Individual Music Therapist Qualifications

Bachelor's degree in music therapy and current certification with the Certification Board for Music Therapists.

Caregiver Training and Education

This service is provided by colleges, universities, AHECs, and other organizations that have expertise as appropriate in the field in which the training is being provided.

Motor Vehicle Modifications

Agency Qualifications

The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license and be capable of installing in accordance with applicable standards and safety codes including manufacturer's installation instructions, National Mobility Equipment Dealer's Association guidelines, Society of Automotive Engineers guidelines, and National Highway and Traffic Safety Administration guidelines, based on evaluation by an adapted vehicle supplier.

Individual Qualifications

Recommended equipment or modification shall be justified by an assessment by a Physical Therapist or Occupational Therapist specializing in vehicle modifications, or a Rehabilitation Engineer or Vehicle Adaptation Specialist.

Home Modifications

Agency Qualifications

The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license and be capable of making modifications and installing equipment according to applicable state and local building codes and other regulations with items that meet applicable standards of manufacture, design, and installation.

Individual Qualifications

Approval for home modifications is based on an assessment by a PT, OT, or Rehabilitation Engineer and accompanying MD certification of medical necessity, with the exception of floor coverings, air filters, and back-up generators which are based on RN assessment and MD certification.

Community Transition Funding

See home modifications and vehicle modifications.

WHO MAY NOT BE REIMBURSED FOR SERVICES

- The beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent
- Anyone who has legal responsibility for the minor beneficiary
- Grandparents of the beneficiary
- Siblings of the beneficiary
- The spouse of an adult (18 and over) beneficiary
- Anyone who has legal responsibility for an adult (18 and over) beneficiary
- Anyone who lives in the same household as the beneficiary

OUT-OF-STATE PROVIDERS

Provider agencies within 40 miles of the North Carolina border may enroll as North Carolina Medicaid providers. A list of zip codes within the 40 miles is located in the Basic Medicaid Billing Guide (available at <http://www.ncdhhs.gov/dma/basicmed/index.htm>). These agencies can provide all services and supplies the same as any in-state provider.

Out-of-state providers (further than the 40 miles) are eligible for enrollment only under the following conditions:

- For reimbursement of services rendered to N.C. Medicaid beneficiaries in response to an emergency or if travel back to the State would endanger the health of the beneficiary as determined by Medicaid's fiscal agent
- For reimbursement of prior-approved non-emergency services
- For reimbursement of medical equipment and devices that are not available through an enrolled provider located within the State of North Carolina or in the 40-mile border area.

CHAPTER REVIEW

🔑 Key Points

1. Providers must be enrolled with Medicaid in order to be reimbursed for Medicaid services.
2. Providers of CAP services need to specify CAP services on their provider agreement.
3. Enrollment and changes to the provider agreement are done through CSC.
4. Certain family members and anyone living in the child's household may not be paid by CAP/C provide services.
5. Providers of CAP/C services are subject to qualifications for the agency and qualifications for individuals within the agency.
6. Agencies within 40 miles of the NC border may enroll as in-state providers. Out of state providers can provide services only in emergency situations and when prior approved by NC Medicaid.

 **Test Your Knowledge**

1. True or False: A beneficiary's grandparent may be their paid CAP/C Nurse Aide.
2. Which entity is responsible for provider enrollment?
 - a. HP
 - b. CSC
 - c. DMA
3. Palliative care services are provided by a certified _____ agency, a home health agency, or an independent provider.
4. Out of state providers can only provide services in an emergency, when there is prior approval of non-emergency services, and _____.

1. False, 2. b, 3. hospice, 4. for reimbursement of medical equipment and devices that are not available through an enrolled provider located within the State of North Carolina or in the 40-mile border area.

SECTION 2 CAP/C GENERAL INFORMATION

CHAPTER 12 Who Does What In CAP/C

The key people involved in the care of the CAP/C child, are:

- The child's family or responsible party
- DMA's HCI Unit
- The case management provider
- The enrolled CAP provider agency
- The physician
- CSC
- The county Departments of Social Services
- CMS
- CCNC

RESPONSIBILITIES OF THE CLIENT'S FAMILY OR RESPONSIBLE PARTY

Actively Participate

The child's family or responsible party help ensure the child's health, safety, and well-being in the home by actively participating , in conjunction with the case manager, provider agencies, and DMA, in planning and providing the child's care.

