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CAP/C Case Manager  
Videoconference:  
2010-2015 Waiver And Policy



WELCOME  
We Will Begin Shortly

# Two Day Training Agenda

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- Opening Remarks
- Person/Family Centered Planning presented by Talbatha Myatt
- Age Limit
- Aggregate Budget
- Levels of Care
- Case Management Plus One
- Services
- Forms, Processes, and Procedures
- Hospice Providers/Enrollment and Billing, presented by Marianne Diana, HP Enterprise Services

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CAP/C Case Manager  
Videoconference:  
2010-2015 Waiver And Policy



Ten Minute Break

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CAP/C Case Manager  
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2010-2015 Waiver And Policy



Thirty Minute Lunch

# So...What's New?

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- Age limit increased
- Aggregate budget
- New levels of care
- Case Management plus one
- New services



New forms, processes, and procedures

In general, an improved more family-friendly and more case manager-friendly program.

# Effective Date

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Most of these changes take place **October 1**.  
Some do not; they will be noted in their  
respective sections.

October



# Is there anything that didn't change?

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All of the core CAP/C concepts remain the same.

CAP/C is a cost-neutral alternative to institutionalization for medically fragile children.

CAP/C supplements rather than replaces.

CAP/C is not a means of obtaining Medicaid.

CAP/C must ensure the health and welfare of its participants.

# Age Limit

Now 21 years of age, not 19

- The last day of waiver services is the day before the child turns 21
- The last day of Medicaid eligibility is the last day of the month in which the child turns 21



Medicaid eligibility will be reviewed once the recipient reaches 18 years of age.

**\*\*This change is effective immediately.\*\***

# Aggregate Budget

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No more recipient monthly budget limits!



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# Aggregate Budget

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Current: Each recipient has a monthly budget that corresponds to what it would cost for that person to be in an institution. Some people have to come off of CAP/C or make do with fewer services because their care needs exceed the budget limit.

New: The state, rather than each recipient, has a budget limit based on the cost of institutionalization for the number of participants on the program. This allows us to take the money that some people have left over in their budget and apply it to those who have higher costs. As a result, everyone can have everything they need.

# Aggregate Budget

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Each CAP/C service or supply has its own budget limit.

A family may have as many services and supplies in their plan of care as are medically necessary.

The budget limits are annual limits, not monthly limits (except for case management). The cost summary form has been changed so that expenses are calculated for the year rather than for the month.

The budget year is the waiver year, July 1 through June 30.

# Aggregate Budget

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Need is still key.

The annual budget limits are just that: limits, not entitlements. Each service or supply and the amount of that service or supply must be medically necessary.

Remember, none of the core concepts have changed.

# Aggregate Budget

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An aggregate budget model requires careful monitoring at both the local (case manager) and the state (DMA) level.

# Aggregate Budget

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- Develop and monitor the plan of care carefully to
  - use ALL of the personal, natural, and community resources available
  - avoid duplication of services
  - ensure that services are being provided in a cost effective manner.
- DMA will provide reports to Case Managers regarding their clients' spending. These reports are still in development. More information in a separate training to be announced.

# Aggregate Budget

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## Clarification

Yes, Case Managers monitor all Medicaid expenses, not just waiver expenses.

Cost effectiveness includes appropriate types and amounts of DME, preventative care to reduce illnesses and hospitalizations, and appropriate use of the emergency room rather than the physician, to name a few. We will discuss this more during the upcoming training.

# Levels of Care

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\*\* This is effective immediately, and has been in effect since July 1. \*\*

Intermediate level of care and Skilled level of care are now combined into one level, called "nursing facility level of care".

FL-2s will no longer be approved as "IC". They will always be approved as nursing facility level of care, designated by the letters "SC". The "SC" incorporates the old "IC" and "SC".

# Levels of Care

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The criteria for approving NF is the same as the old ICF criteria EXCEPT that the number of therapies per week (PT, OT, ST, RT) no longer counts in determining level of care.

These criteria are listed in the CAP/C Manual.

The criteria are based on the criteria for admission to a nursing facility.

# Levels of Care

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There is still a hospital level of care as well, but with some changes.

- The hospital level of care is only used by DMA for its cost reports to CMS. The cost of institutionalization for someone in a hospital is different than the cost of institutionalization for a person in a nursing facility, so when determining cost neutrality, that difference must be factored in.

# Levels of Care

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- As far as the recipient and the case manager, there is no difference between nursing facility level and hospital level. There is no difference in the number of hours, the budget limits, the level of staff, or anything else. These are all based on medical necessity. There is absolutely no advantage to the recipient of being hospital versus nursing facility level of care.

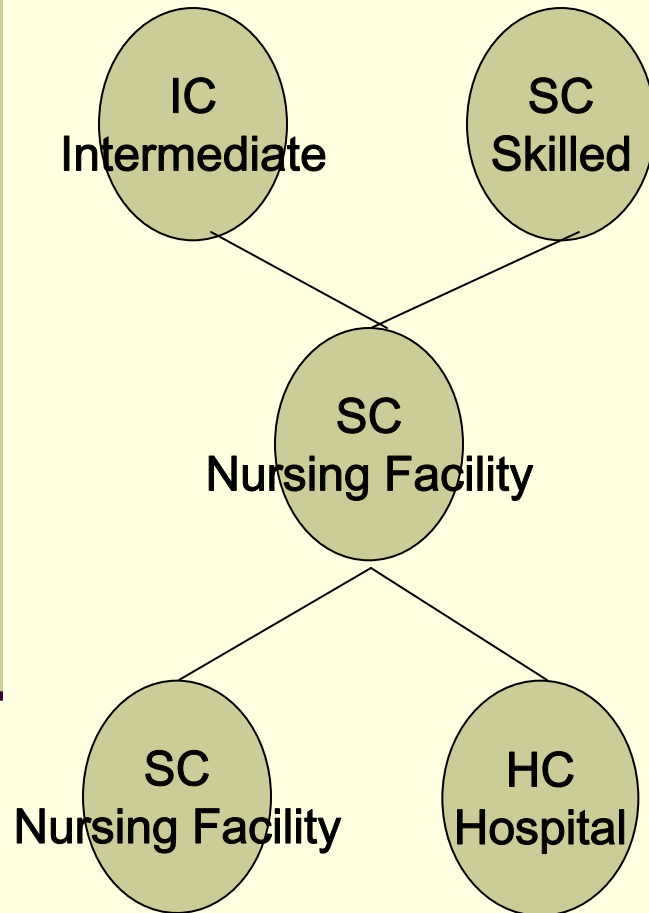
# Levels of Care

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The DMA Nurse Consultant will make the decision regarding hospital level of care according to the criteria in the CAP/C Manual.

