

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid state plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors. A state has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

1. Request Information

A. The State of North Carolina requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

B. Program Title:

Community Alternatives Program for Children

C. Waiver Number: NC.4141

Original Base Waiver Number: NC.4141.

D. Amendment Number: NC.4141.R07.01

E. Proposed Effective Date: (mm/dd/yy)

03/01/23

Approved Effective Date: 03/01/23

Approved Effective Date of Waiver being Amended: 03/01/23

2. Purpose(s) of Amendment

Purpose(s) of the Amendment. Describe the purpose(s) of the amendment:

This amendment is made to articulate the person-centered planning of the availability of hands-on services that assist with ADLs/IADLs or skilled needs in meeting the needs of a waiver participant and family when special circumstances exist.

3. Nature of the Amendment

A. Component(s) of the Approved Waiver Affected by the Amendment. This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
Waiver Application	<input style="width: 90%;" type="text"/>
Appendix A - Waiver Administration	<input style="width: 90%;" type="text"/>

Component of the Approved Waiver	Subsection(s)
and Operation	
Appendix B - Participant Access and Eligibility	
Appendix C - Participant Services	C-1
Appendix D - Participant Centered Service Planning and Delivery	
Appendix E - Participant Direction of Services	
Appendix F - Participant Rights	
Appendix G - Participant Safeguards	
Appendix H	
Appendix I - Financial Accountability	
Appendix J - Cost-Neutrality Demonstration	

B. Nature of the Amendment. Indicate the nature of the changes to the waiver that are proposed in the amendment (*check each that applies*):

- Modify target group(s)**
- Modify Medicaid eligibility**
- Add/delete services**
- Revise service specifications**
- Revise provider qualifications**
- Increase/decrease number of participants**
- Revise cost neutrality demonstration**
- Add participant-direction of services**
- Other**
Specify:

To update the service definitions for In-home aide, attendant nurse care, coordinated caregiving and pediatric nurse aide to articulate the person-centered planning of the availability of hands-on services that assist with ADLs/IADLs or skilled needs in meeting the needs of a waiver participant and family when special circumstances exist.

1. Request Information (1 of 3)

- A. The State of North Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of section 1915(c) of the Social Security Act (the Act).
- B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):

Community Alternatives Program for Children

C. Type of Request: amendment

Requested Approval Period: (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years **5 years**

Original Base Waiver Number: NC.4141

Waiver Number: NC.4141.R07.01

Draft ID: NC.019.07.01

D. Type of Waiver (*select only one*):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 03/01/23

Approved Effective Date of Waiver being Amended: 03/01/23

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

- F. Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid state plan (*check each that applies*):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR § 440.10

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR § 440.40 and 42 CFR § 440.155

If applicable, specify whether the state additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)

If applicable, specify whether the state additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under section 1915(b) of the Act.

Specify the section 1915(b) waiver program and indicate whether a section 1915(b) waiver application has been submitted or previously approved:

Specify the section 1915(b) authorities under which this program operates (check each that applies):

section 1915(b)(1) (mandated enrollment to managed care)

section 1915(b)(2) (central broker)

section 1915(b)(3) (employ cost savings to furnish additional services)

section 1915(b)(4) (selective contracting/limit number of providers)

A program operated under section 1932(a) of the Act.

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

A program authorized under section 1915(i) of the Act.

A program authorized under section 1915(j) of the Act.

A program authorized under section 1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose: This waiver program provides an alternative to institutionalization for individuals between the ages of 0-20. These services allow the targeted individuals to remain in or return to an HCB setting. This waiver serves a limited number of medically fragile and complex children who are at imminent risk due to the severity and intensity of their care needs.

Goals: Improve/maintain participant capacities for self-performance of ADLs and IADLs; improve participant compliance with health and wellness prevention, screening/monitoring standards; reduce participant health and safety risks; implement strategies to mitigate and avoid unplanned hospitalizations and ER visits; enhance participant socialization and reduce social isolation; reduce risks of caregiver burnout; increase participant and caregiver capacities by enhancing awareness maintenance of chronic conditions, and improve drives of health.

Objectives: To promote continuous quality improvement strategies.

State Assurances: Participant Access: CAP participant has access to home and community-based services and supports in their communities; Person-Centered Service Planning and Delivery: Services and supports are planned and effectively implemented in accordance with each CAP participant's unique needs, expressed preferences, and decisions concerning his/her life in the community; Provider Capacity and Capabilities: There are sufficient HCBS providers, and they possess/demonstrate the capability to effectively serve CAP participant; Participant Safeguards: CAP participant is safe and secure in their homes and communities, taking into account their informed and expressed choices; Participant Rights and Responsibilities: CAP participant receives support to exercise their rights and accept personal responsibilities; Participant Outcomes and Satisfaction: CAP participant is satisfied with his/her service and achieved desired outcomes; System Performance: The system supports CAP participant efficiently/effectively, and constantly strives to improve quality.

Organization Structure: NC Medicaid is the administrative authority and outlines the policies/procedures governing the waiver. SMA appoints local entities to provide the day-to-day operation of the waiver through case management services. Medicaid-approved entities are appointed by SMA and attest to following the rules and guidelines outlined in the Medicaid Enrollment Agreement and the clinical coverage policy specific to the waiver. This agreement will also outline remediation methods when non-compliance is identified and corrective action steps to include penalties and sanctions. Service Delivery methods: 1. The case management entity or designated entity shall submit the necessary paperwork (applicant consent and Physician's Worksheet) to the DHHS contractor to assist with initiating an HCBS referral to generate an SRF to determine the level of care eligibility for waiver enrollment consideration. The SRF establishes an initial level of care and is the first eligibility requirement in determining whether an applicant or waiver participant needs at least one waiver service according to the reasonable indication of need criteria.

The case management entity or designated assessors shall complete a comprehensive needs assessment on each applicant or waiver participant, when required, to determine medical, functional, and social determinants to plan for the assessed needs. The assessed needs are reviewed with the applicant or waiver participant. If the waiver participant or their legal representative accepts the findings of the assessment and agrees to freely enroll in the waiver program by an approved signature, waiver participation is approved. The initiation of the service plan begins. The service plan identifies waiver services and State Plan services in the amount, frequency, duration, and scope. The waiver services, along with other State Plan services, are documented in a service plan and plan of care (POC). The service plan specifies the person-centered goals, objectives, and formal and informal services to address the identified medical and functional care needs of an approved waiver participant. The services are documented in the POC, which are instrumental in mitigating the risks identified in the assessment. The CAP participant or legal representative accepts the person-centered service plan by signing the service plan. Upon the approval of the service plan, waiver services are authorized to be rendered.

The case management entity shall authorize selected providers according to the approved service plan through service authorizations.

An online business IT system called e-CAP provides the platform for the waiver Quality Framework in managing level of care, tasks of administrative authority, service plan, qualified providers, health and welfare, and financial accountability. The e-CAP system also provides the platform for this waiver's Critical Incident Reporting System through case management functions of assessing, planning, monitoring, linking, and follow-up as a safeguard for health, safety, and well-being.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, the state will gather data and submit the quality review in addition to any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 reports within 90 days up to 6 months of receiving the final quality review report and 372 report acceptance decision.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this

waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

Yes. This waiver provides participant direction opportunities. Appendix E is required.

No. This waiver does not provide participant direction opportunities. Appendix E is not required.

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in section 1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of section 1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

Not Applicable

No

Yes

C. Statewide. Indicate whether the state requests a waiver of the statewide requirements in section 1902(a)(1) of the Act (*select one*):

No

Yes

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Limited Implementation of Participant-Direction. A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.

Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR § 441.302, the state provides the following assurances to CMS:

- A. Health & Welfare:** The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the

waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of

care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

A written and electronic public notice was made available to stakeholders. A written draft of the waiver amendment was provided at all the local Department of Social Services across North Carolina to make available to the public. The waiver application was published electronically on multiple sites with the DHHS, the NC Medicaid State Plan webpages, the CAP/DA benefit plan page, NC Tracks (MMIS) webpage, and NC Medicaid's contracted Waiver IT contracted vendor website. An electronic copy of the Waiver was emailed to constituent stakeholder groups for publication and socialization.

The SMA announced the expiration of the CAP/C waiver in September 2020 to begin stakeholder engagement to facilitate the renewal of the waiver. All information about the waiver renewal steps and timeline was posted to the NC DHHS-DHB-CAP/C webpage for stakeholders to review and follow. A stakeholder meeting was convened in early 2021 to discuss the project plan to renew the waiver. This stakeholder meeting was used to solicit comments, feedback, and recommendations on efficiencies and other waiver services to address the needs of medically fragile children and solicit volunteers to participate in small work/discussion sessions. Small workgroups were convened, and the feedback/recommendations and comments from those groups assisted the SMA in identifying research areas for consideration to promote changes to the waiver as suggested by stakeholders.

After the small Work session, a statewide webinar was held where beneficiaries, family members, providers, and other interested parties were invited to hear the feedback, comments, and recommendation. One additional session was held specifically for the waiver participant and their family members to hear from that cohort of stakeholders. The feedback, suggestions, and comments received from all engagements were considered, and research was conducted to evaluate feasibility, comparability, and person-centeredness. The research was conducted in the areas listed below.

- Rate methodology change for services provided by a direct care worker
- Address the storage of direct care workers by permitting legally responsible persons to receive pay
- Increase accessibility to supportive waiver services to offer more options for modification to the home and vehicle and address other social determinants.
- Relax budget limit restriction for families with multiple children receiving CAP/C services for each child can have their own modification and respite budget.

From the research, the SMA was able to create definitions to incorporate two new waiver services, expand on other waiver services, and increase the rate methodology for services provided by direct care workers. A stakeholder engagement session was held to review the proposed changes and seek additional comments, feedback, and recommendations. From this engagement, the waiver application was drafted with the proposed changes and shared with stakeholder groups, including the Indian Nation.

The waiver was posted for public comment from August 12 - September 11, 2022. The comments were categorized by each waiver appendix and reviewed individually to determine its impact on the population and other sections within the waiver application—a response made to state if the waiver application would be updated. From the comments, Appendix C was updated to expand on the experience of the professional qualified to render the newly proposed services, Attendant Nurse Aide, and removing the reference to COVID-19 and replacing it with “highly infectious viruses classified by local or federal authorities. A summary of the comment is listed below. A complete listing of the comments and response can be found on the NC DHHS-DHB-CAP/C webpage; <https://medicaid.ncdhhs.gov/providers/programs-and-services/long-term-care/community-alternatives-program-children-capc>.

Appendix A

- Assurance case management entities can continue to perform annual assessments; see comments and the response from the SMA.
- Don't permit an LPN to become a case manager for waiver children.

Waiver Category: Appendix A - Administrative Authority

Public comment: We notice in the description of the CIAE process that the CIAE provider will perform reassessments. We had understood that this would not be the case, and strongly recommend that reassessments be left with case managers. Perhaps this is an inadvertent error in the application. Would you please review.

NC Medicaid proposed action to the comment: The renewed application identified an independent assessment entity that would conduct all initial assessments, and the case management entity would perform annual reassessments. The independent assessment entity may be asked to complete an annual assessment when applicable. No changes will be made to the waiver application.

Public comment: LPNs should not be allowed to be case managers. Case management is an advanced nursing/social work skill. I know of no other healthcare settings in which LPNs are allowed to be case managers. It should remain that only RNs or social workers are allowed to be case managers.

NC Medicaid proposed action to the comment: The waiver application permits a nurse with the required years of experience to assume the case manager role. No changes will be made to the waiver application.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The state assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the state assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Staton

First Name:

Betty

Title:

State Plan Manager

Agency:

NC Medicaid

Address:

2501 Mail Service Center

Address 2:

1985 Umstead Drive

City:

Raleigh

State:

North Carolina

Zip:

27699-2501

Phone:

(919) 527-7093

Ext:

TTY

Fax:

(919) 733-6608

E-mail:

betty.j.staton@dhhs.nc.gov

B. If applicable, the state operating agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: North Carolina

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the state's request to amend its approved waiver under section 1915(c) of the Social Security Act. The state affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The state further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The state certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:

Agency:

Address:

Address 1:

Address 2:

City:

State: **North Carolina**

Zip:

Phone: Ext: TTY

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.**
- Combining waivers.**
- Splitting one waiver into two waivers.**
- Eliminating a service.**
- Adding or decreasing an individual cost limit pertaining to eligibility.**
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- Reducing the unduplicated count of participants (Factor C).**
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and/or approved home- and community-based settings Statewide Transition Plan. The state will implement any CMCS required changes by the end of the transition period as outlined in the home- and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix B

Assurance that children who met the clinical definition to receive private duty nurse care who were not enrolled in the CAP/C waiver were not automatically enrolled in the waiver; see comments and the response from the SMA.

Waiver Category: Appendix B – Participant Count

Public comment: Unless these are new recipients, we are concerned that the Department is intending to transfer the majority of PDN recipients to consumer direction under Attendant Care Nurse under this waiver. In 2020, PDN served 1806 recipients, ½ of whom were children.

Recommendation: Please clarify that the Department is not intending shift the majority of PDN recipients to consumer direction. NC Medicaid proposed action to the comment: The Department does not intend to shift PDN recipients to the consumer direction. Children who qualify for enrollment in the CAP/C waiver will have the option to self-direct their care, similar to other children enrolled in the waiver. All qualifying conditions must be met for individuals at a nursing skill level of care to direct their care.

