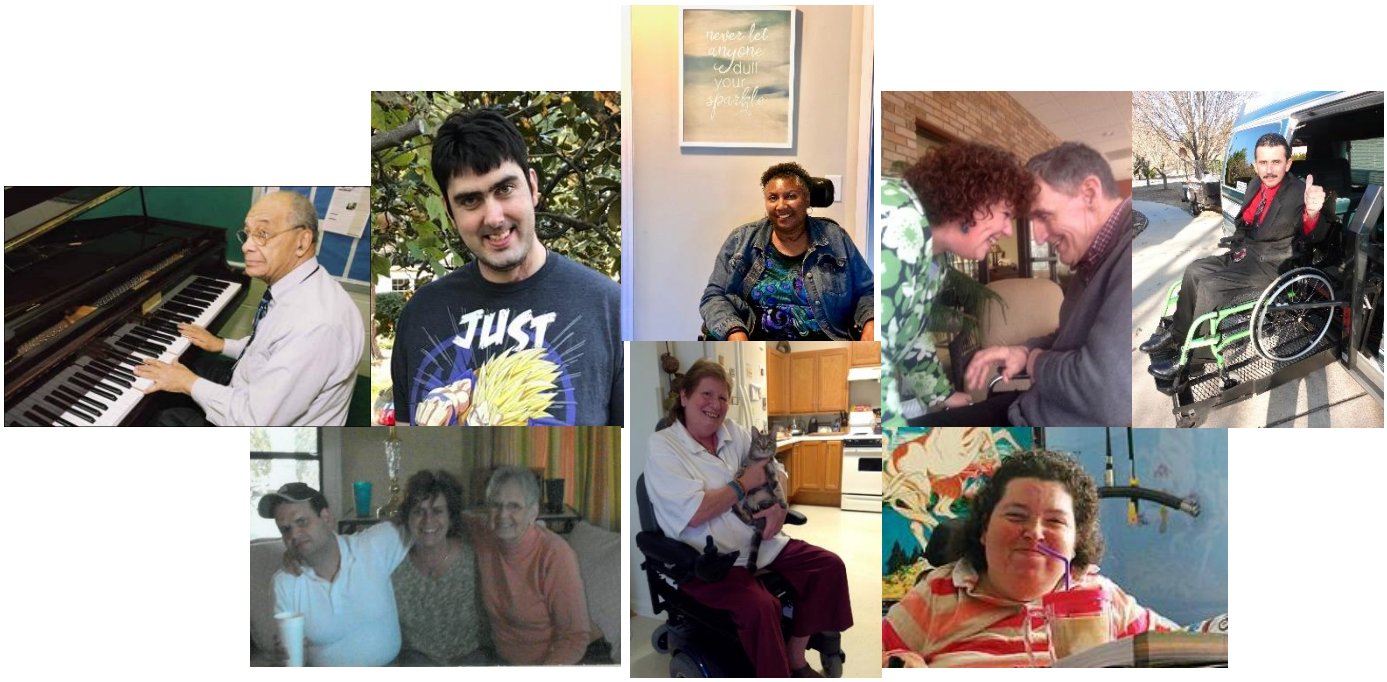
2019 North Carolina Medicaid Long-Term Services and Supports



Program Eligibility and Benefits Reference Guide

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

MONEY FOLLOWS THE PERSON
DEMONSTRATION PROJECT

Department of Health and Human Services | Division of Health Benefits/NC Medicaid
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Community Alternatives Program for Children (CAP-C)

What is CAP-C?

The Community Alternatives Program (CAP) is a Medicaid Home and Community-Based Services (HCBS) Waiver authorized under section1915(c) of the Social Security Act and complies with 42 CFR § 440.180, Home and Community-Based Waiver Services. This waiver program provides a cost-effective alternative to institutionalization for beneficiaries, in a specified target population, who are at risk for institutionalization if specialized waiver services were not available. The CAP/C waiver services allow medically fragile beneficiaries to remain in or return to a home and community-based setting.

Who Qualifies for CAP-C?