The CAP Indicator Code for hospital level of care remains "HC".

# Levels of Care



Old FL-2 approval

New FL-2 approval

New DMA approval

# Case Management Plus One

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Nurse or nurse aide services are no longer **REQUIRED** for participation in CAP/C.

Participation in CAP/C is now based on the need for case management plus at least one other waiver service (excluding respite), with each service being used at least quarterly.

(Plus the other criteria such as age, level of care, and Medicaid eligibility.)

# Case Management Plus One

Case Management + At least one of the services below, + Respite  
used at least quarterly

- CAP/C Nursing
- Pediatric Nurse Aide
- Personal Care
- Attendant Care\*
- Palliative Care
- Caregiver Training and Education
- Waiver Supplies
- Home Modifications
- Vehicle Modifications
- Community Transition Funding

\* Recipients of Attendant Care services are not eligible for respite care

# Questions

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Any questions about the age limit, the aggregate budget, levels of care, or case management plus one?

# Services - Waiver Supplies

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## WHAT IS INCLUDED

- reusable incontinence undergarments (T4539)
- disposable liners (T4535)
- adaptive tricycles (T2029)

## ALSO INCLUDED

- assessment by a professional to identify the specifications for the tricycle or the type of incontinence product needed
- participant or caregiver training as needed
- repair that does not exceed cost of purchase

# Services - Waiver Supplies

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## INDICATIONS

- For incontinence supplies, age 3 or over and incontinent due to a medical issue
- For an adaptive tricycle, when prescribed by a physical or occupational therapist and used for the development of gross motor skills, range of motion, improved endurance, improved circulation, trunk stabilization and balance, or as an adjunct to gait training

# Services - Waiver Supplies

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## LIMITS

- \$500 per year for reusable incontinence undergarments
- \$1000 per year for disposable liners
- \$600 per year for an adaptive tricycle

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Waiver Supplies

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## HOW TO GET IT

### Prerequisites

- Must have physician order on file. For incontinence supplies, order must be renewed at least annually, and must include the type and amount to be provided (a range is acceptable). The signed CMS-485 is acceptable as an order as long as it contains the above components.

# Services - Waiver Supplies

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- The assessment needs to document the need for the supply.
- The plan of care must include goals and outcomes related to the use of the supply.



# Services - Waiver Supplies

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## Process

- The PT/OT certifies the need for and determines the specifications for the adaptive tricycle,
- The physician writes an order.
- The Plan of Care revision is approved by DMA.
- The family chooses a provider
- The Case Manager issues a Service Authorization to the DME provider.
- The enrolled DME provider may bill Medicaid directly for the item using their CAP provider number.

# Services - Waiver Supplies

- The provider sends the Case Manager copies of their invoices. The Case Manager does not need to approve the claim before it is submitted to HP. The Case Manager does need to review the invoice to make sure that the supplies are being provided according to the plan of care and that they are submitted appropriately.



# Services - Home Modifications

## WHAT IS INCLUDED

- Wheelchair ramps, stationary or portable
- Threshold ramps, used to allow wheelchairs to move over small rises such as doorways or raised landings
- Grab bars or safety rails mounted to wall



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# Services - Home Modifications

- Modification of bathroom facilities to improve accessibility for a disabled individual, including : roll in shower, sink modifications, water faucet controls, tub modifications (excluding handheld showers which are covered by EPSDT), toilet modifications, floor urinal adaptations, and plumbing modifications



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# Services - Home Modifications

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- Widening of doorways for wheelchair access, turnaround space modifications for wheelchair access
- Bedroom modifications other than doorway widening to accommodate hospital beds and wheelchairs
- Lifts, elevators, manual, hydraulic, or other electronic lifts, including portable lifts or lift systems that are used inside a participant's home.

# Services - Home Modifications

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- Porch stair lifts
- Floor coverings for ease of ambulation when existing floor coverings are in disrepair and pose increased risk to a recipient with documented fall risk, or when those floor coverings are contributing to asthma exacerbations requiring repeated emergency room or hospital treatment

# Services - Home Modifications

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- Portable or whole house air filtration system and filters under the following circumstances:
  - For recipients with severe allergies or asthma, when all other preventive measures such as removal of the allergen or irritant, removal of carpeting and drapes have been attempted, and the recipient's asthma remains classified as moderate persistent or severe persistent, and a physician has certified that air filtration will be of benefit. Ozone generators and electronic or electrostatic or other air filters which produce ozone or  $\leq 50$  parts per billion ozone byproduct will not be covered.

# Services - Home Modifications

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- For recipients susceptible to infection, when adequate infection control measures are already in place yet the recipient continues to acquire airborne infections, and when a physician has certified that air filtration will be of benefit in preventing infection, a germicidal air filter (with uv light) may be provided.

The smallest unit that will meet the recipient's needs is covered; i.e., if a recipient spends most of his or her time confined to a specific area of the house, then a whole-house system will not be approved.

# Services - Home Modifications

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- Back-up generator for ventilators, oxygen concentrators, and suction machines that in the event of a power outage would require the recipient to be hospitalized if not for the presence of the generator



# Services - Home Modifications

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## ALSO INCLUDED

- technical assistance in device selection
- training in device use by a qualified assistive technology professional
- purchase, including necessary permits and inspections, taxes, and delivery charges
- installation

# Services - Home Modifications

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- assessment of the modification by the case manager and by any applicable inspectors to verify safety and ability to meet recipient's needs
- repair of equipment, as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment, and only when not covered by warranty. The waiver recipient or his or her family shall own any equipment that is repaired.