Appendix C

- Implement more flexible business rules for the newly proposed waiver services (Attendant Nurse Aide and Coordinate Caregiver) to include permitting a legally responsible person to be compensated for more than 40 hours per week
- Change the rate methodology for Coordinated Caregiving from a stipend to a 15-minute rate structure.
- Allowing a parent to be the paid caregiver for a child with skilled intervention when they don't meet the hiring requirements described in the hiring requirements.
- Cover 24/7 hours of care needs for waiver participant
- Expanding the budget on home and vehicle modifications
- Reduce the years of experience for qualified professionals in the newly proposed waiver services, Attendant Nurse Aide
- Not permitting skilled children to dire care because of a violation of the Nurse Practice Act

Waiver Category: Appendix C – Waiver Services: In-home aide/pediatric nurse aide

4 Public Comments: CNA services - application includes CD Lite language and covid exceptions which currently pays parents as CNAs at CNA rate PNA services - application does NOT include CD Lite language but does talk about parents being paid caregivers (why this discrepancy?)

Attendant Nurse Care - It also indicated parents can be paid through this service if they are RN/LPN but is this under coordinated caregiving? It doesn't specify this in this section.

NC Medicaid proposed action to the comment: This waiver renewal application supports the payment of a legally responsible person to be a paid caregiver when all qualifying conditions are met. The reimbursement methodology is through enrollment in a new waiver service called coordinated caregiving. This service pays the live-in legally responsible person a stipend to carry out the care needs of the waiver participant. No changes will be made to the waiver application.

Public comment: More than the current options of paycheck companies should be offered for Cd/CDL. The current ones have major issues and show little transparency when handling Medicaid money.

When using CDL why do parents need to choose between getting auth for their paycheck or getting auth for a medical item for their child? If it can take Medicaid up to 120 days for auth on some items, that means that parents go 120 days without pay. Do the people making these decisions have to wait 120 days for a paycheck when ordering something their child needs?

NC Medicaid proposed action to the comment: Changes will not be made to the waiver. Only qualified providers are approved to provide Medicaid services. Two vendors qualified to render fiscal intermediary services are approved in North Carolina. These agencies follow the guidelines of their Medicaid application and the CAP policies.

Public comment: Attendant care nursing: Please ask CMS for a workaround that would allow agency nursing under the waiver in addition to the consumer direct model so nurses have the option of which form of employment. This would allow nurses with less experience (less than the mandated 2000 or 1000 hours of work experience) or nurses who prefer not to work under consumer direct, to work under the agency model (under the waiver). Without moving the agency model under the waiver, and family will have to choose between consumer direct OR PDN due to duplication of services. This is done in several states and CMS could provide guidance on how the State plan would need to be altered to allow all the LTSS nursing to move under the waiver while still being EPSDT compliant. New grad nurses are a common source of recruiting but due to the hours of required, this removes this large employment pool. In order to retain and recruit experienced nurses, consumer direct is an extremely useful tool BUT if we also want to target new grads, we can't. There must be an option to use consumer direct and hire new grad nurses. Some of our very best home health nurses have been new grads. I speak as an RN. Thanks so much for considering this.

NC Medicaid proposed action to the comment: The service definition, limitations, and experience for these newly added services will not change. Due to the fragility of the CAP/C population and the independent work the hired nurse performs, knowledge and understanding of managing a crisis or unexpected medical event are essential to ensure the health and safety of the waiver participant.

Public comment: We support and agree with these limitations. We recommend the waiver address how appropriateness is determined and by whom.

Recommendation: The waiver application and the subsequent clinical policy governing consumer direction of Attendant Nurse should provide sufficient details and criteria by which appropriateness is evaluated and terminated.

NC Medicaid proposed action to the comment: No changes will be made to the waiver application. Under consumer direction, the waiver application must complete a self-assessment questionnaire and other documents to evaluate the appropriateness of self-direction with the case manager's support.

2 Public comments: Newly proposed waiver service – Coordinated Caregiving

Coordinated caregiving - This is how the state has said previously it intends to pay parents moving forward but language in the application indicates parents can be paid under each individual service, also, which would pay more than coordinated caregiving, so why would someone choose this? None of the individual services ever mention coordinated caregiving.

In the proposed changes for the CAPC Waiver, it is currently listed as is a daily rate, For CNA level of care, the rate is 41.93 per day for year 1. PNA is 63.55 per day. Neither of these rates are a livable income. In many areas of the state, it is extremely hard to find a willing nurse to hire AND harder to keep them. A livable income wage would insure stability for the patients and the families.

NC Medicaid proposed action to the comment: No changes to the waiver application will be made. The rate for coordinated caregiving was actuarially evaluated and in line with other Medicaid services.

Public comment: Attendant Nurse-care states: "Upon requesting a waiver participant to change their care from PDN to attendant nurse care through consumer-directed services, the PDN provider...must submit a request to end-date the prior approval for PDN services consistent with the transition plan." and "A live-in family member hired to render the care cannot be paid more than 40 hours per week."

****The idea that a family member gets paid 40 hours per week for the care that was provided by outside nurses for up to 112 hours/week will strain the family further than already happening. Yes, the caregiver will have income, but no other respite or care options will be offered to the families.

**Many families suffer financial constraints due to inability to maintain employment due to lack of consistent staff - and then parents are threatened with less nursing hours per week because they aren't working outside the home yet will never have enough nurses to cover their hours. Allowing a family member to be able to make money to do work that they are already doing, lessening the amount of outside nurses need to cover that patient, all facilitate the end goal of more nurses for patients at need and more families living in a functional place.

Recommendation: allow a mixture of paid parents who are licensed RN/LPN, consumer-direct nurses, and nursing agencies to fulfill the weekly allotment of hours.

NC Medicaid proposed action to the comment: The family will receive support about the option of waiver services to best meet their family's needs. No change will be made to the waiver application.

Public comment: **Inconsistencies for parents to not be required to be CNAs or PNAs if their child is aide level to be paid to care for their children but they are required to be RN/LPN if their child is nurse level. Nursing care isn't approved for 24 hrs. in a day, so parents/legal guardians are expected to be fully trained caregivers for the other hours not provided, whether they have an RN/LPN license or not so the state is acknowledging they are capable of doing the work. Would you please review these inconsistencies.

NC Medicaid proposed action to the comment: To ensure the health and well-being of a waiver participant who requires skill intervention, a licensed individual must be hired to render the care and can make quick judgments during a crisis or unexpected/unusual event. No changes will be made to the waiver application.

Appendix E

Public comment: Consumer Direct for unlicensed parents. This is a common occurrence now across the country which started during Covid and has now been made permanent nationally in many States. Many unlicensed parents are the sole caregivers of nurse level children due to the chronic shortage. Paying these parents doesn't make things more dangerous, in fact it very well may make things safer as stress would be relieved by having income and being able to pay bills. CAP/C only recipient families require no certifications to be paid caregivers (appendix K and draft waiver), yet nurse level parents are required to be an RN/LPN. States work around this in 2 ways: Some boards of nursing place the nurse practice act aside to allow families members to complete nurse level tasks (they are doing this anyway) and some states will pay families for the aide level tasks as not every task nurse complete is skilled.

NC Medicaid proposed action to the comment: To comply with the NC Board of Nursing, children who are determined to need skill care administered by a nurse must comply with the Nurse Practice Act. No changes will be made to the waiver application.

Public comment: Consumer-directed care: All participants in this waiver are eligible to direct their care using consumer-directed services, including children at a skill level consistent with private duty nursing care.

NC Medicaid proposed action to the comment: This waiver renewal application will permit three care options for waiver beneficiaries and their caregivers-provider-led, consumer direction, and coordinated caregiving services. No changes will be made to the waiver application.

Appendix G and H

Waiver Category – Appendix G – QIS

Public comment: Our consensus is that, overall, the waiver program is stronger and more responsive to clients' needs than it was

five years ago. We are grateful for the proposed 50% increase in slots, as well as the flexible approach to per capita limits. NC Medicaid proposed action to the comment: No changes will be made to the waiver application.

Waiver Category: Appendix H – Health and welfare

Public comment: We agree with the department’s recommendation for consistency on compliance and oversight. It is important to ensure the health and welfare of the waiver participant.

NC Medicaid proposed action to the comment: No changes will be made to the waiver application.

Appendix I and J

Rate increases for direct care workers

Increase the minimum wage for direct care workers to at least \$15.00/hr.

Change the rate methodology for the newly proposed service, Coordinated Caregiving.

Public comment: Coordinated caregiving rates - Caregivers have been forced to give up jobs and careers to stay home with their medically fragile child/children due to lack of available staffing, many of them single parents. We must pay them a living wage.

PNA caregivers would make the equivalent of \$11.12/hr. assuming a 40-hr. work week and a CNA caregiver would make the equivalent of \$7.34/hr. assuming a 40-hr. work week, which are both below the federal poverty guidelines. The state employee minimum wage of \$15/hr. should be the baseline. The General Assembly also recently recommended a \$15/hr. minimum.

NC Medicaid proposed action to the comment: The newly proposed service, coordinated caregiver, is a new service that pays a stipend to a live-in caregiver to support care needs as identified in a care plan. The Session Law encourages but does not mandate a minimum wage rate of \$15.00. No change will be made to the waiver application.

Public comment: Calculating inflation of 9.3% since the 2021 increase to \$45.00 per hour, the PDN rate would need to be \$49.30, simply to keep up.

- Without reimbursement rates that address inflation and wage disparities between home care, other healthcare setting, and other sectors, providers will continue to face these challenges even as the pandemic subsides.
- 81% of NC Voters feel it is important that people who want to be cared for at home, where they feel safest, have the option to do so. (Source: Morning Consult Poll, April 2022)

We appreciate the opportunity to comment on the waiver renewal application.

NC Medicaid proposed action to the comment: No changes will be made to the waiver application.

Public comment: In regard to the proposed changes to the CAPC Waiver, please consider updating the coordinated caregiver pay. It is currently listed as a daily rate. For CNA level of care, the rate is \$41.93 per day for year 1. PNA is \$63.55 per day.

Neither if these rates are a livable income and will make it incredibly hard, if not impossible, for families. Coordinated caregiver is the best option for many families, especially during a nursing shortage, where care is almost impossible to find.

NC Medicaid proposed action to the comment: No changes will be made to the waiver application. The rates included in the waiver application went actuarially evaluated.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

The waiver is operated by the state Medicaid agency.

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

The Medical Assistance Unit.

Specify the unit name:

NC Medicaid

(Do not complete item A-2)

Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.

Specify the division/unit name:

In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. (*Complete item A-2-b*).

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*

The CAP Business system will act as the State's business management system by using programmed algorithms to process entered data from level of care evaluations, comprehensive need assessments, and service plans. The system will also act as the quality assurance system to provide real time reports and data for:

- Waiver participant enrollment.
- Waiver enrollment against approved limits.
- Waiver expenditures managed against approved limits.
- Level of care evaluation and determination.
- Waiver participant service plans.

Critical incident and grievance management

The contracted entity will also be responsible for the following:

- **Real-time Dashboards:** These dashboards provide real-time data concerning the waiver population, allowing the state to monitor performance measures.
- **Service Request Form:** An electronic form that captures the necessary information required to properly evaluate an applicant's initial consideration for enrollment in the waiver. This includes a signed consent form from the applicant or waiver participant indicating their desire to be considered for waiver enrollment and a worksheet from their primary physician that identifies a functioning level that is consistent with an individual in an institutional placement.
- **Level of Care Assessment (LOC):** This electronic assessment takes the information provided in the Service Request Form (SRF) and assesses the applicant's ability to meet the level of care required for the CAP Waiver. Initial and annual assessments where the applicant does not meet the required level of care are reviewed by Registered Nurses (RN) at the SMA to mitigate potential errors in the information entered in the SRF.
- **Assessment of Service Needs:** This electronic assessment tool provides a platform for a comprehensive, person-centered assessment of the needs of each waiver participant. Additionally, as this assessment tool is hosted electronically, the state retains full access to both the assessment results and the information entered in the information entered in assessment tool.
- **Electronic Service Plan:** The results of the assessment provide direct input into the waiver participant's service plan, assuring that the waiver participant's service plan addresses the assessed needs.
- **Automated Tracking of Assessment Dates:** The CAP Business system automatically triggers a notice when each waiver participant approaches the anniversary of his or her previous assessment, assuring that each waiver participant is reassessed both for service needs and for LOC on an annual basis.
- **Monthly and Quarterly Reporting:** The CAP Business system vendor provides both monthly and quarterly reports in addition to the reports provided via the system dashboards. These reports provide the state with additional information to track program participation and identify issues, quickly.
- **Critical Incident Report System and Complaint and Grievance Management:** The CAP Business system provides access to the critical incident forms and workflow management to process the investigative steps.

The SMA is solely responsible for determining eligibility for all waiver participants; however, a contracted entity and local agencies assist the SMA with these administrative tasks. The contracted entity is an Independent Assessment Entity (IAE). The independent assessment entity will be responsible for gathering the health care information and coordinating with other health care professionals to assist the SMA to render a decision for level of care with the sole decision of LOC being made by the SMA. Additional administrative tasks the IAE will assist the SMA include:

- Validation of participant service plans completed by case management entity.
- Slot utilization management.
- Participant waiver enrollment.
- Waiver expenditures managed against approved limits.

Independent Assessment Entity (IAE) will:

1. Assist the SMA in conducting the comprehensive assessment that identifies applicant/waiver participant's risk factors in the following areas - medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational, and other areas.
2. Identify conditions and needs for risk mitigation.
3. Identify informal and paid supports such as family members, medical and behavioral health providers, and community resources to assess whole person care.
4. Analyze the current assessment, previous assessment, and other pertinent information in a multidisciplinary format to determine risk indicators, health and safety concerns, and potential services to mitigate risk factors.
5. Validate annual and change in status assessments completed by the case management entity to ensure that ongoing risk factors and current complexity of need are adequately met.