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

- Qualify for Long-Term Care Medicaid
- Be age 0 through 20 years of age
- Meet medically fragile criteria and a nursing facility Level of Care as specified in Section 3.0 of the CAP/C Clinical Policy
- Require at least one Home and Community-Based Service monthly

How do I Apply for CAP-C?

- Contact the DSS in the county where the individual resides (http://www.ncdhhs.gov/dss/local/) and apply for Long-term Medicaid.
- Contact the county CAP/C case management entity (https://files.nc.gov/ncdma/CAPC-CaseManagementProviders-20190219.pdf) and request for a Service Request Form (SRF) be initiated

Consumer Direction

Consumer direction is an option in the 1915 (c) Waiver that allows beneficiaries or a designated representative to exercise choice and control over a specified amount of Waiver services and act in the role of employer of record to direct the services. A self-assessment which measures the willingness and ability to direct one's own services must be completed to determine capacity for consumer direction.

Important Considerations

- If it is determined that the individual does not qualify for CAP participation other home and community-based services may still be available.
- If the individual is over the 100% Federal Poverty Level (FPL) for Medicaid and approved to receive waiver services, a Medicaid deductible may apply.
- If the individual is residing in a facility when determined eligible, s/he may qualify for transition services.
- A Case Manager will be assigned who will create the service plan, including the Plan of Care, and manage care needs.
- If an individual qualifies for consumer direction, training and education is available to build competencies.

Contact Information

Website: https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/community-alternatives-program-for-children	
Email medicaid.capc@dhhs.nc.gov	**Phone** 919-855-4340

The content included in this overview does not constitute all service and eligibility components of the program. Eligibility and service determination will be based on NC Medicaid Community-Based Services Clinical Policy (https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/community-based-services-clinical-coverage-policies)

Community Alternatives Program for Disabled Adults (CAP-DA)

What is CAP-DA?

The Community Alternatives Program (CAP) is a Medicaid Home and Community-Based Services (HCBS) Waiver authorized under section1915(c) of the Social Security Act and complies with 42 CFR § 440.180, Home and Community-Based Waiver Services. This waiver program provides a cost-effective alternative to institutionalization for beneficiaries, in a specified target population, who are at risk for institutionalization if specialized waiver services were not available. The CAP/DA services allow physically disabled and aged population beneficiaries to remain in or return to a home and community-based setting.

Who Qualifies for CAP-DA?

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

- Qualify for Long-Term Care Medicaid
- Be 18 years of age or older.
- Meet Nursing Facility Level of Care as determined under Section 3.0 of the CAP/DA Clinical Policy.
- Require at least 1 Home and Community-Based waiver service monthly.

How do I Apply for CAP-DA?

- Contact the DSS in the county where the individual resides (http://www.ncdhhs.gov/dss/local/) and apply for Medicaid.
- Contact the county CAP/DA Case Management Entity (https://files.nc.gov/ncdma/CAP-DA_Lead_Agency_Directory.xlsx) and request for a Service Request Form (SRF) be initiated.

Consumer Direction

Consumer direction is an option in the 1915 (c) Waiver that allows beneficiaries or a designated representative to exercise choice and control over a specified amount of Waiver services and act in the role of employer of record to direct the services. A self-assessment which measures the willingness and ability to direct one's own services must be completed to determine capacity for consumer direction.

Important Considerations

- If it is determined that the individual does not qualify for Long-Term Care Medicaid other services may still be available.
- If the individual is over the 100% Federal Poverty Level (FPL) a deductible may apply.
- If the individual is residing in a facility when determined eligible, s/he may qualify for transition services.
- An assessment will be conducted to determine appropriateness for CAP services.
- A Case Manager will be assigned who will create the service plan, including the Plan of Care, and manage the case.
- If an individual qualifies for consumer direction, training and education is available to build competencies.

Contact Information

Website: https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/community-alternatives-program-for-disabled-adults	
Email medicaid.capda@dhhs.nc.gov	**Phone** 919-855-4340

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Home Infusion Therapy (HIT)

What is HIT?