# Services - Home Modifications

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## WHAT IS NOT INCLUDED

- service agreements, maintenance contracts, extended warranties
- roof repair
- central air conditioning
- swimming pools
- hot tubs
- locks

# Services - Home Modifications

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- any modification that adds square footage to the home
- modifications to rented residences unless the modification is allowed by the owner, portable, and does not permanently alter the structure of the home.
- new construction - must modify an existing home

# Services - Home Modifications

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## INDICATIONS

Any CAP/C participant, provided that the modification

- is medically necessary for the recipient's specific disabilities
- does not have general utility for non-disabled individuals (is not primarily for that purpose)

# Services - Home Modifications

## LIMITS

<ul style="list-style-type: none"><li>• A recipient who enters the waiver between</li></ul>	<ul style="list-style-type: none"><li>• may receive _____ to use prior to June 30, 2015</li></ul>
<ul style="list-style-type: none"><li>• prior to June 30, 2011</li></ul>	<ul style="list-style-type: none"><li>• \$10,000</li></ul>
<ul style="list-style-type: none"><li>• July 1, 2011 and June 30, 2012</li></ul>	<ul style="list-style-type: none"><li>• \$8000</li></ul>
<ul style="list-style-type: none"><li>• July 1, 2012 and June 30, 2013</li></ul>	<ul style="list-style-type: none"><li>• \$6000</li></ul>
<ul style="list-style-type: none"><li>• July 1, 2013 and June 30, 2014</li></ul>	<ul style="list-style-type: none"><li>• \$4000</li></ul>
<ul style="list-style-type: none"><li>• July 1, 2014 and June 30, 2015</li></ul>	<ul style="list-style-type: none"><li>• \$2000</li></ul>

# Services - Home Modifications

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- Two CAP/C children in one home does not equal twice the amount of money.
- One CAP/C child in two homes does not equal twice the amount of money.
- A person who leaves and returns to the waiver within the same cycle is entitled to the amount of money they had remaining when they left.

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Home Modifications

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## HOW TO GET IT

### Prerequisites

- Assessment by a PT, OT, or Rehabilitation Engineer (except for floor coverings)
- Physician's order on file
- The assessment needs to document the need for the modification.
- The plan of care must include goals and outcomes related to the modification.

# Services - Home Modifications

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## Process

- The PT/OT/Rehabilitation Engineer completes the assessment and makes their recommendations.
- The physician writes the order, which the Case Manager keeps on file.
- The provider is chosen, using a bid or competitive invoice process and keeping in mind recipient's free choice of providers. The Case Manager keeps the bids/invoices on file.
- The Plan of Care revision is approved by DMA.

# Services - Home Modifications

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- The Case Manager works out a payment arrangement with the contractor: the contractor must wait for Medicaid reimbursement or the contractor will be paid by the case management agency and then reimbursed by Medicaid.
- The Case Manager authorizes the contractor to begin installation (does not need to be a service authorization form).
- The Case Manager does a home visit once the job is completed to assess and "approve" the modifications.
- The Case Manager bills Medicaid using code S5165.

# Services - Vehicle Modifications

## WHAT IS INCLUDED

- Door handle modifications
- Door modifications
- Electric door openers
- Installation of raised roof or related alterations to existing raised roof system to improve head clearance
- Lifting devices
- Devices for securing wheelchairs or scooters inside the vehicle
- Devices for transporting mobility devices such as Rooftop Wheelchair Carriers, Trailers, and Trunk Lifts.



# Services - Vehicle Modifications

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- Adapted steering, acceleration, signaling, and braking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel
- Handrails and grab bars
- Seating modifications
- Lowering of the floor of the vehicle
- Safety and security modifications including additional mirrors and pedal guards

# Services - Vehicle Modifications

- Adaptive car seats or vehicular transport vests for children weighing over 30 pounds or with a seat to crown height that is longer than the back height of the largest safety car seat if the child weighs less than the upper weight limit of the current car seat, who are unable to be transported safely with a seat belt or standard child car safety seat.



# Services - Vehicle Modifications

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## ALSO INCLUDED

- installation
- repair, as long as the repair does not exceed the cost of purchasing a new piece of equipment, and the recipient or family own the equipment being repaired
- training in care and use

# Services - Vehicle Modifications

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## WHAT IS NOT INCLUDED

- the purchase or lease of the vehicle itself
- renting a vehicle with modifications
- service and maintenance contracts and extended warranties
- regularly scheduled maintenance and upkeep
- repair or replacement of a modification when the family's auto insurance covers it or would have covered it if the family kept the policy current

# Services - Vehicle Modifications

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## INDICATIONS

Any CAP/C participant, provided that the modification

- is medically necessary for the recipient's specific disabilities
- does not have general utility for non-disabled individuals (is not primarily for that purpose)

The vehicle may belong to any non-paid primary support person.

# Services - Vehicle Modifications

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Vehicle modifications must be provided and installed in accordance with the manufacturer's installation instructions, and national Mobility Equipment Dealer's Association, Society of Automotive Engineers, and National Highway and Traffic Safety Administration guidelines.

# Services - Vehicle Modifications

## LIMITS

<ul style="list-style-type: none"><li>• A recipient who enters the waiver between</li></ul>	<ul style="list-style-type: none"><li>• may receive _____ to use prior to June 30, 2015</li></ul>
<ul style="list-style-type: none"><li>• prior to June 30, 2011</li></ul>	<ul style="list-style-type: none"><li>• \$15,000</li></ul>
<ul style="list-style-type: none"><li>• July 1, 2011 and June 30, 2012</li></ul>	<ul style="list-style-type: none"><li>• \$12,000</li></ul>
<ul style="list-style-type: none"><li>• July 1, 2012 and June 30, 2013</li></ul>	<ul style="list-style-type: none"><li>• \$9000</li></ul>
<ul style="list-style-type: none"><li>• July 1, 2013 and June 30, 2014</li></ul>	<ul style="list-style-type: none"><li>• \$6000</li></ul>
<ul style="list-style-type: none"><li>• July 1, 2014 and June 30, 2015</li></ul>	<ul style="list-style-type: none"><li>• \$3000</li></ul>

# Services - Vehicle Modifications

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A person who leaves and returns to the waiver within the same cycle is entitled to the amount of money they had remaining when they left.

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Vehicle Modifications

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## HOW TO GET IT

### Prerequisites

- Assessment by an adapted vehicle supplier which contains
  - The rationale for the selected modification(s)
  - The condition of the vehicle to be modified
  - Insurance on the vehicle to be modified
  - Training plan for use of the prescribed modification(s)
- Physician's order on file

# Services - Vehicle Modifications

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- The assessment needs to document the need for the modification.
- The Plan of Care must include goals and interventions related to the modification

# Services - Vehicle Modifications

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## Process

- The adapted vehicle supplier completes their assessment and makes their recommendations.
- The physician writes the order, which the Case Manager keeps on file.
- The provide is chosen, using a bid or competitive invoice process and keeping in mind recipient's free choice of providers. The Case Manger keeps the bids/invoices on file.
- The Plan of Care revision is approved by DMA.