Exercise Freedom of Choice

The family or responsible party must make an informed choice

FC
Free
Choice

- Between CAP/C and nursing facility placement, and
- Among enrolled Medicaid providers.

Be Accessible

The family or responsible party should be accessible to the Case Manager: return phone calls and forms, and be there when scheduled for home visits.

Keep the Case Manager Informed

The caregiver should inform the Case Manager of the following:

- Changes in the child's health and/or care needs,
- Hospitalizations or emergency department visits,
- New equipment and supplies,
- Absences, and
- Other services the child receives, such as school-based or Early Intervention Services.

MN
Medically
Necessary

Use Only Those Services That Are Necessary

The family or responsible party should, with the assistance of the Case Manager, distinguish between "medical needs" and "medical wants", and use only those services and supplies that are necessary. The family or responsible party should understand that unnecessary CAP/C services can not be given in order to make a child eligible for Medicaid and/or CAP/C.

Keep the Home Safe and Accessible to In-Home Staff

The caregiver should correct anything within the home environment that is causing problems finding staff members for the child; i.e., keep large dogs in a separate area, keep the environment clean, and avoid being verbally, physically, or sexually abusive toward staff.

Communicate with the Case Manager in a Timely Manner

The family or responsible party should notify the Case Manager as soon as possible of changes that need to be made to the Plan of Care, particularly extra hours, so that there is adequate time to get approval from DMA.

Maintain Medicaid Eligibility

The family or responsible party must understand that Medicaid eligibility and CAP/C eligibility are different, but both are necessary to participate in CAP/C. They should provide any financial or other documentation requested by Medicaid so that Medicaid eligibility can be maintained.

Maintain Normal Parental Responsibilities

The family should understand that CAP/C can not assume the parent’s responsibility or provide full care for the child. CAP/C can only assist. Parents will be responsible for their child for a portion (at least six hours) of each day.

Understand Service Levels and Amounts

The family should understand that services may change as their child’s condition changes, and that the change may be for more services, for fewer services, or for a discontinuation of services.

Understand Appeal Rights

The family should understand that they have the right to appeal any adverse decisions.

Keep the Legal Guardian Involved

The family should understand that when the caregiver is not the legal guardian, the caregiver and legal guardian must both be involved and forms will require both signatures.

MN
Medically
Necessary

MN
Medically
Necessary

FA
Financial
Accountability

FH
Fair
Hearings

The Client letter of Understanding and Freedom of Choice (located at <http://www.ncdhhs.gov/dma/forms/CAPCLetterOfUnderstanding.doc>) and the CAP/C Parent Handbook (located at <http://www.ncdhhs.gov/dma/capc/capcparenthandbook.pdf>) explain all of the above and give families/caregivers a lot of good information about the CAP/C program. It is the Case Manager's Responsibility to ensure that the family has a copy of the handbook and has reviewed and signed the Letter of Understanding and Freedom of Choice at least annually.

RESPONSIBILITIES OF DMA

DMA's HCI unit is the lead agency for the CAP/C program. DMA's major responsibilities with regard to CAP/C are described below.

Selection of Local Case Management Agencies

DMA designates the case management agencies that provide and arrange for services for CAP/C beneficiaries.

Establishing and Administering Policies and Procedures

DMA develops policies and procedures based on Federal guidelines for operating the program. It also oversees the local case management agencies to ensure that they are operating according to State policies and procedures and Federal guidelines.