The appointed IAE's primary responsibilities are to perform initial eligibility decisions for waiver participation and annual quality assurance of the service plan.

The IAE will be required to:

1. Process a service request to initiate the evaluation process to determine level of care.
2. Complete comprehensive assessments to ascertain medical, psychosocial, and functional needs to identify a reasonable indication of need for waiver participation.
3. Coordinate and collaborate in a multidisciplinary team approach to decide of a reasonable indication for at least one waiver service that may prevent an institutional placement, maintain community placement or community integration.
4. Provide quality overview of the completed person-centered service plan to validate the service are authorized and being provided in the amount, duration, and frequency of the approved service plan.

The MMIS vendor under contract with the State Medicaid Agency, provides for the Medicaid management of the waiver to include prior approval, claim reimbursement, provider enrollment, rate utilization management, and waiver expenditures managed against approved limits.

No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).

Appendix A: Waiver Administration and Operation

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

Not applicable

Applicable - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

Local/Regional non-state public agencies perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

To ensure compliance with the waiver regulations, the SMA utilizes agencies with HCBS experience, proven in the community, and have resources to provide specific administrative functions in assessment and case management and insight in how to ensure the six waiver assurances. The agencies are referred to as case management entities (CMEs). The CME accepts designated administrative roles and agrees to work collaboratively with the SMA in the execution of the waiver authorized through a Medicaid application managed change request to render waiver services. The CME's primary responsibilities are to ensure the safety and well-being of waiver participants through case management services of assessing, care planning, monitoring, and follow-up. The CME must regularly evaluate their case management practices for continuous quality improvement.

A qualified provider guideline is posted on the NC Medicaid website to ensure a provider network to perform case management for waiver participants. At any time, an agency can submit a proposal to become a CME. Each CME must meet a provider qualification threshold that demonstrates experience in HCBS. The provider must be enrolled as a Medicaid provider and approved to provide services under waiver taxonomy. The agency must provide case management services by a nurse and social worker/human service professional. The CME must demonstrate through evidence of past experiences, policy implementation and financial solvency working with medically fragile, complex children. The interested CME must have at least two consecutive years of providing services to medically fragile-complex children; extensive knowledge of community resources to carry out case management activities; care coordination and qualified staff to ensure an appropriate case mix and caseload management. The CME must have access to web-based automation. The CME must show fiscal soundness of Medicaid funds and have financial reserves up to \$80,000 per waiver year.

The core functions of the CME is 1. initiate a referral to assist with generating an SRF to begin the establishment of a level of care for consideration of waiver enrollment. 2. Complete an annual comprehensive assessment to ascertain medical, psychosocial, and functional needs for waiver participation. 3. Coordinate and collaborate in a multidisciplinary team approach to assist with diverting institutionalization. 4. Develop a person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration, and frequency. The SMA approves the SP. 5. Conduct monthly monitoring of the service plan with participant and quarterly monitoring with all approved service providers. 6. Create a more frequent monitoring plan for waiver participants who has high-risk indicators scores. 7. Closely monitor incidents and create a risk mitigation plan when necessary.

The CME is also responsible for other day-to-day case management needs as described below:

- Providing written authorization to the local Department of Social Services and service providers for approval/participation in the waiver.
- Ensuring each waiver participant/primary caregiver has exercised his/her freedom of choice among waiver services/providers.
- Conducting monthly monitoring of the service plan with waiver participant to ensure safe community living.
- Initiating Due Process tasks, specific to the CME's role, when an adverse decision is made and coordinate with waiver participant, providers, and due process vendor.
- Providing feedback, when requested, in verifying whether medical documentation supports nursing facility level of care.
- Mitigating risk when a referral is made to Children Protective Services.
- Providing monthly and quarterly case management/care advisement to the waiver participant. A child with a high-risk indicator score as identified in a completed assessment must have a face-to-face visit every two months and monthly multidisciplinary team meetings.
- Assessing the effectiveness of hands-on personal care provided to the waiver participant.
- Holding a quarterly multidisciplinary treatment team (MDT) meeting with providers listed in the POC to review the provision of and continued appropriateness of the service plan.
- Documenting, monthly, the status of medical, functional, and psychosocial changes in the e-CAP system to be eligible to receive reimbursement for case management services.
- Reviewing quality assurance reports monthly to remedy any identified issues.
- Contacting the waiver participant/responsible party following the construction/installation of home modifications to confirm the modifications safely meet the waiver participant's needs.
- Contacting the waiver participant/responsible party within 48 hours of learned discharge from a hospital/rehabilitation/nursing facility to assess health status and changes in needs.
- Ensuring that services offered to a waiver participant do not duplicate other services.
- Assisting with coordinating informal resources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal supports.
- Ensuring that the policies/procedures of the waiver are upheld and executed to maintain the health/well-being

of the waiver participant.

- Ensuring that waiver participant is aware of his/her rights to select from among enrolled service providers and choose waiver services of his/her choice that align with assessed needs.

To ensure compliance with regulations, SMA utilizes agencies with HCBS experience, proven in the community and have the resources/capacity to provide specific administrative functions in assessment, case management and care coordination, and insight on how to ensure the six waiver assurances through case management activities.

Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

To ensure compliance with the waiver regulations, the SMA utilizes agencies with HCBS experience, proven in the community, and have resources to provide specific administrative functions in assessment and case management and insight in how to ensure the six waiver assurances. The agencies are referred to as case management entities (CMEs). The CME accepts designated administrative roles and agrees to work collaboratively with the SMA in the execution of the waiver authorized through a Medicaid application managed change request to render waiver services. The CME's primary responsibilities are to ensure the safety and well-being of waiver participants through case management services of assessing, care planning, monitoring, and follow-up. The CME must regularly evaluate their case management practices for continuous quality improvement.

A qualified provider guideline is posted on the NC Medicaid website to ensure a provider network to perform case management for waiver participants. At any time, an agency can submit a proposal to become a CME. Each CME must meet a provider qualification threshold that demonstrates experience in HCBS. The provider must be enrolled as a Medicaid provider and approved to provide services under waiver taxonomy. The agency must provide case management services by a nurse and social worker/human service professional. The CME must demonstrate through evidence of past experiences, policy implementation and financial solvency working with medically fragile, complex children. The interested CME must have at least two consecutive years of providing services to medically fragile-complex children; extensive knowledge of community resources to carry out case management activities; care coordination and qualified staff to ensure an appropriate case mix and caseload management. The CME must have access to web-based automation. The CME must show fiscal soundness of Medicaid funds and have financial reserves up to \$80,000 per waiver year.

The core functions of the CME is 1. initiate a referral to assist with generating an SRF to begin the establishment of a level of care for consideration of waiver enrollment. 2. Complete an annual comprehensive assessment to ascertain medical, psychosocial, and functional needs for waiver participation. 3. Coordinate and collaborate in a multidisciplinary team approach to assist with diverting institutionalization. 4. Develop a person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration, and frequency. The SMA approves the SP. 5. Conduct monthly monitoring of the service plan with participant and quarterly monitoring with all approved service providers. 6. Create a more frequent monitoring plan for waiver participants who has high-risk indicators scores. 7. Closely monitor incidents and create a risk mitigation plan when necessary.

The CME is also responsible for other day-to-day case management needs as described below:

- Providing written authorization to the local Department of Social Services and service providers for approval/participation in the waiver.
- Ensuring each waiver participant/primary caregiver has exercised his/her freedom of choice among waiver services/providers.
- Conducting monthly monitoring of the service plan with waiver participant to ensure safe community living.
- Initiating Due Process tasks, specific to the CME's role, when an adverse decision is made and coordinate with waiver participant, providers, and due process vendor.
- Providing feedback, when requested, in verifying whether medical documentation supports nursing facility level of care.
- Mitigating risk when a referral is made to Children Protective Services.
- Providing monthly and quarterly case management/care advisement to the waiver participant. A child with a high-risk indicator score as identified in a completed assessment must have a face-to-face visit every two months and monthly multidisciplinary team meetings.
- Assessing the effectiveness of hands-on personal care provided to the waiver participant.
- Holding a quarterly multidisciplinary treatment team (MDT) meeting with providers listed in the POC to review the provision of and continued appropriateness of the service plan.
- Documenting, monthly, the status of medical, functional, and psychosocial changes in the e-CAP system to be eligible to receive reimbursement for case management services.
- Reviewing quality assurance reports monthly to remedy any identified issues.
- Contacting the waiver participant/responsible party following the construction/installation of home modifications to confirm the modifications safely meet the waiver participant's needs.
- Contacting the waiver participant/responsible party within 48 hours of learned discharge from a hospital/rehabilitation/nursing facility to assess health status and changes in needs.
- Ensuring that services offered to a waiver participant do not duplicate other services.
- Assisting with coordinating informal resources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal supports.
- Ensuring that the policies/procedures of the waiver are upheld and executed to maintain the health/well-being

of the waiver participant.

- Ensuring that waiver participant is aware of his/her rights to select from among enrolled service providers and choose waiver services of his/her choice that align with assessed needs.

To ensure compliance with regulations, SMA utilizes agencies with HCBS experience, proven in the community and have the resources/capacity to provide specific administrative functions in assessment, case management and care coordination, and insight on how to ensure the six waiver assurances through case management activities.

Appendix A: Waiver Administration and Operation

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The State Medicaid Agency is responsible for assessing the performance of the contracted entity, local/regional non-state entities and local/regional non-governmental non-state entity. The case management entities-(hospitals, DSSs, local health departments, case management agencies, Home Health Agencies, or federally recognized Tribes) will be monitored on a monthly basis to ensure compliance of the six waiver assurances and its associated performance measures. Each case management entity will be required to maintain a 90% compliance rate. The CAP Business system will provide the State Medicaid Agency monthly data reports in the timeliness and accuracy to policy in the areas of level of care, service plan, qualified provider, financial accountability, health and welfare and administrative authority. On a quarterly basis, the cumulative score will be aggregated to evaluate the performance of all appointed case management entities.

The Medicaid agency uses a representative sample when reviewing case management entities compliance rate. The representative sample consists of .95 confidence interval with a margin of error at 5%. The monitoring of these entities will be achieved through the objectives and benchmarks described in the assurances and performance measures. The State Medicaid Agency will conduct a quarterly evaluation of the performance of each entity through data analysis and compliance and satisfaction surveys. The data analysis will inform if each entity is meeting its established benchmarks and objectives and the quality assurance of the waiver. Each entity must maintain at least a 90% compliance rate of waiver processes that include waiver eligibility, waiver utilization limits and claim reimbursement.

Each appointed case management entity is required to maintain a compliance rate of 90% at each quarterly assessment. Each month, a compliance score will be generated to inform each case management entity areas of noncompliance to allow for improvement. Technical assistance will be provided to the case management entity during each month of non-compliance and at each quarter if the score is below 90%. The case management entity will be allowed to perform, under a corrective action plan, at less than 90% for a total of two consecutive quarters before a decision is made to rescind their case management appointment. During this time span, NC Medicaid will provide technical assistance to assist with quality improvement of noncompliant performances. If after the two quarters of technical support (corrective action plan), the score remains below the 90% threshold, NC Medicaid will notify the case management entity that within 60 days their case management entity appointment will be rescinded. A case management entity network assessment will be conducted to identify gaps in service provisions for impacted waiver participants. NC Medicaid will provide close oversight and technical assistance to the relinquishing case management entity to ensure the health and safety of each impacted waiver participant.

A case management entity may submit a request to render case management services. A packet that includes documented experience, staffing and fiscal soundness is required for consideration of appointment as a CME. Each entity may be approved if qualifying conditions are met.

The State Medicaid Agency will monitor quarterly the accessibility and usability of the NC Medicaid MMIS system to ensure claims are processing per waiver business rules.

NC Medicaid will monitor the performance and usability of the CAP Business System on a monthly basis. A monthly assessment will be conducted to determine if the case management business system in the areas of waiver entrance, eligibility, assessed needs, utilization limits and health and welfare are functioning per the scope of work and established timelines. Noncompliance area(s) are brought to the attention of the CME through a quality improvement plan to assist in remediating the issue quickly. Conference calls and work sessions are scheduled to discuss the issue and identify the steps of the quality improvement plan. A corrective action plan is implemented when work sessions are not correcting the issue. If noncompliance areas cannot be remediated within a three-month time span, fines and penalties will be imposed. If the non-compliance area(s) span over six months and cannot be remediated, a recommendation will be made to terminate the contract.

Appendix A: Waiver Administration and Operation

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The State Medicaid Agency assesses the performances of all appointed entities through monthly data analysis, quarterly quality assurance audits, and waiver year-end audits. The monitoring of those entities is achieved through the objectives and benchmarks outlined in the clinical coverage policy. Each entity must maintain at least a 90% compliance rating of waiver processes such as waiver eligibility, service plan development, waiver utilization limits, and claim reimbursement. The waiver program has a waiver management processing system that tracks compliance and performance rates to policies and regulations associated with entities' operational and administrative functions. The waiver management processing system is set up into distinct modules (referrals, reviews, notifications, and monitoring) that align with the operational and administrative functions. Scoring and monitoring algorithms are programmed in each module to track the timeliness and required workflow tasks for each operational and administrative function under each module. Data mining for each waiver participant is used to identify the responsiveness to timeliness and required workflow tasks for each operational and administrative function performed by the contracted, local/regional, and non-state entity. The data collected through the data mining process is analyzed using analytics in which real-time reports are created to show the compliance and performance rates for each contracted, local/regional, and non-state entity. In addition to these reports, assessment performance is determined from beneficiary and provider complaints and billing issues.