Home Infusion Therapy (HIT) is a service that covers self-administered infusion therapy and enteral supplies provided to a NC Medicaid or NC Health Choice beneficiary residing in a private residence or an adult care home.

Who Qualifies for HIT?

To be eligible for Home Infusion Therapy, the individual must:

- Qualify for NC Medicaid or NC Health Choice (age 6 – 18)
- Reside in a private residence or Adult Care Home
- Require medically necessary services for the treatment of illness, injury, or medical condition as documented by the ordering physician and set forth in Section 3.0 of the Home Infusion Therapy Clinical Policy.

Important Considerations

- The individual must be under the care of the ordering physician.
- The HIT agency provides the necessary training to the beneficiary and/or caregiver to carry out the therapy according to the physician's orders. Note: responsibilities for training differ with each type of therapy.
- Drug therapy services include equipment, supplies, delivery of these items, and any nursing services needed to teach, monitor, and assist the beneficiary.
- HIT drug therapy is not allowed for Medicaid beneficiaries receiving Private Duty Nursing (PDN).
- Nursing services for enteral and parenteral nutrition therapies are not covered.
- Oral nutrition and supplements are not covered under the HIT program.

How do I Apply for HIT?

- Contact the DSS in the county where the individual resides (http://www.ncdhhs.gov/dss/local/) and apply for Medicaid.
- Have an order for HIT submitted by the beneficiary's Physician to the HIT service provider.
- A registered nurse (RN) representing the HIT agency makes an initial visit to assess the beneficiary and submits a request for Prior Approval to NC Medicaid.

Contact Information

Website:
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/home-infusion-therapy
Phone
919-855-4380

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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Health Benefits | NC Medicaid

Human Immunodeficiency Virus Case Management (HIV)

What is HIV Case Management?

HIV Case Management is a client-focused strategy that provides cost-effective, medically necessary services to enhance beneficiary health status and level of functioning. The goals of HIV case management are to:

- Improve an eligible beneficiary's access to a wide range of appropriate services
- Promote continuity of care by coordinating service delivery arrangements
- Enhance a beneficiary's health status and level of functioning
- Promote efficiency by reducing or containing the overall cost of services

Who Qualifies for HIV Case Management?

To be eligible for HIV Case Management, the individual must:

- Qualify for NC Medicaid
- Have a diagnosis of HIV or seropositivity

How do I Apply for HIV Case Management?

- Contact your local Department of Social Services (DSS) (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid
- Request a list of providers through the local Health Department
- Select a provider from the list and contact the provider directly

Important Considerations

- HIV case management is not intended to be an ongoing service. It is a short-term, goal-oriented service tailored to meeting the specific immediate needs of the beneficiary with a maximum of 16 units per month.
- It is designed to empower clients through education, referrals and facilitating access to care, assisting clients to gain the tools needed to be their own advocates and navigate the health care and social services systems to improve health outcomes.
- Beneficiaries work with a personal case manager who will create a customized care plan based on immediate needs, resources, and strengths.
- Referrals to specific providers and not made.
- Services are available in Medicaid covered facilities.
- An informational flyer is available at: https://files.nc.gov/ncdma/documents/Providers/Programs_Services/HIV/HIVCaseManagement-Flyer_2018_03.PDF

Contact Information

Website: https://medicaid.ncdhhs.gov/providers/programs-services/care-management/hiv-case-management	
Email HIV_CaseMgt@dhhs.nc.gov	**Phone** 919-855-4360

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Home Health

What is Home Health?

Home health services are medically necessary skilled nursing services, specialized therapies (e.g., physical therapy, speech-language pathology and occupational therapy), home health aide services, and medical supplies provided to beneficiaries at home or in adult care homes. Home health services reduce the length and cost of hospital stays for beneficiaries while promoting independence and self-sufficiency and receive required treatment in the comfort of their homes. These services are designed to be offered on a short-term or intermittent basis.

Who Qualifies for Home Health?

To be eligible for Home Health, the individual must:

- Qualify for NC Medicaid or NC Health Choice (age 6 – 18)

How do I Apply for Home Health?

