Acentra HEALTH

Fall Provider Webinar: Overview of CAP/C Services

November 20, 2024

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Today's Agenda

- Acentra Health's Role in CAP/C
- What is CAP/C?
- Who is eligible for CAP/C
- How to Make a CAP/C Referral
- Completing the Consent Packet
  - Example of Beneficiary Consent Form
  - Example of Physician LOC Worksheet
  - Example of Freedom of Choice Form
  - Common Mistakes/Reasons for Delays
- CAP/C Assessments
  - Common reasons for denials
- Questions & Answers

The Role of Acentra Health

- Acentra Health operates NCLIFTSS to ensure:
  - Streamline access to LTSS
  - Reduction in wait time between initial contact and service provision
  - Enhancement in quality through increased provider training and technical support
  - Outreach to underserved areas to promote health equity
  - Improvement in coordination between LTSS and benefit plans

- As the state contractor for NCLIFTSS, Acentra Health is responsible for processing referrals, completing LOC decisions through Service Request Forms, and conducting assessments to determine eligibility for CAP/C enrollment.

What is CAP/C?

- The Community Alternatives Program for Children (CAP/C) is a Medicaid Direct home and community-based service waiver under the 1915 (c) Social Security Act. This waiver targets medically fragile children from birth through age 20 who met an institutional level of care with a primary diagnosis that is physical or medical rather than cognitive or behavioral and are at risk of institutional care. This waiver allows medically fragile children to be cared for and remain in (or return to) their homes and community using wraparound services to offer support in home care, accessing their home and vehicles through modifications and other needed services that may not be covered by insurance/Medicaid Direct.

- The CAP/C Waiver provides additional supportive services to supplement services already received from regular Medicaid Direct/Insurance such as private duty nursing, durable medical equipment and supplies, therapy services, and home health.

CAP/C Home and Community-Based Services:

- Assistive technology
- In-home aide
- Case management/Care advisor
- Community integration service
- Community transition service
- Home accessibility and adaptation
- Specialized medical equipment and supplies
- Respite care
- Pediatric nurse aide
- Vehicle modifications
- Goods and services, such as nutritional services, and non-medical transportation

CAP/C Eligibility

- CAP/C is available to children from birth through 20 years of age who meet a LOC, is determined to be medically fragile, and has a reasonable need for at least one CAP/C home and community-based service. In addition, the child must:
  - Live in a private residence
  - Can be cared for safely at home
  - Has a primary caregiver willing to participate in the care and care planning for their child
  - Abide by the rights and responsibilities of participating in the CAP/C waiver

- It is important to note if CAP/C is not approved, due process is provided, promoting the right to appeal that decision.

How to Make a CAP/C Referral

- A referral can be made by calling NCLIFTSS customer call center at (833) 522-5429 (toll free) or by faxing a completed referral form to (833) 470-0597.
  - Additional information and the referral form can be found on the NCLIFTSS/Acentra Health website (CAP/C - NCLIFTSS)
  - To go directly to the form, click here: CAP/C Referral Form

- A referral can also be made by contacting a local CAP/C case management entity (CME), an In-Home/Health agency, Department of Social Services, or a hospital in the county of residence of the applicant. (CAP/C CME List)