Providing Manuals and Other Guidelines

DMA publishes manuals to guide the case managers and CAP provider agencies in providing CAP/C services. In addition to this CAP/C Manual, there is the basic Medicaid Billing Guide (located at <http://www.ncdhhs.gov/dma/basicmed/index.htm>), and policies and

manuals specific to each Medicaid program (located at <http://www.ncdhhs.gov/dma/mp/index.htm>)

For beneficiaries, there is the 'CAP/C Parent Handbook' (located at <http://www.ncdhhs.gov/dma/capc/capcparenthandbook.pdf>) as well as 'A Consumer's Guide to North Carolina Medicaid; Health Insurance Programs for Families and Children' (located at <http://www.ncdhhs.gov/dma/medicaid/famchld.pdf>).

Providing Training and Technical Assistance

DMA provides training and technical assistance to the case managers about

- Completing CAP/C assessments and plans of care,
- Developing and implementing CAP/C services,
- Coordinating CAP/C services with other resources and services in the community, and
- Providing case management.

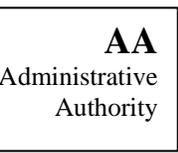
Training is currently provided via on-line self-study, webinars, video conferencing, conference calls, memos, communication between Case Managers and Consultants, and quality assurance activities.

Approving CAP Participation and Plans of Care

DMA is responsible for reviewing and approving CAP/C referrals, assessments, and plans of care for all CAP/C beneficiaries.

Monitoring Program Operation

DMA monitors the CAP/C program to ensure that the provision of CAP/C services complies with the intent of the program and with State policies and procedures. There are multiple methods of monitoring, including eCAP reports, annual case management agency audits, annual satisfaction surveys, reviews of incident and complaint reports, and record reviews.



Determining How Many May Participate

DMA obtains approval from the federal government for the number of individuals statewide that may participate in CAP/C.

FA
Financial
Accountability

Paying For Services

DMA is responsible for reimbursement policies and procedures.

Reimbursement involves provider enrollment, rate setting, and claims processing. DMA contracts with a fiscal agent to process claims and assist provider agencies with reimbursement issues.

Completing Reports and Evaluations

DMA prepares and submits required federal reports and shares information from the reports with the case management agencies. The annual reports include information on the number of beneficiaries served, the services used, costs, and health and welfare issues.

RESPONSIBILITIES OF THE CASE MANAGEMENT PROVIDER

The case management agency is often a county department of social services, health department, agency for the aged, private agency, or hospital within the county.

The local CAP/C case management agency is responsible for managing the CAP/C beneficiary's care on a day-to-day basis and providing certain CAP/C services. The responsibilities of the case management agencies are discussed in more detail below.

Networking, Educating

The case management agency develops and maintains relationships with local physician's offices, hospitals and discharge planners, provider

agencies, parent groups, and other program resources. By maintaining these relationships, case managers ensure access to CAP/C for those who need it and better coordination of care for clients or potential clients. Case managers provide ongoing education and information to clients or their responsible parties regarding the CAP/C program and how CAP/C policies or decisions relate specifically to the client.

Referring Applicants to the Program

When a parent, discharge planner, or other person calls a case management agency to inquire about CAP/C services, the Case Manager has a discussion with the inquirer about the eligibility requirements, services and limitations as well as the needs of the child and their expectations. This discussion is an opportunity to explain what the program can and cannot be expected to provide in relation to the child's needs. The Case Manager then should complete the referral form in eCAP and submit it for prescreening.

Assessing Applicants for the Program

The local case management agencies arrange for a complete assessment of individuals who apply for CAP/C and who have been approved for assessment. The assessment determines the child's strengths and needs. It is the basis for determining whether CAP/C is appropriate for the individual and for developing the plan of care. The assessment is completed by a registered nurse or a registered nurse/qualified case manager team who are experienced in home and community long term care assessment and case management.

SP
Service
PlansDeveloping the Plan of Care

The case manager assists the family in the development of the family-centered plan of care. When the assessment and plan of care are complete, the case manager submits them via eCAP to DMA.

Providing/Billing Some Waiver Services and Supplies

CAP/C Case Managers coordinate with local providers to ensure beneficiaries can receive approved home and vehicle modifications, caregiver training and education, and sometimes waiver supplies.