# Services - Vehicle Modifications

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- The Case Manager works out a payment arrangement with the supplier: the supplier must wait for Medicaid reimbursement or the supplier will be paid by the case management agency and then reimbursed by Medicaid.
- The Case Manager authorizes the supplier to begin installation (does not need to be a service authorization form).
- The Case Manager does a home visit once the job is completed to assess and "approve" the modifications.
- The Case Manager bills Medicaid, using code T2039.

Services -

## Community Transition Funding

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### WHAT IS INCLUDED

The amount of money for home and vehicle modifications that makes up the difference between what a recipient would receive if they had been in the waiver for the full cycle and what they are entitled to receive based on when they actually entered the waiver, to allow the recipient to transition from an institutional setting to a private residence.

All home and vehicle modifications are included.

# Services - Community Transition Funding

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## WHAT IS NOT INCLUDED

- Funding for recipients who change their place of residence
- Anything not included in home and/or vehicle modifications

# Services - Community Transition Funding

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## INDICATIONS

The recipient must

- be currently institutionalized
- be transitioning to a home setting
- need the modifications in order to be cared for in the home

# Services - Community Transition Funding

## LIMITS

<b>Home Modifications</b>	
• A recipient who enters the waiver between	• may receive _____ to use prior to June 30, 2015
• prior to June 30, 2011	\$0
• July 1, 2011 and June 30, 2012	\$2000
• July 1, 2012 and June 30, 2013	\$4000
• July 1, 2013 and June 30, 2014	\$6000
July 1, 2014 and June 30, 2015	\$8000
<b>Vehicle Modifications</b>	
• A recipient who enters the waiver between	• may receive _____ to use prior to June 30, 2015
• prior to June 30, 2011	\$0
• July 1, 2011 and June 30, 2012	\$3000
• July 1, 2012 and June 30, 2013	\$6000
• July 1, 2013 and June 30, 2014	\$9000
July 1, 2014 and June 30, 2015	\$12,000

# Services - Community Transition Funding

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Community Transition Funding is a one-time expense.

All of the limits for home and/or vehicle modifications apply.

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Community Transition Funding

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## HOW TO GET IT

Follow the same procedures as for home and vehicle modifications.

The amount of money that they are entitled to is used first and is billed using the codes for home and vehicle modifications. The remainder is billed as community transition funding, using code T2038.

# Questions

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Any questions about  
waiver supplies,  
home  
modifications,  
vehicle  
modifications, or  
community  
transition  
funding?



# Services - Palliative Care

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## WHAT IS INCLUDED

- Expressive Therapies (art, music, play therapy) (S5108)
- Counseling (99510)
- Bereavement Counseling (S5111)

Services may be provided to the child or to his/her family members,

Services may be provided in the home or in an outpatient setting.

# Services - Palliative Care

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## WHAT IS NOT INCLUDED

- Any palliative care service if the family receives Medicare or Medicaid Hospice services
- Expressive Therapy that is provided for recreation rather than for coping with medical issues.
- Counseling provided for issues not related to the child's condition or care needs

# Services - Palliative Care

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## INDICATIONS

Open to any CAP/C recipient or family when there is a need identified in the assessment that can be met with a palliative care service.



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# Services - Palliative Care

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## LIMITS

- For expressive therapies, 39 hours per year.
- For counseling, 98 visits per year.
- For bereavement counseling, a one time per-diem (actually pre-bereavement/preparation of family).

Limits are per family, not per individual in the family.

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Palliative Care

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## HOW TO GET IT

### Prerequisites

- Physician order, with specific frequency and duration, on file
- The assessment needs to document the need for the service
- The plan of care must include goals and interventions related to the use of the service

# Services - Palliative Care

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## Process

- The assessment identifies a need which palliative care services could help meet.
- The plan of care is developed or revised to add palliative care services and the specific goals or outcomes desired from the service
- A physician's order is obtained and kept on file. For expressive therapies and counseling, the order is renewed at least annually.
- The plan of care is approved by DMA.

# Services - Palliative Care

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- The family selects a hospice provider enrolled as a CAP/C provider
- The case manager issues a Service Authorization to the hospice provider.
- The hospice provider bills Medicaid directly for the service.



# Services - Palliative Care

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- The provider sends the Case Manager copies of their invoices. The Case Manager does not need to approve the claim before it is submitted to HP. The Case Manager does need to review the invoice to make sure that the services are being provided according to the plan of care and are being billed appropriately.

# Services - Caregiver Training and Education

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## WHAT IS INCLUDED

Registration and enrollment fees for a workshop, seminar, or class that an informal caregiver attends in order to improve his or her caregiving ability.



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## Services - Caregiver Training and Education

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The education/training may be attended by any family member, friend, neighbor, or companion who provides unpaid care, support, training, companionship, or supervision to the CAP/C child.

The education/training may include information regarding the nature of the disability, its impact on the child and family, treatment regimens, and equipment.

Updates are included as necessary

# Services - Caregiver Training and Education

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## WHAT IS NOT INCLUDED

- travel, meals, or overnight lodging to attend the education/training
- training not directly related to the individual's role in the caring for the recipient
- training for paid caregivers such as agency employees

# Services - Caregiver Training and Education

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## INDICATIONS

This service is available to any informal caregiver of a CAP/C recipient, when the education or training will improve that informal support person's caregiving skills.

# Services - Caregiver Training and Education

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LIMITS

\$500 per year

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Caregiver Training and Education

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HOW TO GET IT

Prerequisites

Information regarding the event that describes the content of the event, the credentials of the presenter(s), and the cost.

# Services - Caregiver Training and Education

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## Process

- The assessment identifies a need for caregiver training or education.
- The plan of care is developed or revised to include the type of training presented and the specific goals or outcomes desired from the training
- The Case Manager reviews the training brochure or other information to ensure that the content is appropriate and the presenters are qualified.
- The plan of care is approved by DMA.

# Services - Caregiver Training and Education

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- The case manager bills for the registration or enrollment fee, using code S5110. The case manager pays the registration fee directly or reimburses the family.
- The Case Manager keeps a receipt or record of the payment on file.
- The person attending the training provides the case manager a copy of their certificate or proof of attendance. The Case Manager keeps this on file.

# Questions

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Any questions  
regarding  
Palliative Care or  
Caregiver  
Training and  
Education?