- Contact the Department of Social Services (DSS) in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- Submit to the Home Health Service Provider an order from the attending physician detailed required services
- The Home Health Service Provider submits a request for Prior Approval to NC Medicaid.

Important Considerations

- Services provided are dependent upon medical needs.
- Face-to-face contact with the attending physician must occur within 90 days prior to the start of care or within 30 days after the start of care.
- The attending physician shall certify in writing that Home Health services are the most appropriate, and that those services are determined to be best delivered in the home.
- Medical supplies are provided only for the beneficiary receiving Home Health Services.
- Home Health services cannot be limited to services furnished to beneficiaries who are homebound.
- Home Health Skilled Nursing services must be limited to 75 total visits per year per beneficiary.
- Home Health Aide services must be limited to 100 total visits per year per beneficiary.
- Home Health services must be coordinated with other home care service providers to avoid more than one person working with the beneficiary at the same time.

Contact Information

Website:	
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/home-health-services	
Email Medicaid.homecareservice@dhhs.nc.gov	**Phone** 919-855-4380

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Hospice

What is Hospice?

Hospice services is a coordinated and comprehensive program of services that provides medical, supportive and palliative care to terminally ill individuals and their families/caregivers. Services include addressing the physical, psychosocial, spiritual and emotional needs of terminally ill beneficiaries, their families and caregivers. Services are provided in private homes, hospice residential care facilities and a variety of other settings.

Who Qualifies for Hospice?

To be eligible for Hospice, the individual must:

- Qualify for NC Medicaid or NC Health Choice (age 6 – 8)
- Be determined to be terminally ill with a life expectancy of 6 months or less

How do I Apply for Hospice?

- Contact the Department of Social Services (DSS) in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- Submit to the Hospice Service Provider a referral from the attending physician.
- The Hospice Medical Director reviews the information to determine if the individual is terminally ill, including the diagnosis of the terminal condition, health conditions related or unrelated to the terminal condition, and clinical information supporting all diagnoses.
- If the Hospice Medical Director determines that the individual is terminally ill based the individual is admitted into Hospice services.
- The Hospice Service Provider submits a request for Prior Approval to NC Medicaid.

Important Considerations

- Individuals who are dually eligible for Medicare and Medicaid Hospice shall elect both programs simultaneously. Medicare will pay 1st followed by Medicaid.
- Individuals up to 21 years of age can be considered for Concurrent Care which allows for the child to be provided with, or to have payment made for, services that are related to the cure or treatment of the child's condition for which a diagnosis of terminal illness has been made.
- Hospice participation may limit reimbursement of other Medicaid services
- Hospice benefits covers all care pertaining to the terminal illness
- The Hospice provider is responsible for coordination with other service providers for care unrelated to the terminal illness to avoid duplication of service.

Contact Information

Website:
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/hospice-services
Phone
919-855-4380

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Program of All-Inclusive Care for the Elderly (PACE)

What is PACE?

The Program of All-Inclusive Care for the Elderly (PACE) is a managed care program for older adults. This program features a comprehensive service delivery system, and integrated Medicare and Medicaid financing. PACE can provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their homes for as long as safely possible. Medical care is provided by an Inter-Disciplinary Team (IDT) to case manage services provided or arranged by the PACE organization for each participant.

Who Qualifies for PACE?

To be eligible for PACE, the individual must:

- Qualify for Long-Term Care Medicaid
- Be 55 years of age or older.
- Live in a PACE program service area.
- Be determined by a physician to need Nursing Facility Level of Care.
- Be able to live in a community setting when enrolled without jeopardizing health or safety

How do I Apply for PACE?

- Contact the PACE organization in your area and the DSS in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- A referral can be made to the PACE program that has a service area covering the zip code where the beneficiary resides (https://files.nc.gov/ncdma/documents/Providers/Programs_Services/PACE/NCPACE_Providers_2018_06.pdf).
- The program will assess the individual and facilitate the enrollment process for those determined eligible.