The State Medicaid Agency conducts a quarterly evaluation of the performance of each entity using the data from each report. During these reviews, the SMA focuses closely on compliance in the following areas:

Participant waiver enrollment – was the business system available to allow the submission of referrals; were referrals submitted with the required data points; were referral documents completed timely and correctly and moved to the next workflow steps; were workflows closed out timely and correctly, were notification letters prompted and provided to the interested applicant accurately and timely; and is there documentation uploaded to show the individual selected to enroll in the waiver program before services are authorized.

Waiver enrollment managed against approved limits – were assessments queued for the initiation of the assessment and sent to the authorized agency correctly and timely, were assessment documents made accessible and timely for the completion of the assessment within the designated timeframe; were the request for additional information received timely and correctly; are slot being filled timely when slots are vacant; were the timelines met and workflows closed out correctly

Waiver expenditures managed against approved limits – were service limits listed correctly on the POCs, were providers notified timely of the approved services and associated limits; were plans of care/service plans completed timely to show expenditure limits

Review of participant service plan – was the service plan development queue available to the user; were the service plans completed within 30 days of the requested date, were the services listed in the amount, frequency, and duration, was there a freedom of choice selection form uploaded in the beneficiary's file, was there a service authorization that authorizes the selected provider

Prior authorization of waiver services – was there an uploaded freedom of choice provider form in the beneficiary's record, did the provider acknowledge the ability to render the service to the beneficiary, was a PA segment for the authorized service in the amount, frequency, and duration on file

Utilization management - were monthly and quarterly visits held with the waiver participant and service providers to monitor service utilization

Qualified provider enrollment – were the freedom of choice providers approved to render Medicaid services; are providers accepting the service authorization to render services within the specific approval period within the designated timeframe; are providers trained to render the authorized services

A compliance rating under 90% is identified as being out of compliance with the objectives and benchmarks of the waiver. Upon identifying a low performing contracted and local/regional non-state entity, the impacted entity(ies) is notified of the low compliance rating. The entity is requested to develop a corrective action plan to promote future performances at the required performance rating. The SMA works closely with the entity to remediate back to 90%.

Methods that are used to support the contracted and local/regional non-state entity to remediate to the required benchmark include the tasks listed below:

1. A refresher training in the non-compliant area.
2. Weekly technical support from a member of the waiver support team.
3. Weekly monitoring of work performances through data reports from the case management system.

These technical support activities continue until the entity performs at the required level. During the corrective action period, random samples of workflow tasks are collected and reviewed carefully to offer feedback and additional technical guidance as needed.

The appointed case management entities' primary responsibilities are to ensure waiver practices and there is continuous quality improvement of case management practices. Public local agencies such as the departments of social services,

public health agencies, hospitals, case management agencies and home health organizations that have experience in serving this target population are able to act in the capacity of an appointed case management entity by NC Medicaid. Guidance on how to become a qualified case management provider is posted on the NC Medicaid website. An interested provider may submit a case management provider packet to become a CME at any time. The interested provider must identify their preferred service area. The case management provider guidance lists the required credentials to become an appointed case management entity. Each organization must meet a threshold in order to be appointed. The required threshold consists of:

The selected agency must be currently enrolled as a Medicaid provider and approved to provide services under In-Home Services and Supports. The agency must be capable of providing case management by both nursing and social work staff. The agency shall also meet the below criteria:

- a. Demonstrated experience with pediatric and medically fragile-complex children.
- b. Demonstrated experience in home and community care case management.
- c. Demonstrated capacity of web-based automation.
- d. Demonstrated experienced staff to assure case mix and caseload management.
- e. Demonstrated fiscal soundness, on-hand, and reserve resources.

The selected agency shall be able to:

- a. Process a referral to assist with determination of a level of care.
- b. Complete comprehensive assessments to ascertain medical, psychosocial, and functional needs to aid in identifying a reasonable indication of need for waiver participation.
- c. Coordinate and collaborate in a multidisciplinary team approach for the provision of waiver services that prevent institutionalization.
- d. Develop a person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration, and frequency.
- e. Conduct monthly monitoring of the service plan with participant and quarterly monitoring with all approved service providers.
- f. Complete initial trainings and annual trainings.
- g. Maintain standards set by the State Medicaid agency for timely reassessments of qualifications.
- h. Provide privacy and security of all personal health information and electronic personal health information.

On a quarterly basis, a cumulative score will be aggregated to evaluate the performance of all appointed case management entities.

Medicaid providers of waiver services will be monitored on an annually through waiver paid claims and participant’s complaints and feedback.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment			
Waiver enrollment managed against approved limits			
Waiver expenditures managed against approved levels			
Level of care waiver eligibility evaluation			
Review of Participant service plans			
Prior authorization of waiver services			

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Utilization management			
Qualified provider enrollment			
Execution of Medicaid provider agreements			
Establishment of a statewide rate methodology			
Rules, policies, procedures and information development governing the waiver program			
Quality assurance and quality improvement activities			

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Administrative Authority

The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

AA-1 Number and percent of annual recertifications processed and completed for waiver participants by contracted vendors and local agencies within the specified timeframe.

Numerator: number of annual recertifications processed and completed by contracted vendors and local agencies for waiver participant within the specified timeframe

Denominator: number of annual recertifications

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business management system, contracted vendors and local agencies and NC Medicaid MMIS

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% 5% margin
Other Specify: CAP Business system, contracted vendors SOW and local agencies' files and NC Medicaid MMIS	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: CAP Business system and contracted vendor SOW	Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

AA-2 Number and percent of new referrals that were processed and completed by contracted vendors and local agencies within specified timeline. Numerator: number new referrals that were processed and completed by contracted vendors and local agencies within specified timeline Denominator: number new referrals processed and completed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system,contracted vendor SOW and local agencies' files.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% margin of error"/>
Other Specify: <input type="text" value="CAP Business System case management system contracted vendor SOW and local agencies' files"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/> CAP Business system and contracted vendor SOW	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

AA-3 #/% of contracted vendors/local agencies that participated in quarterly QIS identified by SMA and had a favorable outcome as intended by the SMA. Numerator: # contracted vendors/local agencies that participated in quarterly QIS identified by SMA and had a favorable outcome as intended by the SMA. Denominator: number of contracted vendors/local agencies

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = 95% 5% margin of error
Other Specify: CAP Business System case management system	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: CAP Business system	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

AA-4 Number/percent of contract vendors and CMEs that maintained an average

workflow performance score of 90% for each waiver year. Numerator: contract vendors and CMEs that maintained an average workflow performance score of 90% for each waiver year Denominator: number of contracted vendors and CMEs with an average workflow performance score of 90%

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% 5% margin of error
Other Specify: CAP Business System case management system	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
Sub-State Entity	Quarterly
Other Specify: <div data-bbox="323 416 748 499" style="border: 1px solid black; height: 37px; width: 266px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div data-bbox="820 703 1243 786" style="border: 1px solid black; height: 37px; width: 265px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

Contracted vendors and local agencies are assigned to assist with the management of administrative authority functions of the waiver. These entities must carry out their roles and responsibilities while ensuring continuous quality assurances and improvement of the waiver.

The contracted vendors are responsible for ensuring enrollments are conducted per the clinical coverage policy and within the approved limits. The case management entities ensure the effective management of waiver participants while ensuring participant enrollment; waiver enrollment managed against approved limits, the annual level of care evaluations, completion and management of the service plan, and quality assurance and improvement activities. Because these agencies provide the day-to-day oversight of the waiver program, they must meet additional thresholds that validate readiness and ability to provide oversight of the waiver program at the local level.

Although the case management entity plays a critical role in the enrollments, all waiver participants are offered the freedom to choose a CME initially, annually, and as needed.

Participant rights and freedom of choice are explained upon approval for waiver participation. A list of CMEs in their catchment area is offered to each waiver participant for their selection.

NC Medicaid uses a case management business system to evaluate all waiver participants/provider agencies in the processing/performance of waiver activities. To validate the efficiency and capacity of the CAP Business system programmed to support NC Medicaid administrative operations, the sampling methodology will be 100% for each waiver year to ensure processes and benchmarks are working as designed.

The CAP Business system has a quality improvement system for the following:

- Program participation –tracks the waiver enrollment date to ensure annual reassessments are performed in a timely manner by sending alerts to the assigned case manager two months before the due date. The system also checks for a level of care determination, a consent form, and a freedom of choice notice before approving waiver participation.
- Waiver entrance- validates medical and functional status are consistent with the nursing facility of care through the approval of a service request form (SRF). When the level of care is met and a waiver slot is available, the CAP Business system places the SRF in the assignment assessment queue to prepare for the next phase of the waiver entrance (comprehensive assessment) process. Information from the SRF is auto-populated through a method of prompted questions to ensure all medical, functional, behavioral, and social needs were holistically assessed. Key risk factors from the assessment auto-populate the service plan to plan for all identified needs.
- Utilization management- stores all service plans and their associated budget limits to ensure the waiver is cost-neutral and does not exceed the established average per capita cost. The CAP Business system places service utilization limits on all waiver services authorized by the CME to prevent overutilization. The placement of utilization limits ensures a 100% compliance rate of claim reimbursement. Thus, allowing waiver services to be paid in the amount, frequency, and duration as planned in the service plan. These limits ensure services do not exceed the service plan and are not reimbursed before the effective date. The Business system has the capacity to run real-time data analytic reports daily for the purpose of claims analysis that allows for quick remediation if needed.
- Quality Improvement System- has a robust QIS through data analytics that is real-time. The data report allows real-time

discovery and quick remediation when required. Desktop audits can be performed immediately to evaluate the rate of compliance with waiver practices.

As a safeguard to ensure compliance to waiver policies and practices and to ensure established benchmarks are met monthly, every quarter, an analysis of the case management entity’s performance will be conducted.

The contracted vendor and the local agencies will be evaluated quarterly against waiver QIS. A scorecard will be generated through a Business system reviewed monthly by the State Medicaid Agency to ensure compliance with waiver assurances and associated performance measures. Each quarter, the cumulative results will inform waiver compliance and the need for remediation. Continuous failure to comply with waiver assurances will result in fines, penalties, or termination.

- A score of 90 and better, the case management entity will be rated an A organization.
- A score of 89 or less, the case management entity will be rated a B organization.
- A score less than 89, the case management entity is in jeopardy of termination.

Each contracted vendor and local agency must maintain an average compliance score of 90% each waiver year, calculated each quarter. The dashboard for the waiver will be updated quarterly with the accumulative scores and other performance and utilization data.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The State Medicaid Agency has several safeguards to discover/identify problems/issues within the waiver program when appointed entities are performing administrative functions. The State Medicaid Agency has appointed contractor vendors and local agencies to perform tasks of participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved limits level of care evaluation; review of waiver participant service plan; prior authorization of waiver services; utilization management; Quality assurance and quality improvement activities.

Upon discovering non-compliance for any one of these entities, the State Medicaid Agency notifies the entity of the non-compliant area and requests a corrective action plan to correct the non-compliant area. Technical assistance and/or training on policies and procedures are provided. State Medicaid Agency approves the corrective action plan and follows up with the entity to ensure the corrective action plan (remediation plan) is completed. If warranted by persistent non-compliance (more than two occurrences of the same area), sanctions are enforced for no more than 60-days. If remediation efforts cannot be achieved within 60 days, an additional action plan is implemented. The SMA ensures the health and safety of waiver participants during a corrective action or action plan. If remediation efforts cannot reach after repeated remediation steps, a recommendation will be made to dissolve the interest of the said entity. A transition plan will be implemented to reduce access to care and mitigation of health, safety, and well-being.

Upon discovering non-compliance for the CAP IT vendor, the State Medicaid Agency notifies the IT vendor of the non-compliant area(s), requests a corrective action plan to correct the non-compliant area(s), and provides technical assistance/or training on policies and procedures. The State Medicaid Agency approves the corrective action plan (remediation plan) and follows up with the IT vendor to ensure the corrective action plan is completed. If warranted by persistent non-compliance, civil financial penalties are enforced. If consistent noncompliant performance exists, a recommendation will be made to terminate the contract. A transitional plan would be developed before the termination of the contract to ensure the health and safety of waiver participants.

Upon discovering non-compliant area(s) exhibited by waiver Medicaid providers, the State Medicaid Agency Program Integrity Unit will investigate and impose a sanction, if necessary, based on the severity of the incident. A recommendation may be made for the action of closure or civil fines.

Upon discovery of non-compliant area(s) for the fiscal intermediary for consumer-directed services, The State Medicaid Agency notifies the FMS of the non-compliant area(s) and requests a corrective action plan to correct the non-compliant area(s). Technical assistance and/or training on policies and procedures are provided. The State Medicaid Agency approves the corrective action plan (remediation plan) and follows up with the FMS to ensure the corrective action plan is complete. If persistent non-compliance continues to exist, action will be made to dissolve that entity as an FMS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR § 441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - General					
		Aged	<input type="text"/>	<input type="text"/>	
		Disabled (Physical)	<input type="text"/>	<input type="text"/>	
		Disabled (Other)	<input type="text"/>	<input type="text"/>	
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury	<input type="text"/>	<input type="text"/>	
		HIV/AIDS	<input type="text"/>	<input type="text"/>	
		Medically Fragile	0	20	
		Technology Dependent	<input type="text"/>	<input type="text"/>	

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Intellectual Disability or Developmental Disability, or Both					
		Autism		<input type="checkbox"/>	<input type="checkbox"/>
		Developmental Disability		<input type="checkbox"/>	<input type="checkbox"/>
		Intellectual Disability		<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness					
		Mental Illness		<input type="checkbox"/>	<input type="checkbox"/>
		Serious Emotional Disturbance		<input type="checkbox"/>	<input type="checkbox"/>

b. Additional Criteria. The state further specifies its target group(s) as follows:

Each waiver participant must meet an established nursing facility LOC to meet the waiver entrance criteria. When LOC is determined, the result of the comprehensive assessment identifies the acuity level of need. The individual cost limit is based on a combination of both nursing facility and hospital level of care.