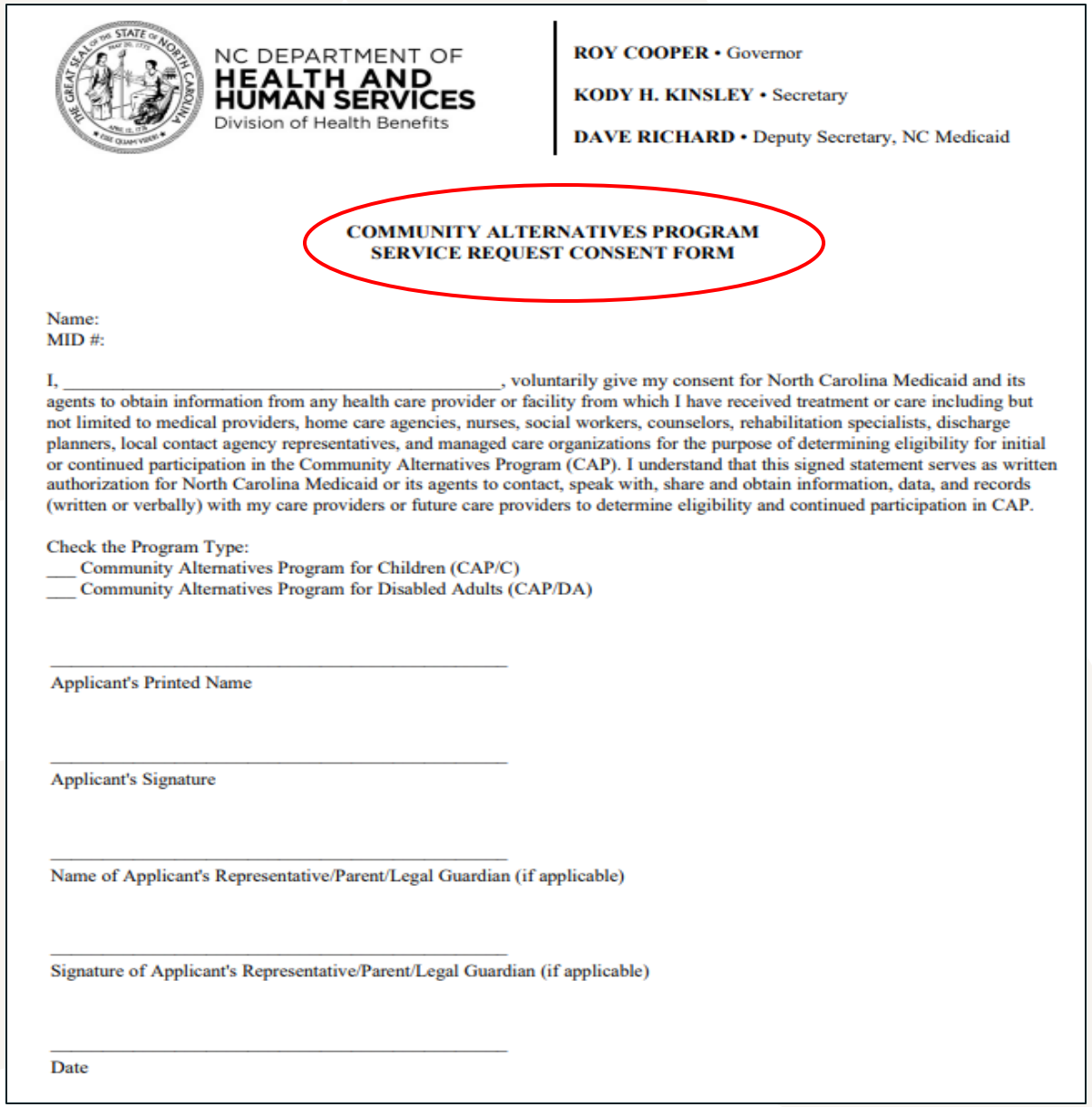
Completing the Consent Packet

- Once a referral has been made and validated, NCLIFTSS will mail out a consent packet within one business day.
- The consent packet includes three (3) documents that are critical for timely processing of the request for services:
  - **Beneficiary Consent Form**: This form allows NCLIFTSS to process the request by exchanging information with other professionals. This form is to be completed by the beneficiary or primary responsible person and must be received to complete the assessment.
  - **Physician LOC Worksheet**: This form is used to obtain clinical information from the physician and their opinion of the level of need. This form is to be completed by the primary physician and must be received to complete the assessment.
  - **Freedom of Choice (CME selection):** This form is used to link to a case management entity to offer additional support while the enrollment decision is being made. This document is to be completed by the beneficiary or the primary responsible person and must be received for services to be approved.

- It is important these documents are returned within the indicated timeframe, or it can delay the assessment and access to services if approved.

Beneficiary Consent Form

- This form is to be completed by the beneficiary or primary responsible person.
- This form **must** be received to complete the assessment.



