Sections of the Waiver Application	Will this section be amended	If amended, what safeguards are put in place to ensure health, safety and well-being of impacted individuals
Proposed Effective Date	Yes; The proposed effective date will be January 2017; however, CMS may approve the waiver with a later effective date. DMA anticipates an approval no later than March 2017	The 2010-2015 CAP/C waiver has been approved for an extension until the new amended waiver is approved.
Major Changes	Yes The areas that were amended are: • The definition of medically-fragile; each waiver beneficiary participating in the CAP/C waiver must meet all three conditions in order to meet the basic CAP/C eligibility criteria: a. A primary medical (physical rather than psychological, behavioral, cognitive, or developmental) diagnosis(es) to include chronic diseases or conditions such as chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, chronic endocrine and metabolic disorders, chronic infectious disease, chronic musculoskeletal conditions, chronic neurological disorders, chronic integumentary disease, chronic renal disease, genetic disorders, oncologic and hematologic disorders. b. A serious, ongoing illness or chronic condition requiring prolonged hospitalization (more than 10 days, or 3 admissions), within 12 months, ongoing medical treatments, nursing interventions, or any combination of these; and	Revised and updated assessment and risk-based monitoring tools.

	c. A need for life-sustaining devices such as endotracheal tube, ventilator, suction machines, dialysis machine, J-Tube and G-Tubes, oxygen therapy, cough assist device, and chest PT vest; or care to compensate for the loss of bodily function. • The definition of at-risk of institutionalization is defined as: Participants who meet nursing facility level of care (LOC) criteria with assessed acuity of needs ranging from skilled to hospital level of care and who do not have available resources to meet immediate needs, medical, psychosocial and functional. Resources consist of both formal and informal, willing and able family members. • Level of Care Instrument: SRF • Number of waiver services to be considered for participation: 1 • Individual Risk Agreement (IRA(to address dignity of risk requirement under HCBS Final Rule • Consumer-direction • Conflict-free case management safeguards	
Sections of the Waiver Application	**Will this section be amended**	**If amended, what safeguards are put in place to ensure health, safety and well-being of impacted individuals**
Target Population	No The target population will remain medically-complex children between the ages of 0-20	N/A
Eligibility Criteria	No Determined to be medically-complex and at-risk of being institutionalized	N/A

Sections of the Waiver Application	**Will this section be amended**	**If amended, what safeguards are put in place to ensure health, safety and well-being of impacted individuals**
Medicaid Eligibility Category	No Medicaid for the Blind (MAB), Medicaid for Disabled(MAD), Medicaid for Children Receiving Adoption Assistance (I-AS), or Medicaid for Children Receiving Foster Care Assistance (H-SF)	N/A
Participant Access-Level of Care (LOC) Instrument to be Used	Yes The Service Request Form (SRF); SRF will replace the FL-2 The SRF will also act as the referral. The SRF will combine the referral information and LOC information to eliminate duplication of the dual eligibility requirements.	A trial test of the SFR will be implemented on 11/01/16 to replace the CAP/C referral form. This trail test will also validate effectiveness of the SRF in determining the LOC.
Management of Number of Individuals Served when capacity is reached	Yes A statewide waitlist will be administered instead of a case management specific waitlist.	If a waitlist is created after the amended waiver is approved, family will be provided resource information on how to meet any unmet needs during the wait time. Individuals who meets priority category will be assessed without a wait time.
Waiver Capacity	Yes 4,000 children	N/A
Quality Management of Beneficiary's outcome	Yes The following items are the objectives of this waiver. • Improve or maintain beneficiary capacities for self-performance of activities of daily living and/or instrumental activities of daily living.	N/A

	• Improve beneficiary compliance with accepted health and wellness prevention, screening and monitoring standards • Reduce beneficiary health and safety risks • Avoid unplanned hospitalizations • Avoid emergency room visits as a means for receiving primary care. • Enhance beneficiary socialization/reduce social isolation • Reduce risks of caregiver burnout • Increase caregiver capacities • Enhance beneficiary self-management of chronic conditions • Foster a more engaged beneficiary • Promote a positive beneficiary personal outlook • Improve informal caregiver(s) outlook and confidence in their caregiving role	
Participant Services - Waiver Benefit Package	**Home and Vehicle Modification and Assistive Technology (New process) -** Individuals in the waiver will have access to a modification budget to make requests for home and vehicle modification and assistive technology. The maximum allowable modification budget is $28,000 per the waiver lifetime (5 year waiver period). Individuals are able to use this budget to meet their medical needs based on medically necessity and eligibility requirements outlined in the clinical coverage policy.	
	Case Management- Each CAP/C beneficiary will be entitled to 72 hours per year of case management services. Case management services will include traditional case management or care advisement for those individuals directing care through consumer-direction. **New Process-** Each CAP/C beneficiary will be entitled to 8 hours per year of assessment time to determine initial eligibility and annual continuation of participation.	
	Community Transition Services- Each CAP/C beneficiary will be entitled to a $2500 one time allotment to arrange services for transition from an institution. This service is available within 90 days of transition and is only approved on a one-time basis during the duration of the waiver lifetime (5 year waiver period).	