The definition for medical fragility include the following:

A. A medically fragile individual 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 months.

B. The individual’s chronic medical condition:

1. Requires medically necessary ongoing specialized treatments or interventions (treatments or interventions that are supervised or delegated by a physician or registered nurse) without which will likely result in a hospitalization; or
2. Resulted in at least four (4) exacerbations of the chronic medical condition requiring urgent/emergent physician-provided care within the previous 12 months; or
3. Required at least one inpatient hospitalization of more than 10 calendar-days within the previous 12 months; or
4. Required at least three inpatient hospitalizations with the previous 12 months; and

C. The individual chronic medical condition:

1. Requires the use of life-sustaining device(s); or
2. Requires life-sustaining hands-on assistance to compensate for the loss of bodily function; or
3. Requires non-age-appropriate hands-on assistance to prevent deterioration of the chronic medical condition that may result in the likelihood of an inpatient hospitalization.

Meet the minimum requirement for HCBS nursing facility LOC criteria approved by SMA prior to participation in the CAP program, refer to Appendix B-6-c.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

Not applicable. There is no maximum age limit

The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

The case management entity shall assist a waiver participant three calendar months prior to his or her 18th birthday, with coordinating with the local DSS to identify any needed changes to the Medicaid application and to initiate the discussion of an adult transition plan in anticipation of the 21st birthday.

The (CME) shall assist a waiver participant at age 20 to develop an adult transition plan in anticipation of the aging out of this waiver at 12:00 am of the 21st birthday.

For a waiver participant aging out of this waiver and wishing to transfer to an adult waiver or another comparable waiver:

1. The CME designee shall implement a transition, transfer plan 12 calendar months prior to the birth month. These coordination activities are:
 - A. Completion of a transition plan during the annual needs review assessment that occurs at age 20;
 - B. Consultation with the waiver participant and primary caregiver to educate about other Medicaid and community resources to meet needs when turning 21 years of age.
2. Three months (90 calendar days) prior to the birth or identified transfer month, a multidisciplinary team meeting must convene to discuss care needs and to ensure the identified formal and informal resources are able to meet care needs
3. The month prior to the birth month, the local DSS shall be notified of the need to change the CAP evidence indicator for CAP/C participation for the identified adult waiver effective start date.
4. On the first day of the birth or identified transfer month, waiver services are authorized and provided to the waiver participant.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

No Cost Limit. The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

Cost Limit in Excess of Institutional Costs. The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

The limit specified by the state is (*select one*)

A level higher than 100% of the institutional average.

Specify the percentage:

Other

Specify:

Institutional Cost Limit. Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is (*select one*):

The following dollar amount:

Specify dollar amount:

The dollar amount (*select one*)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The data elements retrieved from the service request form and the comprehensive assessment provide assurances of ability to meet the waiver participant's needs within the average cost limits of the waiver. Participant's medical, functional, behavioral, mental, and social information will be assessed utilizing a screening tool (Service Request Form). This screening tool will establish assist with the determination of LOC. This screening tool provides for a comprehensive medical overview and information to help determine intensity of support needs as well as risk factors that may impede health, safety, and well-being. This screening tool has a built-in smart logic mechanism that auto-fills the assessment to reduce data entry errors.

A multidisciplinary comprehensive needs assessment is conducted by case management entity's social worker and registered nurse initially and annually on each waiver participant to determine medical, functional, and social determinants to plan for all the waiver participant's assessed needs to assure health, safety, and well-being. The multidisciplinary comprehensive assessment addresses the following areas to assure health, safety and well-being can be maintained within the cost limit:

- a. Personal health information;
- b. Caregiver information;
- c. Medical diagnoses;
- d. Medication and precautions;
- e. Skin;
- f. Neurological;
- g. Sensory and communication;
- h. Pain;
- i. Musculoskeletal;
- j. Cardio-Respiratory;
- k. Nutritional;
- l. Elimination;
- m. Mental Health;
- n. Informal support; and
- o. Housing and finances.

The individual cost limit is a combination of nursing facility and hospital level of care.

The assessment has a scoring logic which yields acuity of care needs. There are two levels of needs that an individual is categorized: high (skilled-hospital), medium and low.

If waiver enrollment is denied due to needs cannot be safely met under the waiver, when all resources are explored and exhausted, referrals to other services are made and the waiver participant is offered due process rights. After admission to the waiver, QA related to health, safety and well-being are performed by the case management entity and NC Medicaid. Program growth will be closely monitored by the Medicaid agency to determine need for a waitlist or amendment to the waiver to increase the number of unduplicated waiver participants to be served based on State budgetary limits.

- c. Participant Safeguards.** When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

The participant is referred to another waiver that can accommodate the individual's needs.

Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Each waiver participant is assigned an acuity level based on their assessed needs. The results of the acuity level identifies utilization of waiver services to ensure health and safety and the capita cost for each waiver participant. As an additional safeguard, each waiver participant is required to implement an emergency back-up plan. An emergency back-up plan is the provision for alternative arrangements for the delivery of services that are critical to a waiver participant's well-being. In the even the formal supports are temporarily unavailable, or the services are at its maximum limits due to a change of status, the emergency back-up plan is activated along with an over per average capita cost transition plan. The over average capita cost transition plan consist of: The wavier participant being granted up to five months to align within the established average capita cost. Every opportunity will be utilized such as annual proration of service(s) or intervention from community resources before a decision is made to disenroll the waiver participant. The waiver participant will be carefully transition in a coordinated process to other community resources with the support of informal caregivers to avert placement in an institution if the average capita cost of care cannot align within the planned over average capita cost planning period.

To further assist in augmenting waiver utilization limits due to a change in status, each waiver participant is allowed to practice assumed risk through an individual risk agreement. An individual risk agreement outlines the risks and benefits to the waiver participant of a particular course of action that might involve risk to the waiver participant, the conditions under which the waiver participant assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement allows a waiver participant or responsible party to assume responsibility for his or her personal choices, through surrogate decision makers, or through planning team consensus. This practice promotes continuous participation in the waiver.

Monthly, the assigned case manager or care advisor will assess the participant's needs and service provision to assure health, safety and well-being are maintained within the waiver average cost limit. Every three months, the case manager or care advisors is required to conduct a home visit to observe hand-on assistance of service to ensure amount, frequency and duration are sufficient to needs and health, safety and well-being are able to be maintained. Upon discovery or by request, adjustments are made to the POC or acuity level. The case manager or care advisor must review supporting documentations to determine the need for a reassessment to determine a change in the participant's level of acuity. A reassessment is performed within 30 days of the request or discovery to review personal health information; caregiver information; medical diagnoses; medication and precautions; skin; neurological; sensory and communication; pain; musculoskeletal; cardio-respiratory; nutrition; elimination; mental health; informal support; and housing and finances to identify medical, functional, and social needs. The new assessment is scored through the scoring algorithm that determines the level of acuity. The participant's POC is planned based on the identified acuity level identified in the reassessment. If participant is not in agreement with the results of the reassessment, an appeal can be requested by the participant/responsible care giver

After admission to the waiver, QA activities related to health, safety and well-being and cost limits are performed by the CAP Business system and case management entities, and NC Medicaid for continuous quality improvement.

The case manager or care advisor corresponds with the participant and service providers within 30-days of the change in the participant's condition to identify an alternative care plan to meet the participant's current needs. A reassessment of needs is performed through a comprehensive multidisciplinary assessment conducted by both the social worker and nurse. Adjustments are made to the POC, or acuity level based upon the summary of findings. An assessment will be conducted on a quarterly basis to assess average cost of care needs. When average cost of care needs are 75% of the average at two consecutive quarters, NC Medicaid will work with the family and the case manager to assess the appropriateness of waiver services, to identify alterative resources to augment expenditures. When cost of care needs are 100% of the average cost, arrangements must be made to access appropriateness of waiver participation to assure cost neutrality of service provision. If an adverse decision is made, the waiver participant is granted an appeal.

Other safeguard(s)

Specify:

Appendix B: Participant Access and Eligibility

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4000
Year 2	4500
Year 3	5000
Year 4	5500
Year 5	6000

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: (*select one*) :

The state does not limit the number of participants that it serves at any point in time during a waiver year.

The state limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	3950
Year 2	4450
Year 3	4950
Year 4	5450
Year 5	5950

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The state (*select one*):

Not applicable. The state does not reserve capacity.

The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Emergency	
Money Follows the Person	
Military	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

Emergency

Purpose (describe):

Reserved capacity is for emergency needs in which the individual is at risk of imminent, significant harm if services from the waiver is not available. Individuals in the following category are eligible for emergency reserve:

- Individuals with an active AIDS diagnosis with a T-Count of 200.
- Individuals transitioning from a nursing facility or hospital utilizing service of Community Transition.
- Individuals whose third party insurance is terminating and the beneficiary needs HCBS for health, safety and well-being.
- Previously eligible waiver beneficiaries who are transitioning from a short-term rehabilitation placement within 90 days of the placement.
- Individuals identified at risk by their local Department of Social Services or federally recognized Tribes who has a need for protection by Child Protective Services for abuse, neglect and exploitation.

Describe how the amount of reserved capacity was determined:

The reserve figure is based on historical numbers of participants statewide who were determined to be in an emergency situation requiring immediate admission to waiver.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	30
Year 2	30
Year 3	30
Year 4	30
Year 5	30

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

Money Follows the Person

Purpose (describe):

To assist individual to transition out of a facility into a home and community-based setting.

Describe how the amount of reserved capacity was determined:

Reserved capacity for these selected individuals is a percentage of the total past utilization and the number of participants approved for waiver participation in the State.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

Military

Purpose (describe):

To allow previously eligible Military dependents who are transferring back to North Carolina after an out-of-State military assignment to re-enter into the waiver without wait time when a waitlist is imposed.

To allow military families with a medically fragile, complex child to be transferred to this state for active duty. The child participated in a 1915(c) HCBS waiver in their previous state before the transfer.

Describe how the amount of reserved capacity was determined:

Reserved capacity is an estimate based on the number of requests of continued services from military families transferring to NC with children on similar waivers in other states.

The capacity that the state reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule (select one):

The waiver is not subject to a phase-in or a phase-out schedule.

The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in

the waiver.

e. Allocation of Waiver Capacity.

Select one:

Waiver capacity is allocated/managed on a statewide basis.

Waiver capacity is allocated to local/regional non-state entities.

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Due to the similar acuity needs of individuals applying for participation in the waiver, this waiver arranges for service consideration on a first-come first-serve basis.

The State will reserve 50 slots per waiver year to meet the needs of individuals transitioning into the waiver program utilizing money follows the person, are determined to meet the established priority list (emergency waiver need) or is a displaced military family member.

Individuals meeting specific criteria shall be prioritized for immediate consideration of waiver participation. If there is not an available slot or reserved slots are at its maximum, the individual shall be placed first in line on an existing statewide waitlist. Prioritization criteria apply to individuals meeting the following:

- a. Individuals transitioning from a facility with Money Follows the Person (MFP) designation.
- b. Individuals transitioning from a facility utilizing services of community transition.
- c. Eligible CAP participant who are transferring to another county or case management entity.
- d. Previously eligible CAP participant who are transitioning from a short-term rehabilitation placement within 90 calendar days of the placement.
- e. Individuals identified at risk by their local Department of Social Services (DSS) who have an order of protection by Child Protective Service (CPS) for abuse, neglect or exploitation, and the CAP waiver is able to mitigate risk; or
- f. Medicaid participant with active Medicaid who are temporary out of the State due to a military assignment of their primary caregiver.
- g. Individuals who were receiving personal care-type services through private health insurance plan and the policy is being terminated by the insurer.

The following items must be in place prior to waiver entrance:

- Service Request Form to initiate the level of care eligibility
- Availability of a waiver slot and assignment of a waiver slot
- Coordinated service/transition plan

The CAP Business system receives a referral for an individual interested in participating in the waiver. When a referral is made, a service request form is created to initiate the determination of eligibility for level of care. If eligibility is determined, and there are no available slots (assigned or reserved, when appropriate), the individual is placed on a waitlist. Data analytic is able to separate the wait-time to reflect county specific, agency specific and statewide. The State Medicaid Agency utilizes the data of the CAP Business system to track waiver slot utilization statewide, to ensure established utilization limits are maintained as well as to track demographic of the referrals and approval, population universe and wait time. Each appointed case management entity must adopt the State Medicaid Agency's Waiting List Policy in approving, accepting, and processing referrals.

Transfer Policy:

The case manager or care advisor shall coordinate the transfer of an eligible waiver participant to another county, agency, or program within 30 calendar days upon a request. Each case manager or care advisor of their respective county or agency shall coordinate the seamless transfer to prevent gaps in service provisions.

The following steps must be completed prior to the transition:

The following steps must be completed prior to the transfer:

1. The identification of the waiver participant's anticipated start date of service;
2. A completed coordinated transition plan between provider agencies;
3. A written narrative of how to plan for the health, safety, and well-being of the waiver participant;
4. A transfer request to e-CAP to have record electronically transferred to the receiving county;
5. A confirmed appointment for a home visit by the receiving entity to ensure the appropriateness of the service plan and the need for a plan revision that takes into consideration the new home environment; and
6. An updated service plan that informs of the start on the first date of service provisions.