# Services - General Information Regarding In-Home Services

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In-Home Services include:

- Nursing (T1000)
- Pediatric Nurse Aide (T1019)
- Personal Care (S5125)
- Attendant Care (T2027)

Except for Attendant Care, these services may be provided on a regularly scheduled basis, as respite, or as short-term-intensive services.

# Services - General Information Regarding In-Home Services

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Services may **not** be reimbursed if provided by a member of the recipient's family, defined as

- The recipient's parent, stepparent, foster parent, custodial parent, or adoptive parent
- Anyone who has legal responsibility for the minor recipient
- Grandparents of the recipient
- Siblings of the recipient
- The spouse of an adult recipient
- Anyone who has legal responsibility for the adult recipient,

even if the family member meets the qualifications for RN, LPN, NA II, NA I+, NA I, or Attendant.

# Services - General Information Regarding In-Home Services

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If a family member as defined above provides paid care, it will be considered Medicaid fraud and any money paid will be recouped.

- None of these services may be provided only in the school. For the service to be approved, there must be a need and use of in-home care as well. (Attendant care services may not be provided in the school.)
- None of these services may be provided through CAP/C if another payer source such as private insurance covers the full amount of services that CAP/C would cover.
- All services require the presence of a back-up caregiver in case the staff is unable to fill their scheduled shift.

# Services - Nursing

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## CHANGES INCLUDE

- Limit of \$265,000 per year. Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.
- Congregate Care: one nurse can care for more than one recipient in the same home at the same time. Services are reimbursed at a higher rate than for a single recipient. Effective November 1.
- Recommendation regarding criminal background checks: nurse should not be placed in home until check comes back satisfactorily, and check should be repeated every two years or more often by agency policy if suspicions arise

# Services - Nursing

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- Must have pediatric experience or complete of DMA pediatric curriculum
- Supervision of the LPN or RN by the RN Supervisor every 60 days



# Services - Pediatric Nurse Aide

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## WHAT IS INCLUDED

- In-home care by a Nurse Aide II or Nurse Aide I+ who has completed a DMA training in pediatric and home care. The service is reimbursed at a higher rate than regular CAP/C Personal Care services.
- Other things currently included or not included remain the same (for instance, home management tasks can still be provided, transportation still cannot be provided)

# Services - Pediatric Nurse Aide

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## INDICATIONS

- The care needs involve hands-on assistance with a minimum of two ADL needs, at least one of which falls into the NA I+ or NA II scope of practice.
- All other indications, such as continuous, complex, medically necessary, and physician-ordered remain the same.

# Services - Pediatric Nurse Aide

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## CHANGES

- The NA I+ or NA II must be CPR-certified. First aid certification is recommended.
- Recommendation regarding criminal background checks: nurse aide should not be placed in home until check comes back satisfactorily, and check should be repeated every two years or more often per agency policy as suspicions arise

# Services - Pediatric Nurse Aide

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- A limit of \$60,000 per year, which includes the combination of all scheduled and short-term-intensive pediatric nurse aide and personal care services

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Personal Care Services

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## CHANGES

- NA I level only
- The NA I must be CPR-certified. First aid certification is recommended.
- Recommendation regarding criminal background checks: nurse aide should not be placed in home until check comes back satisfactorily, and check should be repeated every two years

# Services – Personal Care Services

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- A limit of \$60,000 per year, which includes the combination of all scheduled and short-term-intensive pediatric nurse aide and personal care services

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Attendant Care

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## WHAT IS INCLUDED

In-home care of children who meet the criteria for CAP/C participation, and who need care in the home for a medical reason, but that care is not continuous or complex or is for less than 2 ADLs. The care is observation, supervision, and being there "just in case something happens". The attendant is whatever level of staff is required to meet the child's needs if "something happens".

# Services - Attendant Care

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## WHAT IS NOT INCLUDED

- Skilled services. If skilled services need to be provided they should be billed as personal care, pediatric nurse aide care, or nursing care as appropriate.
- Behavioral or educational supervision. The service must be needed for a medical reason.

# Services - Attendant Care

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## INDICATIONS

- Meets criteria for CAP/C participation
- Care needs are age appropriate or do not meet the criteria for personal care, pediatric nurse aide care, or nursing care
  - Fewer than 2 ADLs requiring hands on assist
  - Interventions do not occur at least every 2-4 hours during the duration of the shift, or do not last the duration of the shift

# Services - Attendant Care

- Despite not meeting the normal criteria, there is a medical need for supervision or observation such that without it, the child's health, safety, and well-being would be at risk.
- There are no other means available to provide the supervision or observation.



# Services - Attendant Care

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## LIMITS

10 hours per day

50 hours per week

2600 hours per year

Remember, Medicaid services and supplies are approved based on medical need, not on entitlement.

# Services - Attendant Care

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## HOW TO GET IT

### Prerequisites

- Signed physician order, renewed at least annually as needed, kept on file by the Case Manager (and the staffing agency)
- If used because the child can not attend daycare or school:
  - Certification from the child's physician that the child is medically prohibited from attending daycare, OR
  - Certification from at least 2 daycares stating that they can not accept the child because of the child's physical condition OR a copy of the IEP which states that the child can not attend school

# Services - Attendant Care

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- The assessment should indicate the measures that have been attempted and the reasons they failed.
- The plan of care should contain goals and interventions related to the use of the service.

# Services - Attendant Care

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## Process

- The assessment identifies a need which attendant care services could help meet.
- The plan of care is developed or revised to add attendant care services and the specific goals or outcomes desired from the service
- A physician's order is obtained and kept on file. The order is renewed at least annually.
- The certification from the physician and/or daycare and/or school is obtained. It is submitted with the plan of care and is kept on file by the Case Manager.

# Services - Attendant Care

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- The plan of care is approved by DMA.
- The family selects a provider
- The case manager issues a Service Authorization to the provider.
- The provider submits their claims to the case manager for review and approval prior to submitting the claims to HP.

# Questions

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Any questions regarding nursing services, pediatric nurse aide services, personal care services, or attendant care services?

# Services - Case Management

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## AGENCY QUALIFICATIONS

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 recipient. Exceptions to this criterion may be approved on a case-by-case basis when

- There is a lack of available providers such that the recipient would be unable to access services

# Services - Case Management

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- There is a written statement signed annually by the parent attesting to his or her free choice of the same agency for both purposes
- All of the normal requirements for both service are met independently; i.e., there is one recipient file for the case management services, which meets all of the CAP/C case management criteria, and a second recipient file for the home health services which meets all of the home health criteria

# Services - Case Management

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## Required Agency Policies

- waiting list management,
- charging for assessment-only visits,
- documentation requirements (referrals, assessments, plans of care, changes in condition, contact notes),
- monitoring visits
- quality management program (to include management of critical incident reports and clinical and financial oversight,
- billing practices,
- admission, transfer, and discharge policies,
- communicable disease reporting and prevention,
- recipient confidentiality,
- provider choice,
- record retention and safekeeping,
- personnel policies (hiring, dismissal, validation of credentials, and continuing education if applicable), and
- language access plan.