SP
Service
PlansCoordinating Services

Case management agencies must coordinate closely with other agencies that work with CAP/C beneficiaries such as departments of social services, provider agencies, schools, and physicians. Close coordination of medical and social services is necessary not only to ensure that the child receives a comprehensive package of services to protect their health, safety, and well-being, but to prevent duplication and ensure cost effective use of the home care resources available to children.

Managing Caseloads

Each CAP/C case management agency determines how many cases it has the capacity to manage at any given time. The number that can safely and effectively be served is based on the resources that are available to provide CAP/C services, such as case management staff. It is important that the health, safety and well-being of beneficiaries not be compromised due to lack of staff resources. Agencies should notify their DMA Consultant if there is a child that can not be served because of agency staffing issues or caseload limitations. All efforts should be made to avoid a waiting list.

SPService
PlansEnsuring Quality Services

Case managers oversee the provision of CAP/C services and locate and recruit qualified provider of CAP/C services. (See Chapter 11 for information about provider enrollment.) The case manager monitors the services the client is receiving through direct observation, client report, and review of provider documentation. The Case Manager acts as an advocate for the client and caregivers, within the benefits and limitations of the CAP/C program.

“Quality Services” means services that meet the service standards set forth in this manual. Concerns that a provider is violating the standards should be reported to both the DMA CAP/C Consultant at 919 855 4380 and the regulatory body who licenses/certifies the provider.

Case management agencies should have their own internal Quality Management policies and practices in place, which should encompass both clinical and financial measures.

FCFree
ChoiceEnsuring Client Freedom Of Choice

Case management agencies ensure that CAP/C clients are aware of their right to select

- Between CAP/C services and institutionalization, and
- Among enrolled Medicaid providers for CAP/C and other Medicaid services.

Special care must be taken to avoid a conflict of interest when the case management agency is also a home care agency. See Chapter 11, Case Management Agency Qualifications, for more information. Freedom of choice should be explained to the client at the start of care and periodically thereafter, particularly any time a client expresses dissatisfaction with their agency services.

MORE
INFORMATION

Cooperating With Monitoring And Reporting Activities

Case management agencies need to respond promptly to requests by DMA for information required for

- Monitoring and quality assurance purposes to meet state and federal requirements.
- Determining CAP/C participation and plan of care approval.

A response regarding quality assurance reporting is expected within 15 business days unless otherwise agreed upon with the DMA CAP/C Consultant or HCI Unit Supervisor. For information impacting an individual's participation in CAP/C or plan of care approval, a response is needed within 10 business days, as per the due process regulations. (Please see Chapter 53 for more information regarding due process.)



MORE
INFORMATION

Documentation

Case management agencies maintain notes and other monitoring requirements described as in Chapter 48 of this CAP/C manual.

Advance Notice Of Intent To Disenroll As A Provider For CAP/C Case Management Services

At a minimum, case management agencies must provide a one month advance notice of intent to terminate an agreement to provide direct case management services. Notice should be in writing, to the attention of the HCI Unit Supervisor. In order for DMA to have adequate time to make alternate arrangement, we request at least four months notice.

RESPONSIBILITIES OF THE LOCAL PROVIDER AGENCIES

The enrolled CAP provider agency provides quality services according to Medicaid guidelines as well as applicable law, rules, and regulations such as the DHSR regulations for nurse and nurse aide services

(<http://www.ncdhhs.gov/dhsr/index.html>). Specifically, the local provider agency must

- Adhere to all applicable licensing regulations.
- Adhere to Medicaid and CAP/C regulations.
- Notify the Case Manager when services need to be increased, decreased, or discontinued.
- Provide documentation as requested by the Case Manager or by DMA to assist in making decisions regarding level of care or services.
- Providers of waiver services submit copies of invoices for services or claims for services to case managers, as required by the particular service,
- Adhere to the service authorization. Get prior Case Manager approval for any services not provided according to the Service Authorization. Provide a deviation notice to the Case Manager when services are not provided as scheduled.