	New Service: Financial Management Services- CAP/C beneficiary/representative determined eligibility to direct own care through consumer-direction is entitled to 4 units/month of financial management services; 4 units per month of initial start-up financial management and 4 units of transfer services of the financial management companies.	
	Institutional and Non-institutional Respite Services- Change in way services is approved. New process: Each CAP/C beneficiary will be entitled to 30 consecutive days of institutional care or 720 hours/fiscal year of non-institutional respite from July-June.	
	New service: **Participant Goods and Services**- Each CAP/C beneficiary is entitled to $800 per fiscal year (July-June) to arrange for goods and services that are not listed in State Plan or as a waiver service that will promote continuous community living per an assessment of medical necessity.	
	Pediatric Nurse Aide services- Personal care service available to a CAP/C beneficiary who has two extensive limitation with their ADLs and requires the assistance from an NAII certified personnel.	
	Specialized Medical Equipment and Supplies – Medical items that are determined medically necessary such as reusable incontinence supplies, medication boxes, adaptive tricycles and vehicle vests.	
	Training, Education and Consultative Services – Each CAP/C beneficiary is entitled to a $500 allotment per fiscal year (July-June) to arrange training and supportive services to manage and learn the care needs of a medically-complex child. **New process;** this service will be billed by dollar amount up to the maximum allowable.	
Sections of the Waiver	**Will this section be amended**	**If amended, what safeguards are put in place to ensure health, safety and well-being of impacted individuals**
Discontinued Waiver Services	Yes 5 waiver services will be shifted to State Plan: • Palliative Care Counseling • Palliative Care Expressive Therapy • Palliative Care Bereavement Counseling • CAP nursing • Personal care services	These services are offered through other Medicaid services such as Home Health, Hospice, Private Duty Nursing, Personal Care services and Behavioral Health. Waiver participants are able to access these services through regular Medicaid services or through other waiver services.

Sections of the Waiver	Will this section be amended	If amended, what safeguards are put in place to ensure health, safety and well-being of impacted individuals
Individual Cost Limit	The average per capita cost for each waiver beneficiary is $129,000 per year. This amount is merely an average. Each waiver beneficiary's care needs, both waiver and non-waiver services, will be planned on an average per capita cost per year.	Assessment of care needs will be reviewed on a quarterly basis to ensure alignment with the average per capita cost.
Person-Centered Planning	No	N/A
Consumer-Directed care	Yes Consumer-directed care is a service option under the waiver for individuals who wish to have increased control over their own services and supports. It offers flexibility over the types of services the beneficiary receives, when and where the services are provided, and by whom the services are delivered. This service will be available to CAP/C beneficiaries who qualify for pediatric nurse aide services.	A self-assessment questionnaire must be completed to determine capacity and willingness to direct own care. In addition, an assessment of the hired assistant must be completed to determine competencies and need for training. The care advisor will monitor monthly and conduct a quarterly home visit to assess care provision and health and safety.
Qualified Providers	No However new processes will include: • Each case management entity must maintain a 90% compliance rate on a quarterly basis in all waiver areas in order to maintain designation as lead waiver overseer in catchment area. • CAP services providers must complete a CAP specific training to be approved to provide CAP services. • Assignment of case management entities to conduct independent assessments.	These measures will ensure the health, safety and well-being of all CAP/C beneficiaries as well as compliance with the requirements of conflict-free case management.
Waiver Administration and Operation	No The CAP waiver will be administered by State Medicaid Agency (DMA) and appointed case management entities (local agencies that provide administrative oversight of the CAP/C program in local communities). The case	The provider qualification threshold ensures providers are fully qualified to provide home and community-based services to medically-complex children.

	management entities will be responsible for the day-to-day management of the waiver beneficiary. The case management entities must met a provider threshold in order to be designated as lead. The threshold includes: Qualified Case Management Entities shall have: • A resource connection to the service area provide continuity and appropriateness of care; • Experience in geriatrics, pediatrics, and physical disabilities; • Policies and procedures in place that aligns with the governance of the state and federal laws and statutes; • Three (3) years of progressive and consistent home and community base experience; • Ability to provide case management by both social worker and nurse; • Physical location; • Computer technology and Information Technology web-based connectivity to support the requirement of current and future automated programs; • Meet the regulatory criteria under DHHS/DHSR, when applicable. Federally reorganized organizations are exempt. • Staff to participant ratio (appropriate case mix); and • Authorize services within five (5) days of POC approval. • Signed the CAP clinical coverage policy to accept the roles and the responsibility of case management entity that attest to the adherence of the provision and implementation of the CAP Waiver.	