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

COMMUNITY ALTERNATIVES PROGRAM
SERVICE REQUEST CONSENT FORM

Name:
MID #:

I, _____, voluntarily give my consent for North Carolina Medicaid and its agents to obtain information from any health care provider or facility from which I have received treatment or care including but not limited to medical providers, home care agencies, nurses, social workers, counselors, rehabilitation specialists, discharge planners, local contact agency representatives, and managed care organizations for the purpose of determining eligibility for initial or continued participation in the Community Alternatives Program (CAP). I understand that this signed statement serves as written authorization for North Carolina Medicaid or its agents to contact, speak with, share and obtain information, data, and records (written or verbally) with my care providers or future care providers to determine eligibility and continued participation in CAP.

Check the Program Type:
___ Community Alternatives Program for Children (CAP/C)
___ Community Alternatives Program for Disabled Adults (CAP/DA)

_____
Applicant's Printed Name

_____
Applicant's Signature

_____
Name of Applicant's Representative/Parent/Legal Guardian (if applicable)

_____
Signature of Applicant's Representative/Parent/Legal Guardian (if applicable)

_____
Date

Physician LOC Worksheet

This 2-page document is to be completed by the Beneficiaries **Primary Physician**

Applicant Information
Beneficiary Name:
DOB:
Primary Caregiver:
Address:

Program Type the applicant is requesting:
☐ Community Alternatives Program for Children (CAP/C)
☐ Community Alternatives Program for Disabled Adults (CAP/DA)

Check all clinical indicators the applicant is currently experiencing or has a history of:
Has a primary physical diagnosis: ☐ Yes If yes, what is the ICD-10: _____ ☐ No

Provide a list of all diagnoses that includes ICD-10, date of onset, and primary or secondary diagnosis.

Prescribed medication: ☐ Yes ☐ No

Provide a list of all prescribed medications and its routing that are dispensed and over the counter (OTC) with the completed form.

Specialized treatments: ☐ Yes ☐ No

Include an attachment of specialized treatments (such as MACE, in and out catheters, regularly prescribed enemas or digital stimulation, Vagus Nerve stimulation swipe, oropharyngeal suctioning) **with the completed form, or describe the specialized treatment in the text box below.**

Describe specialized treatment here:

To be determined to meet a level of care, the above-named applicant requires a need for any one of the following:

☐ Receiving physical therapy	☐ Receiving occupational therapy
☐ Receiving speech therapy	☐ Dialysis
☐ Specialized therapeutic diet	☐ IV drug administration
☐ Controlled medication	☐ Frequent drug injections
☐ Requiring respiratory therapy	☐ Nasogastric feeding

☐ Need or uses life-sustaining devices (endotracheal tube, ventilator, suction machine, oxygen therapy, cough assist device, high-frequency chest wall oscillation vest)

☐ Gastrostomy feeding	☐ Wound care
☐ Alzheimer's Disease	☐ Bowel and bladder program

In your clinical judgment, are the health care conditions (diagnosis, medication, specialized treatments, and medical regiment) chronic and severe enough to meet an institutional level of care?
☐ Yes ☐ No

Select one: ☐ Applicant's primary care Practitioner ☐ Outpatient Specialty Practitioner

