Nothing Compares
NORTH CAROLINA

Community Alternatives Program 1915 (c) HCBS Waiver
February 2017

Department of Health and Human Services
CAP/C Waiver Training

Agenda

Overview of the following eligibility criteria:

- Target population
- Waiver entry
- Continuation of waiver participation
- Waiver provider
- Reimbursement of waiver services

Overview of the following non-eligibility criteria:

- Denial of waiver participation
- Termination of waiver participation
- Denial of waiver service

Target Population

Individuals under age 21 who are determined to:

- Be medically-complex
- Meet an institutional level of care
- Be at risk of institutionalization and need at least one (1) waiver service to return to or maintain community placement
- Be eligible in the Medicaid categories of MAB or MAD or I-AS or H-SF

Importance of Established Criteria

- Meet both federal and state assurances
- To ensure the individuals of the target population is in fact the target population
- To protect the health, safety, and well-being of the CAP beneficiary
- To effectively assign the unduplicated slot allotment of 4,000

Waiver Entry

1. Medically-Complex
2. Level of Care (LOC)
3. At-Risk of Institutionalization
4. Person-Centered POC

Medically Complex Criteria

Meet all of the following medically complex conditions:

A. A primary medical (physical rather than psychological, behavioral, cognitive, or developmental) diagnosis(es) including:

Includes: Cardiovascular disease, pulmonary disease, congenital anomalies, disease of the alimentary system, infectious disease, musculoskeletal conditions, endocrine and metabolic disorders, neurological disorders, integumentary disease, oncologic and hematologic disorders, renal disease, and genetic disorders.

Medically Complex Criteria

B. A serious, on-going illness or chronic condition requiring prolonged hospitalization (more than 10 calendar days or 3 hospital admissions) within 12 months, ongoing medical treatments (treatment performed by a registered nurse or medical doctor), nursing interventions, or any combination of these that must be provided by a registered nurse or medical doctor; and

C. A need for life-sustaining devices such as endotracheal tubs, ventilator, suction machines, dialysis machine, Jejunostomy Tube and Gastronomy Tube, oxygen therapy, cough assist device, and chest PT vest; or care to compensate for the loss of bodily function.

Establishing LOC

- Professional judgment and a thorough evaluation of the beneficiary's medical condition and psychosocial needs to differentiate between the need for nursing facility care and other health care alternatives.
- Identification of interventions, safeguards (health, safety, and well-being) and the stability of each beneficiary to ensure community integration and prevention of institutionalization as a result of chronic medical and physical disabilities.

At-Risk of Institutionalization

Needs based:

1. Comprehensive assessment justifying risk of institutionalization
2. Able to have health, safety, and well-being maintained at primary private residence or approved location
3. Medical needs can be met within the average cost limits of CAP/C waiver
4. Requires at least one CAP/C service on a monthly basis that mitigates institutionalization through coordinated case management and hands-on personal assistance

At-Risk of institutionalization

5. Has primary physician or connected to Medical Health Home

6. Has an emergency back-up and disaster recovery plan with reliable formal/informal supports to meet needs

Consumer-direction:

- Understand the rights and responsibilities of directing his or her own care;
- Be willing and intellectually capable to assume the responsibilities for consumer-directed care, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care; and
- Complete a self-assessment questionnaire to determine intellectual ability to direct care, ensure health and safety, and identify training opportunities.

At-Risk of Institutionalization

Temporary need based participation:

- Requires only an installation of a home or vehicle modification or assistive technology to return to or remain in the primary private residence that prevents risk of institutionalization (the installation of equipment or modification must be completed within three calendar months of approval).

Person-Centered Service Plan

- Summarizes the evaluation and assessment information to highlight the beneficiary's strengths and needs;
- Outlines person-centered goals, objectives, and case management tasks based on the assessment and identified needs;
- Identifies beneficiary's outcomes to be supported;
- Develops a comprehensive list of CAP/C waiver and non-waiver services, medical supplies and durable medical equipment (DME), and document the authorized provider name, amount, frequency, and duration of each service;

Person-Centered Service Plan

- Summarizes plan of care cost totals to ensure the Medicaid and waiver services are within the average established cost limit;
- Identifies health and welfare monitoring priorities during the service plan period;
- Ensures the beneficiary's right to choose among providers as evidenced by a signed provider Freedom of Choice form; and
- Develops a service plan annually and update when warranted due to status changes in the CAP/C beneficiary's care needs

Tools Used to Establish Waiver Entry

- Service Request Form (SRF) – referral and LOC of care tool – used to determine if medically-complex and LOC
- Interdisciplinary comprehensive assessment addresses 17 core areas
- Person-Centered Service Plan
- Emergency-Back-Up Plan – addresses emergency care needs and disaster recovery plan
- Signed Beneficiary Rights and Responsibilities Form demonstrates understanding of and responsibilities while participating in the waiver