# Services - Case Management

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## Individual Qualifications

### ■ Degree and Experience

Bachelors in social work or a human services field plus one year experience

RN with one year experience

Bachelors not in a human services field and two years experience

All degrees must be from an accredited school

Experience must be in pediatrics, nursing, medical social work, case management, assessment and referral, or intervention and treatment planning.

An RN or SW contracted to do CM functions must also meet these degree and experience qualifications

# Services - Case Management

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- Bloodborne pathogen/infection control training
- HIPAA training
- Completion of DMA sponsored CAP/C training within 90 calendar days of employment and prior to billing any case management services
- 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>
- One year of pediatric experience or completion of the DMA pediatric training curriculum

# Services - Case Management

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Current case managers have one year to meet qualifications

New case managers must meet qualifications at time of hire

An RN Case Manager or an RN contracted to perform nursing functions of case management may not also provide direct care to any CAP/C recipient.

# Services - Case Management

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## CASELOADS

- Agencies are encouraged to serve a geographic area large enough to support a full CAP/C caseload.
- DMA supports the use of one case manager with a full caseload rather than multiple case managers with partial caseloads when this is practical for the case management agency. However, if there is only one CAP/C case manager, there must be someone knowledgeable enough to cover her caseload during vacations or absences.

# Services - Case Management

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## RN/SW Teams

It is recommended that recipients of CAP/C Nursing services have an RN Case Manager.

For all recipients, the RN is involved in the

- initial and annual assessments,
- a joint home visit with the social work case manager every 6 months, to coincide with the midyear review as applicable,
- review of all incident reports regarding emergency room use, hospitalization, injury, or other medical issues, and
- quarterly review of the recipient's file and consultation with the social work case manager.

# CAP/C Forms and Processes - Inquiries

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Keep a log of all inquiries, regardless of whether or not they result in a referral. At a minimum, note the date, name/relationship to client of the caller, name of the child, and result of the inquiry.

DMA will periodically ask for this information for Quality Assurance reporting.

Chapter 25, page 4 of the manual contains an example.

# CAP/C Forms and Processes - Referrals

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- New referral form
- Approval criteria
  - Primary medical diagnosis
  - Age under 21
  - Lives in (or will be transitioning to) a non-institutional setting
  - Need for and willingness to have case management
  - Risk of institutionalization
  - Current and potential resources, as effective and less costly program

# CAP/C Forms and Processes - Assessment Anyway

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No changes!



# CAP/C Forms and Processes - Wait Lists

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- Your wait list policy must now give priority to
  - Transferring from another county
  - Transferring from another Medicaid program (particularly if the other program has been terminated)
  - New applicants requiring home care in order to be discharged from current institutionalization

# CAP/C Forms and Processes - Wait Lists

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- Remember that under EPSDT, recipients on the wait list who already have Medicaid must be linked to other available and appropriate services while they wait. This should be done for everyone on the wait list, but is crucial for Medicaid recipients.
- Remember that if you have a wait list it must be submitted to DMA on the 5<sup>th</sup> of every month.

# CAP/C Forms and Processes - Wait Lists

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Remember, CAP/C does not have 'slots', and there is no wait list at the state level.

The State does have a capacity of total recipients. For July 1 2010 through June 30 2011, CAP/C may serve 1057 children.

# CAP/C Forms and Processes - Applying for Medicaid

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No changes!



Yay!

# CAP/C Forms and Processes - The Cover Letter

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Please use every time you submit any thing to DMA.



# CAP/C Forms and Processes – The FL-2 and Levels of Care

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- Two levels of care: Nursing Facility (SC) and Hospital (HC).
- Both levels offer the same benefits to the recipient/family.
- Therapies no longer count towards meeting level of care.

# CAP/C Forms and Processes - The FL-2 and Levels of Care

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For recipients of in-home nurse, nurse aide, and attendant services:

- Nursing Facility (SC) level of care can be any level of staff
- Hospital level (HC) will usually be nurse level.

# CAP/C Forms and Processes - The FL-2 and Levels of Care

Level of care MUST be reviewed annually. Whichever month the original FL-2 was approved by HP, the next year's FL-2 may be completed any time during that same month the next year.

The FL-2 may be done earlier, but not later.



# CAP/C Forms and Processes - The FL-2 and Levels of Care

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- If the FL-2 is done early, the next FL-2 must be done with the CNR. An FL-2 must always accompany the CNR, even if the FL-2 was done less than one year ago.
- If the FL-2 is not called in to HP, the next FL-2 is done during the same month as the previous FL-2's physician signature date

# CAP/C Forms and Processes - The FL-2 and Levels of Care

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## CHANGES IN COMPLETING THE FORM

- In Box 10, 'Current Level of Care', if the client is already on CAP/C, check 'Other' and write 'SC'.
- In Box 11, 'Recommended Level of Care', check 'Other' and write 'SC'.
- When you receive telephone approval, write 'SC' in Box 13, where IC or SC used to be written.

# CAP/C Forms and Processes - The Physician's Request Form

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- Now only has to be completed at the initial request for in-home nursing (the initial assessment, or when services are first changed from nurse aide to nurse, or when Medicaid first starts paying for in-home nursing.)
- Must be signed by the MD.

# CAP/C Forms and Processes - Employment Verification

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No changes, but remember:

- The form is a last resort. It should be used only when obtaining verification on company letterhead has failed or is impractical or harmful. Please notify your Consultant if you think you need to use the form.
- Work hours will not be authorized for any child whose caregivers can not provide verification of employment.

# CAP/C Forms and Processes - Employment Verification

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- verification needs to be obtained only when the up-to-50-hours-per-week for work is being requested, and then it must be obtained on all working caregivers.

