Community Alternatives Program for Children (CAP/C) **NC Division of Medical Assistance** **August 2009**

- 1915c HCBS waiver for medically fragile children ages birth through age 18
- Three Levels of Care with monthly budget limits: Hospital LOC: $28,729 Skilled LOC: $3537 Intermediate LOC: $2730
- SFY 09 Stats: 846 recipients in SFY 09 Avg Cost per recipient $37,348 Program Cost $36,414,446 (stats from July paid claims report)
- All CAP/C recipients receive case management, billed under code T1016 at a rate of $15.25 per 15 minute unit.
- There are currently 67 case management agencies and approximately 200 case managers across the state.
- CAP/C services also include: in-home nurse or nurse aide care, in-home or institutional respite care, select home modifications, and select waiver supplies.

DMA	Case Management Agency	Individual Case Manager
Division of Medical Assistance The state Medicaid agency, responsible for 1) waiver , policy, and procedure development, 2) training , consultation, and technical assistance to case managers, and 3) RN approval of CAP/C participation and plans of care for all recipients 4) monitoring activities for CMS and for quality assurance 5) Representation at Hearings and Appeals	A DSS, Health Department, Case Management agency, home health agency, or hospital-based home care agency approved by and enrolled with Medicaid as a CAP/C Case Management provider, responsible for 1) hiring and direct supervision of Case Managers, 2) internal policy development, 3) internal quality assurance activities related to CAP/C Case Management, and 4) outreach to potential recipients and providers.	Person meeting the OSP qualifications for Social Worker I or higher or Public Health Nurse I or higher, responsible for a caseload of approximately 20 (if 1 FTE) children/families for whom they provide direct case management services. Experience working with medically fragile children is beneficial.
Recipient/Family	Physician	Provider Agency
Child/family of child aged birth through 18 with a medical diagnosis and associated need for a nurse or nurse aide to provide continuous (as opposed to intermittent visits) in-home care in order to avoid institutionalization.	The child's primary care physician or coordinating care physician, responsible for 1) recommending nursing facility level of care, 2) ordering CAP/C services and supplies, 3) reviewing and signing the provider agency's plan of care for nurse or nurse aide services, 4) providing direction when needed for issues that arise that do or could potentially impact the child's health	An enrolled Medicaid provider who provides direct services (nurse, nurse aide…) to the recipient/family and communicates/coordinates with the CAP/C Case Manager.
CMS	EDS	CSC
The Center for Medicare and Medicaid Services The federal agency governing Medicaid programs. CMS approves waivers for a 5 year period. The current CAP/C waiver will need to be renewed July 1, 2010.	Electronic Data Systems A contracted entity that 1) gives prior approval for nursing facility level of care (as well as other Medicaid services and supplies), and 2) processes claims for waiver services and supplies (as well as Medicaid services and supplies).	Computer Sciences Corporation A contracted entity that enrolls qualified agencies as providers of CAP/C Case Management services (as well as other Medicaid services).

CAP/C Case Management Activities

1. Case Managers and agencies outreach to/network with
    a) local referral sources for potential recipients
    b) local providers, particularly of nurse and nurse aide services, to enroll qualified providers as CAP/C providers, particularly in times of nurse/nurse aide shortage.
2. The case management agency serves as the preferred portal of entry into the program, although there is 'no wrong door'. The case manager is responsible for
    a) taking inquiries about the program,
    b) doing a preliminary assessment of the patient's/family's needs and resources, and
    c) guiding the person to CAP/C if appropriate, and/or other Medicaid or non-Medicaid resources as appropriate.
    d) Submitting the CAP/C referral form to DMA for pre-screening if appropriate or if the recipient wishes
    e) Giving the recipient/family a copy of or the link to the CAP/C Parent Handbook

    The agency is responsible for managing their wait list, if there is one.
3. Upon authorization from DMA based on a favorable screening, the Case Manager
    a) sends the family to apply for Medicaid and disability as appropriate
    b) obtains a signed FL-2 form with level of care recommendation from the physician
    c) obtains EDS approval of level of care
    d) performs a comprehensive individualized assessment
    e) in conjunction with the family, develops a plan of care
    f) instructs the recipient/family regarding freedom of choice and their other rights and responsibilities
    g) submits the FL-2, assessment, plan of care, and any other pertinent documentation to DMA for approval
4. Upon DMA approval, the Case Manager
    a) makes referral to potential provider agencies per the instructions of the family
    b) meets minimum CAP/C monitoring criteria, including
        - monthly contact with recipient/family
        - quarterly home visit with recipient/family while services are taking place
        - monthly contact with providers of waiver services
        - quarterly contact with providers of non-waiver services
        - contact with recipients and providers at other times, such as post-hospitalization, or after installation of home modifications
        - coordinates and advocates for child within school system
        - quarterly review of nurse/nurse aide documentation
        - incident reporting
        - review of claims for waiver services and supplies prior to those claims being sent to EDS.

        During these monitoring activities, the case manager evaluates whether services are being provided according to the plan of care, whether the plan of care meets all of the recipient's needs, recipient satisfaction with services, CAP/C policy adherence by recipient and by providers, whether resources are utilized appropriately, whether care is provided in a cost effective manner, and the recipient's health, safety, and well-being.
5. The case manager makes changes to the plan of care as needed, and completes a re-assessment (CNR) annually.
6. Upon DMA denial, the case manager
    a) helps recipient understand reasons for denials
    b) links recipient to other services as needed and available
    c) helps recipient understand appeal rights, process, and helps them and DMA with providing information for appeal prep
7. The case manager engages in quality assurance activities within his/her own agency and as requested by DMA.

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