If the participant is aging out of CAP/C

The case management entity shall assist a CAP participant three months prior to their 21st birthday with completing the following:

- The development of a comprehensive adult transition plan.

Coordination activities shall include:

- A. conference between both entities to derive a comprehensive transition plan that outlines timelines and case management needs;
- B. the transferring entity to provide a breakdown of case management utilization activities to ensure appropriate case management activities to not duplicate services;

- C. an established date to conduct a home visit by the receiving entity to assure health, safety, and well-being as well as to review the service plan to determine accuracy and need for revision;
- D. consultation with the CAP waiver participant and primary caregiver to provide policy information about the new services and providers.
- E. Transfer of the electronic record to the receiving entity at least 10 days prior to the transfer.

To coordinate the transition of children's Medicaid to adult Medicaid at age 17.75, the case manager or care advisor will assist the waiver participant with coordinating with their local DSS to assist as needed with changes to their Medicaid status. family to file a Medicaid application 90 days prior to the 18th birthday to ensure appropriate Medicaid eligibility prior to the 18th birthday.

For CAP participant transferring to a different county:

A. conference between both counties to derive a comprehensive transfer plan that outlines timelines and case management needs;

B. The case manager or care advisor of the transferring county shall coordinate the transfer with the case manager or the care advisor of the receiving county at least 30 calendar days prior to the anticipated transfer.

C. The case managers or care advisors of the transferring and receiving counties shall discuss and plan for the health, safety, and well-being of the waiver participant.

D. The electronic health record is transferred to the receiving county within 10 business days prior to the transfer.

E. The case manager or care advisor of the receiving county shall arrange for a home visit to assess the home environment to identify any health and welfare concerns to plan for mitigation and safety.

F. The case manager or care advisor shall coordinate the provision of services to start on the first date of the transfer into the receiving county.

A transferring waiver participant is considered under the priority category and is guaranteed a slot in the receiving county, agency, or program. Waiver participation will continue under the current Medicaid eligibility until the next Medicaid certification period (Medicaid eligibility and waiver annual reassessment).

Waiver participant requesting to transfer from one case management entity to another the newly requested case management entity has a waiver compliance score of 89% or less, the waiver participant will be provided education and consultation of what this means and how these issues may cause concern with health, safety, and well-being. Education will also be provided about the possibility that the transfer may not be to grant as a result of current performance issues.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

- a. **1. State Classification.** The state is a (*select one*):

Section 1634 State

SSI Criteria State

209(b) State

- 2. Miller Trust State.**

Indicate whether the state is a Miller Trust State (*select one*):

No

Yes

- b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR

§435.217)

Low income families with children as provided in §1931 of the Act

SSI recipients

Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121

Optional state supplement recipients

Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

100% of the Federal poverty level (FPL)

% of FPL, which is lower than 100% of FPL.

Specify percentage:

Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)

Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)

Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)

Medically needy in 209(b) States (42 CFR §435.330)

Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Children receiving foster care or adoption assistance who are covered under 42 CFR 435.145.
Individuals receiving services under 42 CFR 435.135

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.

Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.

Select one and complete Appendix B-5.

All individuals in the special home and community-based waiver group under 42 CFR § 435.217

Only the following groups of individuals in the special home and community-based waiver group under 42 CFR § 435.217

Check each that applies:

A special income level equal to:

Select one:

300% of the SSI Federal Benefit Rate (FBR)

A percentage of FBR, which is lower than 300% (42 CFR § 435.236)

Specify percentage:

A dollar amount which is lower than 300%.

Specify dollar amount:

Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)

Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)

Medically needy without spend down in 209(b) States (42 CFR §435.330)

Aged and disabled individuals who have income at:

Select one:

100% of FPL

% of FPL, which is lower than 100%.

Specify percentage amount:

Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- b. Regular Post-Eligibility Treatment of Income: SSI State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR § 441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The state requires (select one):

The provision of waiver services at least monthly

Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

Directly by the Medicaid agency

By the operating agency specified in Appendix A

By an entity under contract with the Medicaid agency.

Specify the entity:

Other

Specify:

The SMA is solely responsible for the determination of the initial and annual LOC for all waiver participants; however, a contracted entity, Independent Assessment Entity (IAE), will assist the SMA with this administrative task. This entity will be responsible for gathering the necessary documents to assist the SMA in evaluating the initial level of care and reasonable indication of need for consideration of waiver enrollment, refer to Appendix A-3 and D for specific details. An independent assessment entity is an independent organization that does not perform case management services and is not directly or indirectly affiliated with the prospective or enrolled waiver participant. The independent assessment entity will assist the SMA in making initial and ongoing level of care decisions about waiver participation by completing the SRF and needs-based comprehensive assessment eligibility enrollment paperwork. The State Medicaid agency will provide second-level reviews known as registered nurse (RN) exception reviews when the independent assessment entity does not have enough information to assist with assist the SMA in deciding the level of care. A SMA-employed RN will conduct a second-level review known as registered nurse (RN) exception review when the LOC decision is placed in the exception review queue because the SMA algorithms of determining LOC and the health information entered in the CAP Business system are not triggered. During the absence of an IAE, the SMA will work collaboratively with case management entities to gather and provide the necessary health information to yield a LOC decision that is interest free.

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR § 441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered Nurse (RN). An RN who holds a current NC license with a minimum of 3-4 years of LTSS and HCBS experience. The RN must also possess knowledge and skills/abilities: assessment practices such as motivational interviewing and population awareness (disability and culture). Abilities to 1. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, and summarizing. 2. Develop a trusting relationship to engage participant and natural supports. 3. Engage waiver participants and families to elicit, gather, evaluate, analyze, and integrate pertinent information, and form assessment conclusions. 4. Recognize indicators of risk (health, safety, mental health/substance abuse). 5. Gather and review information through a holistic approach, giving balanced attention to individual, family, community, educational, work, leisure, cultural, contextual factors, and participant preferences. 6. Consult other professionals and formal and natural supports in the assessment process. 7. Discuss findings and recommendations with the participant in a clear and understandable manner. 8. Identify and evaluate a participant's existing and accessible resources and support systems. 9. Document in a written format specific information of assessment activities.

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

This HCBS waiver targets individuals who meet an HCBS nursing facility level of care (LOC) (comparable to Medicaid Agency State Plan nursing facility level of care) due to a medical diagnosis or physical disability. Professional judgment and a thorough evaluation of the waiver participant's medical condition and psychosocial needs are required to differentiate between the need for nursing facility care and other health care alternatives. The HCBS LOC must address interventions, safeguards (health, safety, and well-being) and the stability of each potential and actively approved waiver participant to ensure community integration and prevention of institutionalization because of chronic medical and physical disabilities.

A LOC assessment must be completed at initial enrollment and during the annual continued need review for all entrants. Supporting documentation for individuals meeting a level of care due to placement in an institution or a similar 1915(c) HCBS waiver in the state will be used as supporting documents to make a determination of the level of care for enrollment in this waiver program.

An initial LOC is established using a Service Request Form (SRF). This form is consistent with the Medicaid State Plan nursing facility LOC criteria. The SRF has identifying mandatory fields that capture demographic information, diagnoses, medications, nursing interventions, dietary concerns, ancillary therapies, behavioral concerns, falls and other related medical needs to analyze health care information to yield a LOC decision. This form screens three core areas: targeted population, level of care and priority group. If the responses to the questions align with the target population and level of care, the SRF is approved which is a clear indication that nursing facility level of care has been met. The SMA uses the collected information from the completed SRF and screen for the SRF criteria listed in the clinical coverage policy. An algorithm is used in the CAP IT system to screen for the LOC criteria. When the LOC criteria are found, the SMA uses that data mining process to approve the LOC. During an annual review for LOC, the comprehensive assessment verifies the level of care continues to be met. The SMA uses the collected information from the completed assessment and screen for the SRF criteria listed in the clinical coverage policy. An algorithm is used in the CAP IT system to screen for the LOC criteria. When the LOC criteria are found, the SMA uses that data mining process to approve the annual LOC. When the comprehensive assessment cannot clearly validate LOC is met, a SRF is initiated to establish or re-establish the LOC.

The HCBS LOC is comparable to the State Plan Nursing Facility LOC with the following exclusions:

This waiver uses the following LOC criteria in addition to a comprehensive assessment to evaluate a reasonable need for waiver services. HCBS Nursing Facility Level of Care Criteria must require a need for any one of the following:

1. Need for services, by physician judgment, requiring:
 - A. supervision of a registered nurse (RN) or licensed practical nurse (LPN); and
 - B. other personnel working under the direct supervision of a registered nurse or licensed practical nurse.
2. Observation and assessment of participant needs by a registered nurse or licensed practical nurse. The nursing services must be intensive and directed to an acute episode or a change in the treatment plan that requires such concentrated monitoring.
3. Restorative nursing measures once a participant's medical condition becomes stable as noted in the treatment plan. Restorative nursing measures are used to maintain or restore maximum function or to prevent advancement of progressive disability as much as possible. Restorative nursing measures are:
 - A. A coordinated plan that assist a participant to achieve independence in activities of daily living (bathing, eating, toileting, dressing, transfer, and ambulation).
 - B. Use of preventive measures or devices to prevent or delay the development of contractures, such as positioning, alignment, range of motion, and use of pillows.
 - C. Ambulation and gait training with or without assistive devices; or
 - D. Assistance with or supervision of transfer so, the participant would not necessarily require skilled nursing care.
4. Dialysis (hemodialysis or peritoneal dialysis) as part of a maintenance treatment plan.
5. Treatment for a specialized therapeutic diet (physician prescribed). Documentation must address the specific plan of treatment such as the use of dietary supplements, therapeutic diets, and frequent recording of the participant's nutritional status.
6. Administration or control of medication as required by state law to be the exclusive responsibility of licensed nurses:
 - A. Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration.
 - B. Drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgment on a continuous basis; or
 - C. Frequent injections requiring nursing skills or professional judgment.
7. Nasogastric or gastrostomy feedings requiring supervision and observation by an RN or LPN:
 - A. Primary source of nutrition by daily bolus or continuous feedings.
 - B. Medications per tube when participant on dysphagia diet, pureed diet, or soft diet with thickening liquids; and
 - C. Per tube with flushes.

8. Respiratory therapy: oxygen as a temporary or intermittent therapy or for a participant who receives oxygen continuously as a component to a stable treatment plan:
 - A. Nebulizer usage.
 - B. Nasopharyngeal or tracheal suctioning.
 - C. Oral suctioning; and
 - D. Pulse oximetry.
9. Isolation: when medically necessary as a limited measure because of a contagious or infectious disease.
10. Wound care of decubitus ulcers or open areas.
11. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan; or
12. HCBS Nursing Facility LOC may be established by having two (2) or more conditions in Category I OR one (1) or more conditions from both Category I and II below.
 - b. Conditions that must be present in combination as listed above may justify HCBS nursing facility level of care:
 1. Category I: (Two or more, or at least one in combination with one from Category II)
 - A. Ancillary therapies: supervision of participant's performance of procedures taught by a physical, occupational, or speech therapist, consisting of care of braces or prostheses and general care of plaster casts.
 - B. Chronic recurrent medical problems that require daily observation by licensed personnel or other personnel for prevention and treatment.
 - C. Blindness
 - D. Injections: requiring administration or professional judgment by an RN or LPN or a trained personal assistance.
 - E. Diabetes: when daily observation of dietary intake or medication administration is required for proper physiological control:
 - i. Vision, dexterity, and cognitive deficiencies; or
 - ii. Frequent hypoglycemic and diabetic ketoacidosis (DKA) (high blood sugar) episodes with documentation requiring intravenous or intramuscular (IV or IM) or oral intervention.
 - F. Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction as prescribed by a primary care physician.
 - G. Frequent falls due to physical disability or medical diagnosis.
 - H. Behavioral problems symptoms due to cognitive impairment and depressive disorders such as:
 - i. Wandering or exit seeking behavior due to cognitive impairments
 - ii. Verbal disruptiveness.
 - iii. Physical aggression.
 - iv. Verbal aggression or physical abusiveness; or
 - v. Inappropriate behavior (when it can be properly managed in the community setting)
 2. Category II: (One or more conditions from both Category I and II)
 - A. Need for teaching and counseling related to a disease process, disability, diet, or medication.
 - B. Adaptive programs: re-training the participant to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the participant's participation in the program and document the participant's progress.
 - C. Factors to consider along with the participant's medical needs are psychosocial determinants of health such as:
 - i. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders and progress notes or by nursing or therapy notes).
 - ii. Age.
 - iii. Length of stay in current placement.
 - iv. Location and condition of spouse or primary caregiver.
 - v. Proximity and availability of social support; or
 - vi. Effect of transfer on individual, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning helps alleviate the fear and worry of transfer).

A LOC evaluation using the SRF is only completed at initial enrollment. Annual reevaluation of LOC is performed through a needs assessment that determines ongoing eligibility for LOC and functional needs. A favorable change to a waiver participant's condition that improves functionality and mobility to the point LOC is not met and it appears continuous support is needed to maintain community inclusion; a decision may be made not to dis-enroll the waiver participant.

The functional acuity levels of skilled and hospital are established through a comprehensive assessment that covers the following areas:

The multidisciplinary assessment includes the following functioning areas to ensure waiver participant access and

eligibility:

- a. Personal health information;
- b. Caregiver information;
- c. Medical diagnoses;
- d. Medication and precautions;
- e. Skin;
- f. Neurological;
- g. Sensory and communication;
- h. Pain;
- i. Musculoskeletal;
- j. Cardio-Respiratory;
- k. Nutritional;
- l. Elimination;
- m. Education
- n. Mental Health;
- o. Informal support; and
- p. Housing and finances.