## CAP/C Forms and Processes - Request for Nurse or Nurse Aide Services in the School

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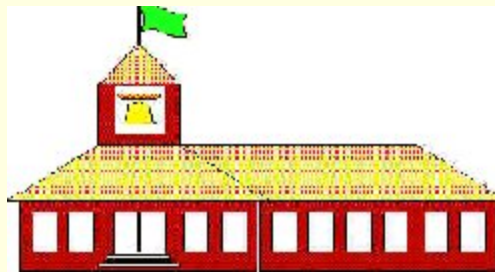
According to CMS regulations, waiver funding may not be used to pay for any services that are part of the child's IEP, except under the following circumstances

- The school's plan for meeting the child's identified IEP service plan needs is not adequate to ensure the child's health and welfare as determined by the child's waiver team
- The school is developing a plan to meet the identified IEP service needs, but the plan is not yet in place.

# CAP/C Forms and Processes - Request for Nurse or Nurse Aide Services in the School

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- There is a discrepancy or difference of opinion regarding what is to be included in the IEP and how the IEP needs are to be met
- The child is attending a private school, per parental preference, and the child needs a medically necessary service during school hours



## CAP/C Forms and Processes - Request for Nurse or Nurse Aide Services in the School

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The 'Request from School for Nurse or Nurse Aide Services Under Medicaid Program: CAP/C' form documents the reason for the use of waiver funding.

It is completed by the Case Manager and/or the Exceptional Children's Director

It is completed during the IEP process, and then annually thereafter

# CAP/C Forms and Processes - Assessment

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- Now two separate forms: the family assessment and the case manager assessment.
- The complete assessment must be done even if the recipient is not requesting nurse or nurse aide services

If an RN and a SW both complete separate assessments, they should each be shared and discussed with the other team member, with each team member giving input into the subsequent plan of care development.

# CAP/C Forms and Processes - Plan of Care

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- New form
  - Goals and interventions, Cost summary, 24 hour coverage schedule
  - Annual instead of monthly
  - Effective July 1 through June 30. Goals and interventions updated quarterly.

# CAP/C Forms and Processes - Letter of Understanding

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The wording has been changed to reflect the changes to the program.

No other changes.

Should be reviewed and discussed with the family, not just handed to them for signature.

# CAP/C Forms and Processes - DMA Evaluation and Approval

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If only home or vehicle modifications are requested, approval for CAP/C participation will be granted for only three months. At the end of the three months, CAP/C participation may be voluntarily withdrawn, involuntarily terminated, or a plan of care revision may be submitted if the recipient requires a new service.

If the plan of care revision is approved, participation may be extended for up to the remainder of the CNR year.



# CAP/C Forms and Processes - Expedited Initial

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- No changes, except use new forms.
- Remember, this is intended only for recipients who must have services in place before arriving in the home.

To use this process, the child must be awaiting arrival to the home and have a condition in which the child would not be safe at home even for a short time unless services and equipment were in place.

# CAP/C Forms and Processes - Notifying DSS

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- No changes.
- Some additional follow-up may be required during the first year for recipients who were IC, to make sure that the code is changed in the system.

# CAP/C Forms and Processes - Verifying Medicaid Eligibility

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- Remember that Medicaid cards are now issued annually, and are not proof of eligibility
- Monitor the CAP Indicator code as well as Medicaid eligibility

# CAP/C Forms and Processes - Service Authorization and Participation Notice

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- New forms
- Dates are now the first of the month after the recipient's birth month (or start of services if an initial or new service) until the last day of the recipient's birth month.

# CAP/C Forms and Processes - Coordination of Care

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- Hospice and Palliative Care Services can not be provided at the same time.
- Attendant Care Services can be provided to recipients of CAP/C Nursing, Pediatric Nurse Aide, or Personal Care Services, just not during the same hours of the day.
- Recipients of attendant care services may not also receive respite services.
- Waiver services can only be provided in the school system under the very specific circumstances previously described.

# CAP/C Forms and Processes - Coordination of Care

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- DME providers may now bill directly for the incontinence waiver supplies. The CM sends a service authorization to the provider. The provider sends copies of their invoices to the Case Manager. The Case Manager needs to review the invoices, but does not need to approve claims prior to the claims being submitted to HP.

# CAP/C Forms and Processes - Coordination of Care

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## ■ Respiratory Therapy Policy

Respiratory therapy can only be provided at the same time as CAP/C Nursing when it is for the purpose of a 1-2 hour training with each nurse caring for the recipient. A follow-up may be done quarterly if needed.

# CAP/C Forms and Processes - Monitoring

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- verify Medicaid eligibility monthly.
- Contact the recipient/family at least every 30 days to
  - Assess the provision of services
  - Assess the family's satisfaction with services
  - Address questions and concerns
  - Get an update on the child's medical condition, appointments, results of studies, etc

Address any identified needs.

Document on the 'Note of Case Manager Contact With Recipient/Family/Caregiver/Legal Guardian' or similar form

# CAP/C Forms and Processes - Monitoring

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- Quarterly home visit with the recipient/family
  - Recipient and caregiver must be present at each visit
  - Staff must be present annually
  - The purpose of the home visit is to
    - update the child's health status, care needs, changes in treatment or medication, new diagnoses, physician visits, acute illnesses, emergency room visits, hospitalizations
    - Assess for changes in caregiver availability or in the child's schedule

# CAP/C Forms and Processes - Monitoring

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- Assess the home environment
  - Assess the equipment and supplies, including amount and the family's ability to use them
  - If in-home care is provided, assess for lack of staffing or other problems with staff
  - Assess whether services and supplies are being provided according to the plan of care
  - Verify Medicaid eligibility and assess for changes to private insurance or other funding sources
- Address any identified needs
  - Document on the 'CAP/C Case Manager Quarterly Visit Note' or similar document. This is also a good time to do the quarterly progress notes on the plan of care.

# CAP/C Forms and Processes - Monitoring

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- Quarterly Consult With RN

If the Case Manager is a Social Worker, ideally the quarterly home visit is conducted by both the SW and the RN. If this is not possible, the SW conducts the home visit and then consults with the RN.

The RN consulted should be the nurse that conducted the assessment and/or should be the same nurse each quarter

# CAP/C Forms and Processes - Monitoring

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The RN should review any medically related incident reports, case management notes, and any other documentation such as physician letters, discharge summaries, the CMS-485, and service notes.

Together, the RN and SW review the plan of care and revise it as needed.

The reverse process is beneficial as well. An RN Case Manager can consult with a Social Worker, particularly for assistance recommending resources and sources of assistance.