Important Considerations

- Medicaid recipients and individuals who are dually-eligible may request PACE services through their local DSS (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices)
- All services are provided directly by the program and through its provider network.
- PACE will only pay for services which have been pre-approved by the Interdisciplinary Team (IDT).
- Individuals enrolled in PACE who move outside the service area will no longer be eligible for PACE services, unless the move is to another program's service area.
- PACE IDT members will perform periodic assessments while the individual is in the nursing facility.
- Only a small percentage of PACE participants reside in a nursing facility, even though *all* must be certified to need nursing facility level of care. If a PACE recipient needs nursing facility care, as determined by the IDT's assessments, the PACE program will pay for it and continue to coordinate the individual's care with the facility.
- A participant's PACE enrollment is effective the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

Contact Information

Website:
https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/program-of-all-inclusive-care-for-the-elderly
Phone
919-855-4340

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Personal Care Services (PCS)

What is PCS?

For eligible Medicaid beneficiaries, PCS provides hands-on assistance by paraprofessional aides in certain types of beneficiary living arrangements. Hands-on assistance is provided for the five qualifying activities of daily living (ADLs) which include eating, dressing, bathing, toileting, and mobility. The amount of approved service is based on an assessment conducted by an independent assessment entity to determine the beneficiary's ability to perform their ADLs.

Who Qualifies for PCS?

Medicaid covers the cost of PCS if:

- The individual qualifies for Medicaid.
- The individual has either 1) three of five ADLs which require limited hands-on assistance; 2) two ADLs, one of which requires extensive assistance; or 3) two ADLs, one of which requires complete assistance.
- PCS is linked to a documented physical or developmental disability, cognitive impairment, or chronic health condition.
- The individual is under the ongoing direct care of a physician for the medical condition(s) causing the functional limitations.
- The individual is medically stable and does not require continuous monitoring by a licensed nurse or other licensed health care professional.
- The individual lives in an approved residence under General Statutes that is safe for the beneficiary and the PCS provider(s) and is adequately equipped to implement needed services.
- There is no available, willing, or able family, household member or other informal caregiver to provide ADL assistance at the time when services are provided.
- There is no other third-party payer responsible for covering PCS.

Important Considerations

- If the beneficiary has not been seen within 90 calendar days prior to the IAE receiving the form, the request will not be processed.
- The beneficiary shall be notified of the assessment results within 14 business days of a completed PCS assessment.
- Does not require nursing facility level of care for participation.
- Must be ordered by a physician, nurse practitioner, or physician assistant.
- Is appropriate for individuals whose needs can be met safely in the home by family members and other informal care-givers, with support by scheduled visits from PCS aides.
- Does not provide enough assistance to replace facility-based services for individuals who require ongoing care, supervision, or monitoring by a nurse or other health care professional.
- Cannot duplicate in-home aide services provided under Medicaid waiver pro-grams, private duty nursing, state block grants, and other state and local pro-grams that provide hands-on assistance with ADLs.
- Cannot be provided by an individual whose primary private residence is the same as the beneficiary's primary private residence, legally responsible person, spouse, child, parent, siblings, grandparent, grandchild, or equivalent step or in-law relationship to the beneficiary.

How do I Apply for PCS?

- Contact the DSS in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- The individual's primary care or attending physician, physician assistant, or nurse practitioner must make the referral for the individual to be assessed for PCS using the Request for Independent Assessment for Personal Care Services Attestation of Medical Need Form (Form 3051) on the NC Medicaid website (https://files.nc.gov/ncdma/Request-for-Independent-Assessment--NC-Medicaid-3051--9.2018.pdf).
- The Individual Assessment Entity (IAE) will review the form and schedule an assessment.

Contact Information

Website: http://dma.ncdhhs.gov/providers/programs-services/long-term-care/personal-care-services	
Email PCS_Program_Questions@dhhs.nc.gov	**Phone** 919-855-4360

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Private Duty Nursing (PDN)

What is PDN?

Private Duty Nursing (PDN) is substantial, complex, and continuous skilled nursing care that is considered supplemental to the care provided by the beneficiary's trained, informal caregiver. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility; or that requires more continuous care than is available through home health services.

Who Qualifies for PDN?