When the LOC is determined, an assessment is generated to assess health care information and identify determinants to assist with confirming a reasonable indication of need for waiver services

- e. **Level of Care Instrument(s).** Per 42 CFR § 441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

The same instrument is used in determining the level of care for the waiver and for institutional care under the state plan.

A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

A different instrument is used to initiate the eligibility for level of care for waiver participant than the FL-2, used by the State Medicaid Plan. This tool is referred to as a Service Request Form (SRF) and is equivalent to the State instrument and is statistically valid. This tool has been used with evaluating the LOC of this population since 2007. The Service Request Form captures a comprehensive overview of medical, functional, behavioral, and social needs of an individual that allows for an accurate assessment of nursing facility equivalent level of care for community-dwelling individuals.

Health care conditions documented in the SRF is obtained from the Physician's Worksheet along with data analytics of paid claims. Upon the completion of the SRF, the CAP Business system initiates the scoring algorithm to locate clinical indicators of nursing level of care. The SRF includes the fields listed below.

- o Program request.
- o Waiver participant demographics.
- o diagnosis, medication, specialized therapies, and special care needs.
- o Date of LOC request

When a LOC clinical indicator is present, the CAP Business system electronically transmits to the Medicaid's Fiscal Agent the level of care confirmation decision to indicator prior approval for waiver services. An approved LOC is one of two components required in the State's MMIS in order to adjudicate waiver claims. The second component is the assignment of a waiver special coverage code.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR § 441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

An annual SRF is not completed. The ongoing LOC is established through an annual assessment of need. During the annual assessment, a comprehensive assessment is completed to determine if a level of care continues to be met. Within each assessment modular, assessment areas contain components of the level of care criteria for this waiver. Upon entering the responses in the waiver business management system by the assessment evaluator and attesting to the completeness and accuracy of the information, the business system analyzes the assessment using the programmed level of care algorithms (logic to evaluate the waiver participant level of care through entries of medical, functional, behavioral, and psychosocial conditions) to validate LOC continues to be met. Further, an assessment reviewer also reviews the assessment to confirm LOC continues to be met along with the level of risk and needs. All final determinations of annual LOCs are made by the SMA.

This reevaluation of need is conducted annually, which is referred to as the continued need review (CNR). The annual reevaluation is conducted each year in the month the waiver participant was initially approved to participate in this HCBS program. The CAP Business system is primarily responsible to notify all parties of the annual review to ensure the timely reevaluation of level of care. Two months prior to the anniversary date of each waiver participant's level of care determination, the CAP Business system, releases the CNR paperwork to the assigned assessment entity to initiate the reevaluation of level of care and needs. The reevaluation must be completed by the last day of the month in which the anniversary occurs to maintain continuous eligibility for level of care.

The assessment will confirm the need for home and community-based planning and validates the LOC continues to be met and the applicant is medically fragile. The assessment includes the components listed below.

- Personal health information.
- Caregiver information.
- Medical diagnoses.
- Medication and precautions.
- Skin.
- Neurological.
- Sensory and communication.
- Pain.
- Musculoskeletal.
- Cardio-Respiratory.
- Nutritional.
- Elimination.
- Mental Health.
- Informal support.
- Housing and finances.

The approval of LOC is transmitted to the State Medicaid MMIS for the management of waiver eligibility, claim processing and utilization management.

An annual SRF is not completed. The ongoing LOC is established through an annual assessment of need. The assessment has logic to evaluate the waiver participant level of care through entries of medical, functional, behavioral, and psychosocial conditions. When the assessment cannot confirm the LOC, a new SRF is initiated to reconfirm or validate the LOC continues to be met. All final determinations of annual LOCs are made by the SMA.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

Every three months

Every six months

Every twelve months

Other schedule

Specify the other schedule:

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations (*select one*):

The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.

The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR § 441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care (*specify*):

The level of care reevaluation is performed annually. This reevaluation is included in the reassessment of need evaluation that is referred to as the continued need review (CNR). The annual reevaluation is conducted each year in the month the waiver participant was initially approved to participate in this HCBS program. The CAP Business system is primarily responsible to notify all individuals parties of the annual review to ensure the timely reevaluation of level of care. Two months prior to the anniversary date of each waiver participant's level of care determination, the CAP Business system, releases the CNR paperwork to the assigned assessment entity to initiate the reevaluation of level of care and needs. The reevaluation must be completed by the last day of the month in which the anniversary occurs to maintain continuous eligibility for level of care.

A reevaluation notification alert is transmitted two months in advance to the case management entity. Thirty days prior to the required reevaluation, the case management entity is provided another alert of the urgency to complete the reevaluation. The State Medicaid agency is also made aware of the reevaluation and can track all reevaluations to ensure timely review. When a reevaluation is not completed timely, a corrective action is issued with a timeline to complete the reevaluation. For circumstance beyond the case management entity control such as a significant change in the participant status where the reevaluation cannot be conducted, a decision may be made to postpone the reevaluation and suspend services until the reevaluation may be performed. The waiver participant signs a rights and responsibilities form that addresses the requirement of the level of care reevaluation and the potential need to suspend services when the level of care cannot be established.

The records for evaluation and reevaluation of level of care are kept in an electronically-retrievable format in the CAP Business system. This system has a safe storage for all files entered in this system. The initial approval of level of care is also kept in an electronically-retrievable format in the Medicaid Management Information System (MMIS). These records are kept for five years after the end of each waiver year when the evaluation or reevaluation was performed. The case management entity may also keep a paper file or an electronic copy in a participant case file in the office, although this maintenance is not a requirement.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR § 441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR § 92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The records for evaluation and reevaluation of level of care are kept in an electronically-retrievable format in the CAP Business system. This system has a safe storage for all files entered in this system. The initial approval of level of care is also kept in an electronically-retrievable format in the Medicaid Management Information System (MMIS). These records are kept for five years after the end of each waiver year when the evaluation or reevaluation was performed. The case management entity may also keep a paper file or an electronic copy in a participant case file in the office, although this maintenance is not a requirement.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. Sub-assurance: *An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LOC-A1 Number and percent of all applicants who receive a LOC evaluation

Numerator: number all applicants who received a LOC evaluation **Denominator:** number of all applicants reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT Business system and NC Medicaid MMIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify:	Annually	Stratified Describe Group:

<div style="border: 1px solid black; padding: 5px; width: fit-content;"> CAP Business system case management system and NC Medicaid MMIS </div>		<div style="border: 1px solid black; width: 100%; height: 30px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 2px; width: 100%;">CAP Business system</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px;"></div>

b. Sub-assurance: *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

LOC-C1 #&% of new enrollees who received a LOC evaluation using processes/instrument in the approved waiver that are applied appropriately & according to the approved description. N: # of new enrollees who received a LOC evaluation using processes/instrument in the approved waiver that are applied appropriately & according to the approved description D: # of new enrollees reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and NC Medicaid MMIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>

<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> CAP Business system case management system and NC Medicaid MMIS </div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CAP Business system is a business system procured by the State Medicaid Agency to manage the administrative function of waiver enrollment, which includes LOC for all waiver participants, initially and annually.

This system assists in the discovery of non-compliant LOC practices through aggregating and analyzing LOC workflow. The CAP Business system performs the following tasks to ensure compliance with LOC policies and procedures, which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- No wrong door referral (referrals can be received from any provider type, vendor, or agency)
- Service request forms workflow- referral, consent forms, physician’s worksheets, and required forms
- RN exception reviews to reassess health care information, when applicable
- Notification letters to providers and waiver participants
- Assessment modules
- Prior approval segments
- Workflow timelines and alerts

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Upon discovering noncompliant waiver workflow activities in the area of LOC, the State Medicaid Agency notifies the said agency within 30-days of the discovery; requests a corrective action plan to remediate the concerns and a summary of the root cause. The State Medicaid Agency provides technical assistance and training on policies and procedures in the noncompliant area(s). The State Medicaid Agency approves the corrective action plan and follows up with the noncompliant agency to ensure the corrective action plan is being followed through the duration of the action plan. If the noncompliant issue continues, a freeze on performing LOC activities for waiver participants is imposed until continuous quality is achieved. After three months of remediation strategies have not promoted the quality improvement, and it appears the entity will not be able to achieve compliance, a recommendation is made to terminate that entity's investment in the waiver program. A transition plan is created to ensure no access to care issues and the health and well-being of all waiver participants.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified

strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR § 441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and*
- ii. given the choice of either institutional or home and community-based services.*

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals seeking Medicaid services and have an indication to meet the eligibility criteria of the waiver, a service provider, a case management entity and the county department of social services or Tribal Nation may provide general information about the waiver and a referral can be made for waiver enrollment consideration. Individuals interested in home and community-based services are offered and provided information on the freedom of choice for choosing institutional or home and community-based services prior to the enrollment into the waiver program. A CAP Waiver Enrollment Notice is mailed to each waiver participant initially and annually by the SMA to confirm their freedom of choice decision to enroll in the waiver. The waiver participant must sign and return the enrollment notice to the SMA acknowledging their agreement/choice to enroll in the waiver to receive waiver services.

Each waiver participant is informed of the case management entities in his/her catchment area and of case management entities' roles and responsibilities. Upon the approval of waiver entry and at the approval of annual reevaluation, each waiver participant is mailed a CAP Disclosure Notice that outlines the purpose of the waiver, services available through the waiver, what freedom of choice is and how to exercise their choice of services, providers, and participation in the waiver. This notice also includes information about abuse, neglect, and exploitation. During the assessment and planning phases of initial and annual waiver enrollment, the waiver participant is required to select an agency of their choice to perform the four core functions of case management (assessing, care planning, monitoring, linking and follow-up) monthly. During the assessment phase, the waiver participant is informed of their rights and responsibilities as a waiver participant and how he or she has the right to select any provider (freedom of choice) at any time including another case management entity to render approved waiver and non-waiver services.

There are at least two case management entities per county to enable choice of provider for the waiver participant. If a designated case management entity in a county is not able to provide case management services for any reason, to offer choice, another case management entity, within a 30-60 miles radius, will be permitted to serve that service area. The participant has a choice of providers. NC Medicaid will also solicit a case management provider through a Request for Providers posted to the NC Medicaid website, to ensure there are at least two case management providers in each catchment area.

NC Medicaid utilizes the services of local agencies, specifically to as case management entities (CME), to perform administrative responsibilities of the waiver that complies with freedom of choice. During the service plan development phase, the waiver participant is provided a list of Medicaid-approved agencies in his or her catchment area to select and exercise freedom of choice. This list of agencies is referred to as Freedom of Choice of providers. The waiver participant selects a provider independent of the case management entity agency. Upon selection, a referral is forwarded to the Medicaid provider for initiation of services. Upon the completion of the service plan, a service authorization is forwarded to the provider, selected by the waiver participant to render the waiver or non-waiver service(s). The waiver participant can choose any provider at any time without forfeiting or experiencing a gap in service provision.

The CAP Disclosure Notice informs of what Freedom of Choice is and how to select an agency of their choice at any given time. Once a selection is made, a referral by NC Medicaid is made to the chosen CME to initiate case management activities. Even though the referral for waiver participation can be initiated from the local entry point in the participant's catchment area, each approved individual who meets the eligibility requirements to participate in the waiver is required to verify the CME of their choice by selecting an entity approved in their catchment area. Services are paused by the referring CME until NC Medicaid receives the signed Freedom of Choice document from the waiver participant that clearly identifies the chosen CME. This requirement is in place to ensure interest free case management is being exercised.

To ensure interest free case management, NC Medicaid will appointment an independent assessment entity to be responsible for the completion of initial assessments.

- b. Maintenance of Forms.** Per 45 CFR § 92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Waiver Freedom of Choice forms are maintained in CAP Business system and in the case management entity's file.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access

to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Federal law requires that all Medicaid providers in North Carolina comply with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act of 1964 (Title VI), Section 504 of the Rehabilitation Act (Section 504), and Section 1557 of the Affordable Care Act (Section 1557).

The ADA requires the provision of reasonable accommodations. Such accommodations may include providing individuals who are deaf, deaf-blind, or hard of hearing with auxiliary aids and services, such as sign language interpreters, to achieve effective communication. The State uses services from the sister Divisions to make accommodations for individuals who may be blind, blind-deaf, and hard of hearing. This accommodation is made on an individual basis when a request is made or when these disabilities are realized.

The SMA translates documents according to Title VI of the Civil Rights Act of 1964 which requires the state agency to translate all vital documents. Vital documents contain information that is critical for obtaining federal services and/or benefits or is required by law. Some examples of vital documents:

1. Applications
2. Consent forms
3. Notices of rights
4. Notice advising individuals of free language assistance
5. Letters or notices that require a response from the participant or client

NC Medicaid has no-cost language services available for non/limited English-speaking individuals.

Title VI prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. Programs that receive Federal funds cannot distinguish among individuals on the basis of race, color, or national origin, either directly or indirectly, in the types, quantity, quality or timeliness of program services, aids or benefits that they provide or the manner in which they provide them. The courts have held that Title VI prohibits recipients of Federal financial assistance from denying limited English proficient (LEP) persons access to programs, based on their national origin.

Section 1557 builds upon already existing federal laws and prohibits discrimination on the basis of sex in any health programs and activities receiving federal financial assistance, such as Medicaid providers and the state Medicaid program. In general, the requirements adopted under Section 1557 include equal treatment of men and women with respect to health coverage and prohibitions against discrimination based on pregnancy, gender identity, and sex stereotyping. This section also updated notice requirements to ensure access to individuals with limited English proficiency (LEP).