# CAP/C Forms and Processes - Monitoring

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- Monthly Contact with Providers of Waiver Services

Assess the provision of services - Are services being provided as per the plan of care/service authorization? Are there problems staffing? Are there problems working with the family or recipient? Have they identified any needs the case manager needs to address?

Address any identified needs.

Document on the 'Note of case Management Contact with Provider' or similar form.

# CAP/C Forms and Processes - Monitoring

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- Quarterly contact with providers of non-waiver services

Perform the same type of assessment you performed with the providers of waiver services.

Address any discrepancies between what is on the Participation Notice and what is actually being provided.

Address any other identified needs,

Document on the 'Note of case Management Contact with Provider' or similar form.

# CAP/C Forms and Processes - Monitoring

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- Quarterly review of in-home care notes  
Review a random sample of service notes each quarter.
  - Is the recipient getting the appropriate level of staff?
  - Are medically related interventions taking place during the time the staff is there?
  - Does the care being provided match the assessment data?
  - Are there violations of Medicaid or CAP/C policy?
- Address any identified needs
- Document on the 'CAP/C Case Manager Supporting Documentation Review Note' or similar form.

# CAP/C Forms and Processes - Monitoring

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## Review of Claims

- Assess
  - Were services coded appropriately?
  - Were services provided according to the service authorization?
  - Are there patterns of misuse of services, caregiver refusal of services, or lack of services?
  - Do you have deviation notices when care differed from the service authorization?
- Address any identified needs.
- Document on the 'CAP/C Case manager Claims Review Note' or one similar to it.

# CAP/C Forms and Processes - Monitoring

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## ■ Additional Contacts with Families

- Contact the recipient's caregiver within 72 hours of discharge from a hospital or rehabilitation facility to assess the recipient's health status and changes in his or her needs
- Contact the recipient's caregiver within 72 hours following construction or installation of home or vehicle modifications to confirm that the modifications meets the recipient's needs.

# CAP/C Forms and Processes - Monitoring

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- Cost Monitoring



Training will be provided at a later date.

# CAP/C Forms and Processes - Plan of Care Revisions

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- No changes to why or when a revision needs to be submitted or the process of getting it approved.
- Remember you are updating the plan of care form. You are not deleting anything already there in order to make the change.
- When sending in a CNR, please don't also attach a separate plan of care revision. Doing so will delay the approval of the revision.

# CAP/C Forms and Processes - Mid-Year Review

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## The Purpose of a Mid-Year Review

- To ensure that the most medically fragile and highest cost recipients are monitored more closely
- To ensure that care and services are both effective and cost-effective
- To prevent instances of a child continuing to receive a service long after it should have been stopped or changed
- To help keep our assurance to CMS of cost neutrality and to help keep our aggregate budget in check

# CAP/C Forms and Processes - Mid-Year Review

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## Who Needs a Mid-Year Review

- Recipients of CAP/C Nursing whose waiver expenses meet or exceed \$135,000 per year
- Recipients of CAP/C Pediatric Nurse Aide or CAP/C Personal Care whose waiver expenses meet or exceed \$30,000 per year.

# CAP/C Forms and Processes - Mid-Year Review

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## What Is Done for the Mid-Year Review

- The Case Manager submits the following to the DMA Nurse Consultant
  - The cover letter
  - The current plan of care
  - The CMS-485 or similar document
  - 3-5 days of service notes
  - Case management notes for the previous quarter
- The DMA Nurse Consultant will contact the Case Manager regarding approval or recommended changes

# CAP/C Forms and Processes - CNR

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- Effective January 1, the CNR date will be determined by the recipient's birth month, not by the original FL-2 approval date.
- The CNR is due on the 5<sup>th</sup> of the recipient's birth month.
- It is effective the first day of the month after the recipient's birth month and ends one year later on the last day of the recipient's birth month.

# CAP/C Forms and Processes - CNR

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## The Transition to Birth Month CNR

- If the birth month occurs before the current (FL-2 based) CNR date, at the birth month due date submit a new FL-2 and the documentation that you would submit for a mid-year review (regardless of the patient's expenses). Do not do anything on the current (FL-2 based) CNR date. Complete a full CNR the next year, due on the 5<sup>th</sup> of the birth month.

# CAP/C Forms and Processes - CNR

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- If the birth month occurs after the current (FL-2 based) CNR date, at the current (FL-2 based) CNR date submit a new FL-2 and the documentation that you would submit for a mid-year review (regardless of the patient's expenses). Submit a full CNR on the 5<sup>th</sup> of the recipient's birth month.

# CAP/C Forms and Processes - Absences

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- Any time that a recipient is in the hospital, for any length of time, notify the DSS.
- If a recipient is in the hospital for longer than 30 days, CAP/C must be terminated. If a recipient enters a nursing home or rehab center, CAP/C must be terminated immediately. If CAP/C is to be resumed after discharge, complete a regular or expedited initial assessment.

# CAP/C Forms and Processes - Transfers

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- When a recipient moves to a different county, the CAP Indicator code had been getting removed by the old county and put back in by the new county, Effective immediately, the CAP Indicator Code will no longer be removed.

# CAP/C Forms and Processes - Documentation

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- Requirement for retaining documentation has changed from 5 years to 6 years.
- It is still recommended that you retain documentation until the later of
  - Six years from the last date of service, or
  - Five years from the age of majority (23<sup>rd</sup> birthday).

# CAP/C Forms and Processes - Claims

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No changes!



# CAP/C Forms and Processes - Voluntary Reductions and Withdrawals

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No changes!



## CAP/C Forms and Processes - Involuntary adverse decisions

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Only change is that a service will be terminated if it is not used at least quarterly, and CAP/C participation will be terminated if there is not at least one waiver service besides case management and respite being used at least quarterly.

# CAP/C Forms and Processes - Appeals

No changes!



# CAP/C Forms and Processes - Quality Management

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- Essentially the same activities as last year
- Addition of provider survey
- Quality Framework on website



# Fraud

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"Medicaid fraud and abuse cost YOU!"

Medicaid recipients, providers or members of the general public who suspect Medicaid fraud should report it via the TIP Line

**877-DMA-TIP1 (1-877-362-8471).**

Failure to report suspected Medicaid fraud and abuse could result in a civil penalty.



August 16-17, 2010

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# Additional Training Dates

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To Be Announced

Look for:

frequent conference calls

FAQs

this videoconference and this Powerpoint on website

new brochure, Parent Handbook, and Manual on website

# Questions

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Any  
questions  
about  
anything?



The End

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Thanks for  
coming!

And thanks  
for all you  
do!