Prioritizing Waiver Entry

- Cancellation of private health insurance plan for individuals receiving personal care-type services
- Transitioning from a NF with or without Money Follows the Person (MFP) designation
- Returning from a 90-day hospital or nursing facility stay
- Eligible CAP/C beneficiaries who are transferring to another county or case management entity
- Individuals identified as at-risk by their local Department of Social Services (DSS) who have an order of protection by Child Protective Service (CPS) for abuse, neglect or exploitation; and the CAP/C Waiver is able to mitigate risk; or
- Medicaid beneficiaries with active Medicaid who are temporarily out of the State due to a military assignment of their primary caregiver

Continuation of Waiver Participation

- Annual reassessment of needs
- Signed and approved SP that addresses person-centered goals
- Emergency back-up plan
- Signed Beneficiary Rights and Responsibilities Form

Waiver Provider

- Receive a service authorization to render CAP/C services;
- Have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- Bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Waiver Provider

- Criminal background checks of staff, which must be repeated every two (2) years, at the time of certification renewal
- Verification of cardiopulmonary resuscitation (CPR) certification and every two (2) years, coinciding with expiration dates;
- Review of trainings and beneficiary-specific competencies at each job performance review as per agency policy;
- Pediatric nursing experience
- Supervision of CNA every 60 days

Reimbursement

- When the CAP/C services were provided in an amount, duration, and scope, consistent with the beneficiary's medical needs
- The amount did not exceed what is contained in the approved CAP/C service plan
- When a provider bills for a service that is valid for the CAP/C benefit program
- When the required documentation is obtained and in the CAP/C beneficiary's record

Waiver Entry Denial for Non-Eligibility

- The HCBS Service Request Form (SRF) is incomplete, has been denied or request for additional information was not received within the specified timeframe
- An assessment of medical and functional needs has not been completed by an RN or social worker
- The beneficiary does not require and use CAP/C services planned in the service plan that are available to the beneficiary during a 90 calendar day
- The required annual assessment recertification was not approved or completed within 60 calendar days of the annual assessment date

Waiver Entry Denial for Non-Eligibility

- The beneficiary is receiving other Medicaid services or other third-party reimbursed services that are duplicative
- The beneficiary's currently approved services (Medicaid and non-Medicaid) are meeting assessed care needs and the beneficiary is not determined to be at-risk of institutionalization
- The beneficiary's health and well-being cannot be met through an individualized person-centered service plan or risk agreement when the beneficiary resides in an unsafe home environment placing the eligible beneficiary at risk
- The beneficiary's Medicaid eligibility is terminated

Waiver Entry Denial

- The beneficiary or responsible party refuses to sign or cooperate with the established service plan and any other required documents, placing the eligible beneficiary's health, safety and well-being at risk
- The case management entity has been unable to establish contact with the beneficiary or his or her responsible party for more than 90 calendar days, for the provision of care, despite more than two (2) verbal and two (2) written attempts
- The beneficiary does not have an emergency back-up or disaster plan with adequate social support to meet the basic needs outlined in the interdisciplinary comprehensive assessment to maintain his or her health, safety, and well-being
- The beneficiary or responsible party demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP/C Waiver as outlined in the "Beneficiary Rights and Responsibilities" form signed by the CAP beneficiary

Reasons for Disenrollment

- The beneficiary's Medicaid eligibility is terminated;
- The beneficiary's physician does not recommend nursing facility;
- The SRF is not approved for nursing facility LOC;
- DSS removes the CAP/C evidence;
- The CAP/C case management entity has been unable to establish contact with the beneficiary or the primary caregiver(s) for more than 90 calendar days despite two written and verbal attempts;

Reasons for Disenrollment

- The beneficiary fails to use CAP/C services as listed in the service plan during a 90 consecutive day time period of CAP/C participation;
- The beneficiary's health, safety, and well-being cannot be mitigated through a risk agreement;
- The beneficiary or primary caregiver does not participate in development of or sign the service plan;
- The beneficiary or primary caregiver(s) fails to comply with all program requirements, such as failure to arrive home at the end of the approved hours of service, or

Reasons for Disenrollment

- The beneficiary or primary caregiver demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP/C Waiver as outlined in the "Beneficiary Rights and Responsibilities," form signed by the CAP/C beneficiary.
- There are three (3) such occurrences, and the beneficiary or primary caregivers have been counseled regarding this issue; or after one occurrence, if the beneficiary's health and welfare is at risk and cannot be mitigated.

Rollout CAP/C Training Plan

Introductory Case Management Entity Trainings:

- Feb. 23 – New Waiver Objectives
- Feb. 27 - Waiver Eligibility Criteria

Beneficiary Waiver Introductory Training:

- Feb. 28 – CAP/C Beneficiary Training- What I Need to Know about the Waiver

Direct Service Provider Training:

Feb. 21

Feb. 23

Feb. 27

Feb. 28

Rollout CAP/C Training Plan

Future trainings planned in March:

1. Case management- Four Core Activities
2. Person-Centered Planning - The Waiver Service Package
3. Waiver Compliance:
   - Assurances –State and Federal
   - Score Cards
   - Training Requirements
4. Critical Incident Reporting System
   - Critical incident reports
   - Grievances and complaints

Additional future trainings will be announced in March

Support and Assistance

- DMA Nurse consultants
- e-CAP Telephone Assistance- (888) 705-0970
- e-CAP Assistance on-line- e-CAP portal
- DMA office – 919-855-4340