Practitioner's Name: _____

Practitioner Signature and Credentials: _____

Date: _____/_____/_____

Practice Name: _____

NPI #: _____ Phone: _____

Address or Physician Practice Stamp: _____

_____

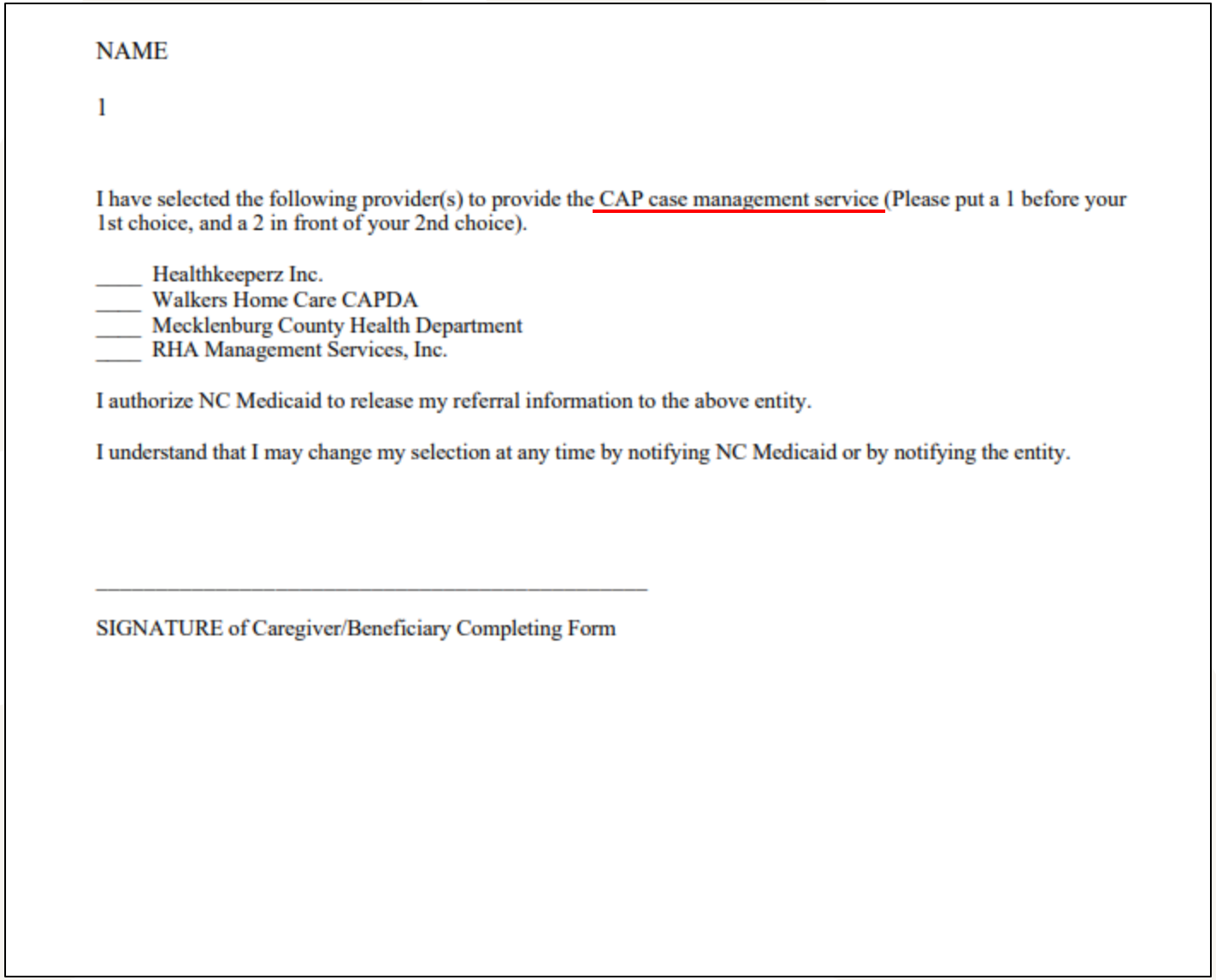
Practice Stamp

Thank you in advance for your assistance in completing pages 2 and 3. Upon completion, please fax back to (919) 715-0052 within 15 business days from the date of this letter. **Also include with the fax the medication and diagnosis lists.** If you have any questions or need additional assistance, you may contact the CAP unit at NC Medicaid at 919-855-4340.

Check the items enclosed:
☐ Meds list
☐ Dx list
☐ Specialized treatments

Freedom of Choice (CME selection)

- This document is to be completed by the beneficiary or the primary responsible person.
- This form **must** be received so that the POC can be initiated if enrollment is approved.



NAME

1

I have selected the following provider(s) to provide the CAP case management service (Please put a 1 before your 1st choice, and a 2 in front of your 2nd choice).

____ Healthkeeperz Inc.
____ Walkers Home Care CAPDA
____ Mecklenburg County Health Department
____ RHA Management Services, Inc.