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

- Be eligible for NC Medicaid.
- Reside in a private primary residence with at least one trained, informal caregiver who may provide direct care to the beneficiary during planned and unplanned absences of PDN staff.
- Have an order for PDN by the beneficiary's attending physician (MD) or Doctor of Osteopathic Medicine (DO) and a Prior Approval (PA) granted by NC Medicaid.
- Beneficiaries under 21 years of age may qualify for PDN under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provision if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition. In addition, service limitations on specific PDN criteria may be exceeded or may not apply if the requested service if medically necessary.

Important Considerations

- Services must be medically appropriate and medically necessary.
- There are two clinical policies related to Private Duty Nursing: 3G-1 (for beneficiaries 21 and older) and 3G-2 (for beneficiaries under 21 years of age).
- Prior approval is required for PDN services and is granted based on the beneficiary qualifying for the health criteria as described in the Clinical Coverage Policies for beneficiaries age 21 and older, or for beneficiaries under 21 years of age, as applicable.
- PDN is based upon a written individualized plan of care approved by the beneficiary's primary physician and must be provided by a licensed registered nurse (RN) or licensed practical nurse (LPN) employed by a licensed home care agency.
- Eligible individuals may receive up to 112 hours per week or 16 hours per day. Hours are dependent upon a comprehensive review of required documentation as defined in the PDN clinical coverage policies, primary and secondary diagnosis, overall health status, level of technology dependency, amount and frequency of specialized skilled interventions required, and the amount of caregiver assistance available.

How do I Apply for PDN?

- Contact the DSS in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- Ask an attending physician (MD) or Doctor of Osteopathic Medicine (DO) to make a referral for PDN through a PDN service provider.
- The PDN service provider will review the referral and send to the Nurse Consultants at NC Medicaid for prior approval.
- Nurse Consultants at NC Medicaid review the referral request and provide prior approval determinations for PDN.

Contact Information

Website: https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/private-duty-nursing-pdn	
Email medicaid.homecareservice@dhhs.nc.gov	**Phone** 919-855-4380

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Skilled Nursing Facility (SNF)

What is a SNF?

A "nursing facility" is an institution or a distinct part of an institution, other than an intermediate care facility for individuals with intellectual disabilities (ICF/IID), that is certified by Medicaid to provide nursing facility level of care services. A skilled nursing facility provides beneficiaries with short- and long-term daily nursing care that does not require the more complex acute care medical consultations and support services available in a traditional hospital setting. Beneficiaries are under the close supervision of doctors and nurses specially trained to treat a variety of conditions. Additionally, skilled nursing facilities offer rehabilitative care to patients recovering from stroke, surgery or other events, offering patients an alternative to hospitalization that still provides continued full-time care.

Who Qualifies for a SNF?

To be eligible for Skilled Nursing Facility services, the individual must:

- Be eligible for Long-Term Care NC Medicaid.
- Meet financial and medical necessity based on the nursing facility level of care criteria.

How do I Apply for SNF?

- Contact the DSS in the county where the individual resides (https://www.ncdhhs.gov/divisions/dss/local-county-social-services-offices) and apply for Medicaid.
- Facility submits request prior approval for nursing facility level of care by submitting an FL-2 (NC Medicaid form 372-124) electronically through the DHHS utilization review contractor website.

Important Considerations

- NC Health Choice (NCHC) beneficiaries are not eligible for Skilled Nursing Facility services.
- Medicare covers 100% of skilled nursing facility costs for the first 20 days, but only 80% afterward, up to 100 days. Some beneficiaries are unable to cover the cost of treatment when Medicare runs out. Medicaid coverage for skilled nursing care helps ensure continued access to care for beneficiaries.
- Since January 1989, (42 CFR 483 Subpart C) requires Pre-Admission Screening and Resident Review (PASRR) review for every individual who applies to or resides in a Medicaid-certified Nursing Facility, regardless of the source of payment for Nursing Facility services. NC MUST Link: https://www.ncmust.com/

Contact Information

Website: https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/nursing-facilities
Phone 888-245-0179

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