RESPONSIBILITIES OF THE PHYSICIAN

The child’s primary care physician or coordinating care physician is responsible for

- Recommending nursing facility level of care and signing the FL-2.
- Completing the physician’s request form as applicable.
- Ordering CAP/C services and supplies and/or providing certification of the medical necessity for them.
- Reviewing and signing the nurse or nurse aide plan of care.
- Providing direction when needed for issues that arise that do or could impact the child’s health.

LOC
Level of
Care

MN
Medically
Necessary

QPQualified
Providers**RESPONSIBILITIES OF CSC**

Computer Sciences Corporation (CSC) is currently responsible for the enrollment of providers. Please see Chapter 11 or refer to the website at <http://www.ncdhhs.gov/dma/provenroll/index.htm> for more information regarding provider enrollment. CSC approves the nursing facility level of care and processes claims. It provides guidance and training related to these activities. The fiscal agent for North Carolina Medicaid is currently CSC (as of July 1, 2013). Please see Chapter 29 for more information regarding prior approval of level of care. Please see Chapter 49 for more information regarding claims.

RESPONSIBILITIES OF THE COUNTY DSS

The county Departments of Social Services handle Medicaid eligibility determinations and enter the CAP Indicator Code into Medicaid's computer system. (Case Mangers should follow-up with DSS to make sure CAP Indicator codes have been entered, changed, or removed as applicable.)

RESPONSIBILITIES OF CMS

The Center for Medicare and Medicaid Services (CMS) is the federal authority over Medicaid. CMS sets the criteria for waiver programs and approves the CAP/C waiver. Please see Chapter 3 for more information regarding the waiver and CMS.

RESPONSIBILITIES OF CCNC

Community Care of North Carolina (CCNC) provides information from its Provider Portal to case managers. This information is based on Medicaid claims data and includes diagnoses, care needs, medications, services, supplies, etc. Case managers can access this information from their local CCNC network in preparation for a CNR or at any other time such

MORE
INFORMATION

information is needed.

CHAPTER REVIEW

🔑 Key Points

1. The child's family/caregiver must actively participate in their child's care, maintain parental responsibility, and work collaboratively with their case manager.
2. The HCI Unit of DMA sets policies, provides training and consultation to case managers, and approves or denies beneficiaries' CAP/C plans of care.
3. The case management provider assesses beneficiaries, develops a plan of care, and provides monitoring, follow-up, and coordination of care.
4. Other provider agencies such as home care agencies or DME providers abide by all Medicaid policies and regulations and work collaboratively with the case manager to keep her informed and able to coordinate care. Service providers submit claims or copies of monthly invoices to the Case Manager as applicable to the service.
5. The physician completes the FL-2, orders the services and supplies on the plan of care, reviews and signs home care agencies' care plans, and intervenes when a problem arises regarding the child's health.
6. CSC is responsible for enrolling agencies as Medicaid providers, approving the FL-2 for nursing facility level of care, giving prior approval for some regular Medicaid services/supplies, and paying claims.
7. DSS determines the beneficiary's Medicaid eligibility and maintains the CAP Indicator code in the system.

8. CMS is the federal authority over Medicaid.
9. CCNC provides claims based data to case managers that will assist case managers in needs identification and planning.

 **Test Your Knowledge**

Match the activity with the party responsible for it.

- | | |
|---|--|
| 1. _____ approves referrals to CAP/C | a. the child's family or responsible party |
| 2. _____ recommends nursing facility level of care | b. DMA's HCI Unit |
| 3. _____ maintains communication with and availability to the case manager | c. the case management provider |
| 4. _____ reviews Medicaid eligibility | d. the provider agency |
| 5. _____ approves, regulates, and oversees the waiver | e. the physician |
| 6. _____ coordinates the child's care | f. CSC |
| 7. _____ pays claims | g. DSS |
| 8. _____ provides documentation to case manager and notifies case manager of needed changes in services | h. CMS |