I authorize NC Medicaid to release my referral information to the above entity.

I understand that I may change my selection at any time by notifying NC Medicaid or by notifying the entity.

_____

SIGNATURE of Caregiver/Beneficiary Completing Form

Common Mistakes/Reasons for Delays

- Not returning the consent form
- Dates and signatures missing from the beneficiary and/or physician
- Incorrect address/county listed
- LOC incomplete – Clinical judgement question left unanswered
- LOC not recommended
- Not checking the preferred case management entity or selecting an alternative CME

Common Reasons for an SRF Denial

- Inappropriate referrals
  - Primary Diagnosis **must** be chronic, physical, or medical rather than cognitive, developmental, psychological, or behavioral.
  - Misinterpretation or lack of knowledge of qualifying conditions for HCBS Nursing Facility LOC Criteria or and Medical Fragility criteria.
- Does not meet HCBS Nursing Facility LOC Criteria
- Does not meet Medical Fragility Criteria
  - All 3 Criterions must be met: A, B, & C

CAP/C Medical Fragility

A. A medically fragile child has a primary chronic medical condition or diagnosis (physical rather than psychological, behavioral, cognitive, or developmental) that has lasted, or is anticipated to last, more than 12 calendar months; and

B. The child's chronic medical condition:
- i. Requires medically necessary, ongoing, specialized treatment or interventions (treatments or interventions that are supervised or delegated by a physician or registered nurse) without which would likely result in a hospitalization; or
- ii. Resulted in at least four exacerbations of the chronic medical condition requiring urgent or emergent physician-provided care within the previous 12 calendar months; or
- iii. Required at least one inpatient hospitalization of more than 10 calendar-days within the previous 12 calendar months: or iv. Required at least three inpatient hospitalizations within the previous 12 calendar months; and

C. The child's chronic medical condition requires one of the following:
- i. the use of life-sustaining device(s); or
- ii. life-sustaining hands-on assistance to compensate for the loss of bodily function; or
- iii. non-age appropriate hands-on assistance to prevent deterioration of the chronic medical condition that may result in the likelihood of an in patient hospitalization.

NC Medicaid Community Alternatives Program for Children (CAP/C) Clinical Coverage Policy No: 3K-1

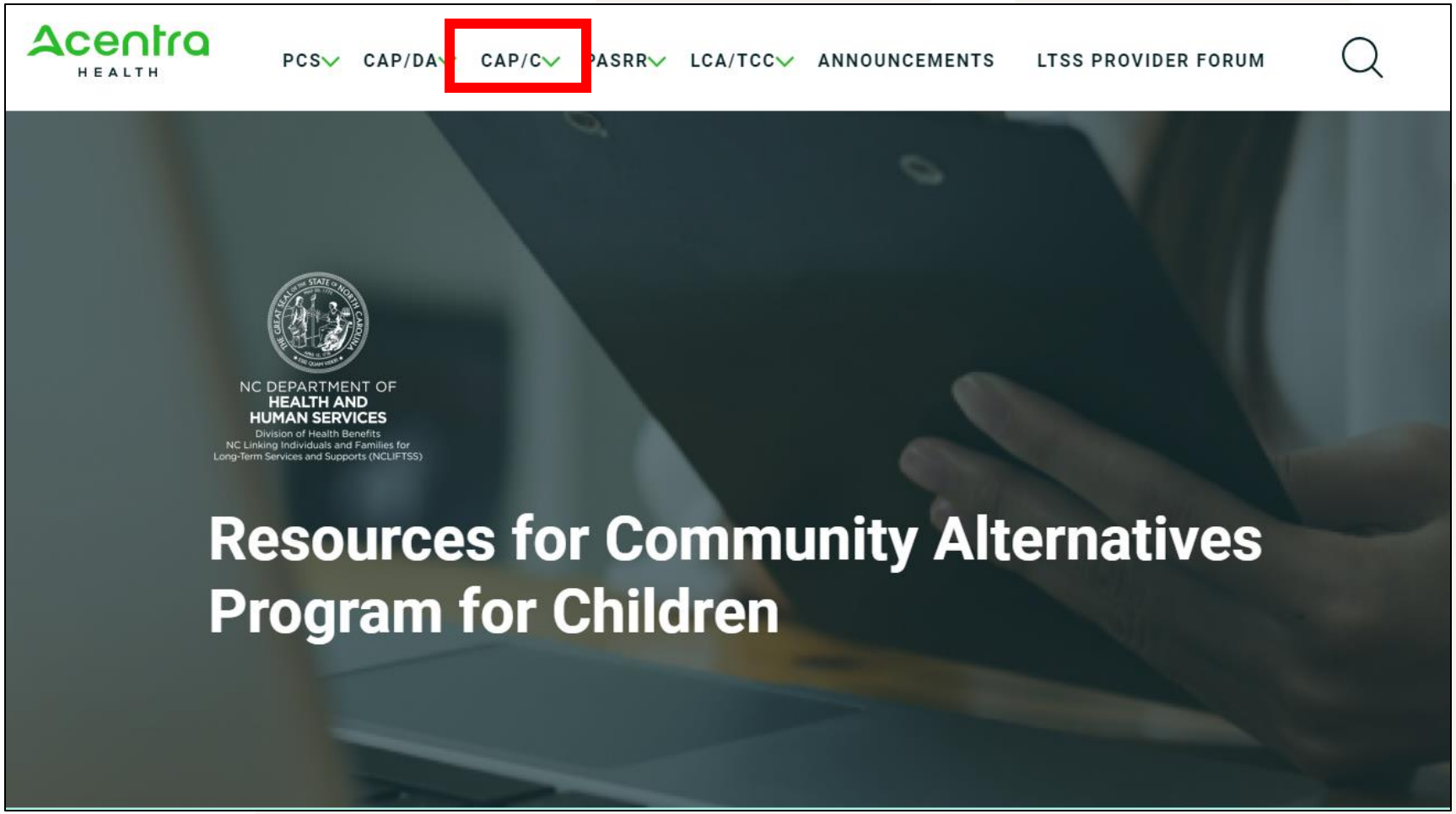
CAP/C Assessments

- Once the Service Request Form (SRF) determines level of care is met a full assessment is scheduled to evaluate risks and reasonable need for CAP/C services
- Assessments are conducted face-to-face
- When NCLIFTSS calls to schedule the assessment, they will ask the beneficiary or caregiver their preference for date and time
- The Assessor will ask questions about various functional activities and the beneficiary's ability to perform these activities or the caregiver process of performing those activities
- The Assessor requires the beneficiary/primary caregiver to demonstrate these activities to determine level of ability
- The Assessor will review provided medical records or other information that is helpful for them to understand the needs of the beneficiary/family

Common Reasons for an Assessment Denial

- Individual no longer meet Medical Fragility criteria (MF) at the assessment stage.
- Level of Care (LOC) changed at the assessment stage.
- An individual can meet Medical Fragility, but there's not a reasonable indication of need for at least 1 CAP Waiver service within 30 Calendar days that would avert institutionalization into a skilled nursing facility.

NCLIFTSS Website



NCLIFTSS.ACENTRA.COM

CAP/C - NCLIFTSS

Additional Resources on NCLIFTSS Website

Additional Resources

- CAP/C Forms
- DMA-3201-ia Critical Incident Report - Community Alternatives Program for Children (CAP-C)
- CAP Standard Operating Procedures
- Clinical Coverage Policy
- CAP/C Service Regions
- NCTracks
- E-Cap Provider Portal
- CAP/C Lead Agency List

Website Link: CAP/C Resources - NCLIFTSS

- For questions, contact NCLIFTSS at: 833-522-5429 (toll free) or 919-568-1717
- Call Center Hours: Monday - Friday 8:00am to 5:00pm
- CAP/C Fax Number: 833-470-0597
- Email Address: NCLIFTSS@acentra.com
- CAP/C Website: CAP/C - NCLIFTSS
- CAP/C Frequently Asked Questions: CAP/C FAQ's
- CAP Program Referral Request Form: CAP Program Referral Request Form