1. b, 2. e, 3. a, 4. a, 5. h, 6. c, 7. f, 8. d

SECTION 2

CAP/C GENERAL INFORMATION

SECTION REVIEW

1. John turns 21 on June 23. He will be transitioning to Private Duty Nursing. The last day he can receive CAP/C services is
 - a. June 23.
 - b. June 22.
 - c. May 31.
 - d. June 30.
2. Mary's parents are applying to CAP/C because they want respite services and more physical therapy. They do not want regular nurse or nurse aide services in their home and do not require any other waiver services. You advise them that
 - a. They can have those services under CAP/C, but they must also have case management.
 - b. In order to get CAP/C, they must use regularly scheduled nurse or nurse aide care in the home.
 - c. In order to get CAP/C, they have to use case management plus another waiver service besides respite.
3. George has a nurse who meets him at the school bus stop and stays with him until Mom arrives home from work. George's home is being painted and the fumes will aggravate his respiratory problems. The parent and the nurse discussed it and agreed that the nurse would take the child to her home and the parent could pick him up from there. You

Section 2 Review

- a. Agree; it sounds like an ideal solution.
 - b. Disagree; care can not be provided in the home of a paid caregiver.
 - c. Disagree; care may only be provided in the beneficiary's home.
4. Ann has developmental delays related to autism. She has no medical needs. The parents need help caring for Ann at home. You
- a. Explain that Ann does not meet CAP/C criteria, and help the parents make a referral to CAP-MR/DD.
 - b. Explain that CAP-MR/DD would be a better program for Ann, but there is a long waiting list, so she can get CAP/C during the time she is on the waiting list.
 - c. Explain that it will be no problem for Ann to get CAP/C.
5. Frank's FL-2 does not get approved for nursing facility level of care. The parents have appealed the decision and lost the appeal. They are not planning to pursue it any further. Which of the following statements is true?
- a. Frank is ineligible for CAP/C.
 - b. Frank may still be eligible for CAP/C.
6. Sara's family needs help paying for physical therapy sessions. Sara gets PT every week, and the family's private insurance only covers 15 visits per year. The parents make too much money to qualify for Medicaid. They would like to get on CAP/C so that Sara can get the therapy she needs. Which of the following statements is true?
- a. Therapy is not a CAP/C service, and CAP/C can only be approved for waiver services. CAP/C can not be approved for state plan services or to get Medicaid.

- b. Sara can have CAP/C, but only after her 15 visits have been used.

Match the child's need to the appropriate waiver service.

- | | |
|--|------------------------------|
| 7. ____ wheelchair ramp | a. Home modifications |
| 8. ____ in-home help caring for a child with a trach | b. Vehicle modifications |
| | c. Personal care |
| 9. ____ registration fee for a conference for caregivers of people with spina bifida | d. Pediatric nurse aide care |
| | e. RN/LPN |
| | f. Palliative care |
| 10. ____ in-home care for a child with gastrostomy tube feedings | g. Caregiver training |
| 11. ____ in-home care for a child with ADL needs and incontinence | |
| 12. ____ van tie-downs for a wheelchair | |
| 13. ____ help for the family in coping with care of a special need child | |
| 14. Mike needs a cranial helmet for positional plagiocephaly (one side of his head is flat from laying on it all the time). Medicaid does not cover this item. Your course of action is to | |
| a. Tell the parents he can't have it. | |
| b. Submit a 'request for non-covered services' form because he may be able to get it under EPSDT consideration. | |
| 15. Meghan's family is applying for CAP/C and you are in the process of developing the plan of care. Meghan's mother asks you how much money she is allowed to spend. You advise her that: | |
| c. There is not a budget limit per child; each service has a budget limit, but Meghan can get as many services as she qualifies for. | |
| d. There is not a budget limit per child, but each child can receive only up to three services. | |

Section 2 Review

- e. There is a limit of \$5000 per month per child.
16. Susan has a heart condition, and her parents are concerned about their in-home nurse aide being CPR certified. You advise them that
- a. CPR certification is up to the individual Nurse Aide.
 - b. Some agencies require their aides to be CPR-certified; others do not.
 - c. To be a CAP/C Nurse Aide, the aide is required to be CPR certified.

1. b, 2. c, 3. b, 4. a, 5. a, 6. a, 7. a, 8. e, 9. g, 10. d, 11. c, 12. b, 13. f, 14. b, 15. a, 16.. c