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	Coordination of Care- case management and care advisement		
Statutory Service	In-Home Care Aide Service		
Statutory Service	Respite-Institutional and In-Home		
Supports for Participant Direction	Financial Management		
Supports for Participant Direction	Individual-Directed goods and services		
Other Service	Assistive Technology		
Other Service	Attendant Nurse Care		
Other Service	Community Integration		
Other Service	Community Transition		
Other Service	Coordinated Caregiving		
Other Service	Home Accessibility and Adaptation		
Other Service	Non-Medical Transportation		

Service Type	Service		
Other Service	Nutritional Services		
Other Service	Participant Goods and Services		
Other Service	Pediatric Nurse Aide Services		
Other Service	Pest Eradication		
Other Service	Specialized Medical Equipment		
Other Service	Training, Education, and Consultative Services		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Coordination of Care- case management and care advisement

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

01 Case Management

Sub-Category 2:

01010 case management

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service that directs and manages the special health care, social, environmental, financial, and emotional needs of a waiver participant to maintain the waiver participant's health, safety, and well-being and for continual community integration. Case management services are available to assist waiver participants in gaining access to needed medical, social, educational, and other services. Case management includes the following principal components: assessing, care planning, referral or linkage and monitoring and follow-up. Individuals transitioning out of an institutional setting may receive pre-transition case management activities to assist with the transition to a home setting. The pre-transition activities are limited to 30-days or 60-days (for MFP) prior to the waiver participation approval date. These services are not billable until after the applicant has transitioned home and meet all remaining eligibility requirements to participate in the waiver. The case manager performs the following:
 . assesses well-being of beneficiary monthly to identify if services plan continues to meet need.

. Assists with the development and approval of the person-centered service plan.

. Links and refers to community resources.

. Monitors formal and informal services to ensure health, safety and well-being

. Follows-up to ensure services are meeting assessed needs

Assessing includes the following:

1. Assess all aspects of the beneficiary, including medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational and other areas to make recommendations to the IA for a change in status assessment;
2. Identify needs to prevent health and safety factors to assist in maintaining community placement;
3. Consult with informal and paid providers such as family members, medical and behavioral health providers, and community resources to ensure service plan is consistent with needs;
4. Review completed assessment from the CME assessors and IAE (after May 2020) and other summary information to assist with identifying care needs, risk indicators and support system;
5. Assess periodically to determine whether a beneficiary's needs or preferences has changed to report to the CME assessor or IAE (after May 2020) for potential assessment of need.

Care Planning include the following:

. Development and periodic revision of a person-centered care to identify all formal services received in the amount, frequency and duration. The care plan also identifies both formal and informal supports to assure the health, safety and well-being of the waiver participant.

Care Planning Knowledge include the following:

1. The values that underlie a person-centered approach to providing services to maintain integration and prevent institutionalization within the context of the beneficiary's culture and community.
2. Models of chronic disease management and preventative interventions.
3. Biopsychosocial theories of practice, evidenced-based standards of care, and practice guidelines.
4. Processes used in a variety of models for multidisciplinary planning to promote beneficiary and family involvement in case planning and decision-making.
5. Services and interventions appropriate for assessed needs for the development of a service plan.
6. Person-centered practices, beneficiary focused
7. Emergency safety planning

Referral/Linkage includes the following:

. Activities to refer and link a waiver participant with medical, behavioral, social, and other programs, services, and supports to address identified needs and achieve goals specified in the care plan.

Referral/Linkage knowledge includes:

1. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, recreation, housing resources, peer support.
2. Current laws, regulations, and policies surrounding medical and behavioral healthcare.

Skills and Abilities to:

1. Research, develop, maintain, and share information on community and other resources relevant to the needs of beneficiaries.
2. Maintain consistent, collaborative contact with other health care providers and community resources.
3. Initiate services in the care plan to achieve the outcomes derived for the beneficiary's goals.
4. Assist and advocate for the beneficiary in accessing a variety of community resources.

Monitoring and follow-up include:

. Activities and contacts with the waiver participant, responsible party, and service providers that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the waiver participant.

Monitoring and follow-up knowledge:

1. Outcome monitoring and quality management.
2. Models of chronic disease management and preventive intervention.
3. Peer support groups

To ensure access to needed services as identified in an approved service plan, the case manager can develop a one-time purchase order process for each approved service in the service plan to promote an on-demand quick procurement of items available by retail. The purchase order may include the waiver participant being given a check made out directly to the provider (that the provider has to sign), a purchase account at the retailer where the waiver participant and the provider must sign (the invoice is submitted to the case manager for verification), or the designation of a VISA card number explicitly assigned to a waiver participant for on-line procurement of approved services, arranged by the case manager. The VISA card will not be given to the individual. The case manager will document the VISA card number and the associated pin. The case manager will identify the most efficient purchase order process to ensure quick access to the approved services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Case management services shall not exceed the maximum limit listed on the published fee schedule. A monthly fee is reimbursed for case management services per waiver participant for combined use of both case management and care advisor services. The SMA has a process in place for a case management entity to request additional case management units/hours per calendar year when the original allocation is exhausted for the following reasons:

1. The waiver participant experiences a natural disaster and requires additional case management support to link to housing and other needed supports; or
2. The waiver participant is experiencing a crisis that requires the case manager to perform at least weekly monitoring, planning and linking activities to ensure health, safety and well-being.

A waiver participant shall not receive another Medicaid-reimbursed case management service in addition to CAP case management. The following activities are non-coverable: employee training for the case manager; completion of time sheets; travel time; staff recruitment; staff scheduling and supervision; billing Medicaid claims; case management activity documentation; any form of case management activities for an individual not approved to participate in CAP to include preparation for due process.

Case Management entities are prohibited from providing case management services in conjunction with other waiver and non-waiver services when interest free case management can not be achieved.

The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Entities

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Coordination of Care- case management and care advisement

Provider Category:

Agency

Provider Type:

Case Management Entities

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

An enrolled Medicaid provider with three or more years of case management and HCBS experience.
 Qualifications:

- a. A direct connection to the service area to provide continuity and appropriateness of care;
 - b. Experience with 0-17 children and adults 18 years and older with medical-complexities or physical disabilities;
 - c. Policies and procedures that align with the CAP/C policies and procedures;
 - d. Three (3) years of progressive and consistent home and community based services experience; a provisional status may be granted to new agency without required experience- over-the-shoulder monitoring by State Medicaid Agency for 12 consecutive months; if no deficiencies after the 12th month, only quarterly monitoring and QA will be required for the next 24 months. If performance requirements are met, no intensive supervision will be required
 - e. Ability to provide case management services through approved qualified professionals;
 - f. Architectural requirement to support the requirement of current and future automated programs;
 - g. Adequate staff to participant ratio based on acuity of need for each case manager's caseload (appropriate case mix); best-practice is 40 participants for one FTE; and
 - h. Ability to collaborate with network of providers, to ensure services can be rendered within five (5) days of submission of the service authorization;
 - i. Ability to make home visits as required and requested. Provider enrollment and recertification and claim submission training provided by NCTracks (GDIT)
 - j. Demonstrate fiscal soundness by having financial reserves on-hand (\$84,000)
- Participate in initial and annual refresher trainings to include:
- a. Person-centered training;
 - b. Abuse, neglect, exploitation;
 - c. Program integrity (PI);
 - d. Conflict resolution;
 - e. Mental Health First Aid;
 - f. Critical incident reporting;
 - g. Health, Safety and Well-being and Individual Risk Agreement;
 - h. Medicaid Due Process Appeal Rights and EPSDT;
 - i. Consumer-Direction;
 - j. Quality Assurance and Performance Outcomes
 - k. Cultural Awareness; and
 - l. Motivation interviewing or a similar training
- In addition, the case manager or care advisor shall complete other required trainings sponsored by their organization annually:
- a. Bloodborne Pathogens and Infection Control;
 - b. Health Insurance Portability Accountability Act (HIPAA)
 - c. End of Life planning;

Verification of Provider Qualifications

Entity Responsible for Verification:

Case managers are qualified providers for case management and responsible for the development of the service plan. Case managers are required to have at a minimum a 4-year degree in social work or a human service profession or be a registered nurse at an RN or LPN level, licensed to practice in the state. Additional qualification information is described in Appendix D-1. All case managers must meet the hiring requirements of their organization and successfully pass a background check that includes an abuse registry check.

State Medicaid Agency will verify credentials of the case managers and NC DHHS fiscal agent and MMIS (GDIT/NCTracks) will verify credential of the case management entity.

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the

04/22/2026

Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

In-Home Care Aide Service

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

In-home aide service is a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. In-home aide services provide hands-on assistance with ADLs and basic home management tasks. CAP/C is intended to provide services to children age birth through 20 who need non-age appropriate hands-on assistance with ADLs. A child (0 through 20 years of age) who has not reached the developmental milestones for his or her chronological age for the ADLs, based on the evaluation of a licensed professional, is considered to require non-age appropriate assistance for a specific ADL. The need for assistance is identified through a comprehensive assessment that evaluates physical, social, environmental, and functional condition. Hands on assistance is provided for seven keys ADLs: bathing, dressing, eating, toileting, hygiene, mobility and transfer, and key IADLs to include: light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication, and money management). Such assistance also may include the supervision of participants as provided in the service plan. Personal care aide services must fall within the Nurse Aide I scope of nursing practice. Personal care aide services may be provided in the community, home, workplace, or educational settings at the discretion of the Home Care Agency. Personal care aide services can be provided in the workplace for waiver participants who meet the specified qualifications. Level I tasks, which consists entirely of home management tasks, are covered only when provided in conjunction with Level II Personal Care tasks. Typical Level II tasks will include oxygen therapy, break-up and removal of fecal impaction, sterile dressing change, wound irrigation, I.V. fluid assistive activities, nutrition activities, suctioning, tracheostomy care, elimination procedures and urinary catheters. Typical Level I tasks include paying bills as directed by the participant; essential shopping, cleaning and caring for clothing; performing basic housekeeping tasks such as sweeping, vacuuming, dusting, mopping and washing dishes; identifying medications for the participant; providing companionship and emotional support; preparing simple meals; and shopping for food, clothes, and other essential items. Assurance: The services under the waiver's personal care aide are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. For those eligible, EPSDT must be used for all mandatory and optional state plan services to the extent medically necessary. Tasks, amount, frequency, and duration must be clearly outlined in job duties developed by the waiver participant or responsible party or representative participating in consumer-directed care.

Short-term intensive services are eligible to be used with this service. Short-term intensive services are used for a significant change in the acuity status of the waiver participant where the duration of care needs is less than three consecutive weeks. Short-term intensive services are listed in the service plan. Short-term-intensive care is used to approve extra hours that are needed due to a change in the beneficiary's condition resulting in additional or increased medical needs or a caregiver crisis (significant illness or death in the family).

Unplanned waiver service occurrence requests are eligible to be used with these services. Unplanned waiver services occurrence requests are used to request an adjustment beyond the approved waiver service for a particular day(s) due to an unexpected event (such as a flat tire or accident).

ADL care for children under the age of three years is considered age appropriate and the responsibility of the parent or responsible representative.

A waiver participant can use up to 14 days per year of recreational leave (family vacation), when planned for in the initial and annual person-centered service plan. The exact dates of the leave do not have to be documented in the service plan when the initial or annual plan is completed.

Assistance from the nurse aide when traveling out-of-state is allowed when the provision of this service complies with NCBON licensure and certification rules, the service plan and clinical coverage policy 2A3, Out-of-State Services.

An assigned nurse aide shall accompany or transport (based on the agency's policy) a waiver participant and the primary caregiver to a medical appointment, to and from school or other activities, if documented in the service plan to provide medical care or personal assistance for the waiver participant

ADL care is eligible to be provided in the workplace when identified as person-centered goals in the service plan.

A spouse, parent, step-parent, or grandparent can be hired as the employee when extraordinary circumstances are met.

When a legally responsible person is assigned as the paid caregiver, the assurances listed below are implemented. In-Home Aide services, Pediatric Nurse Aide services and Coordinated Caregiving can be combined when special conditions are met for provider-led services. Combining services for a legally responsible (parent) person that are inclusive of the extraordinary conditions is permissible under special conditions when a justification of need documented by the multidisciplinary team in the assessment and service plan.

1. When a legally responsible person is authorized to receive payment for providing personal assistance services, the CAP/C participant is temporarily enrolled in the consumer-direction program. The enrollment in this service will provide quality assurance of the health, safety and well-being of the CAP/C participant and provides the controls to ensure that payments are made only for the services authorized to provide.
2. The assigned Case Management Entity (CME) shall monitor the CAP/C participant closely to ensure the services are provided according to the service plan and the waiver participation business requirements are met. Weekly monitoring visit will be conducted telephonically.
3. The Critical Incident Management Plan must be completed and fully describes the ability of the caregiver to function in that role.
4. A competency skill checklist must be completed on live-in family member, legally responsible person, or close kinship to identify ability and any training needs.
5. A training will be provided in fraud, waste, and abuse
6. A training will be provided on critical incident reporting and management
7. A training will be provided in abuse, neglect, and exploitation

A provider's external employment must not interfere with or negatively affect the provision of services; nor supersede the identified care needs of the waiver participant.

Individuals directing their own care must comply with the U.S. Department of Labor Fair Labor Standards Act.

This service is subject to the 21st Century Cures Act for Electronic Visit Verification requirements (EVV).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The type, frequency of tasks and number of hours per day of this CAP service is authorized by the case management entity based on medical necessity of the CAP beneficiary, caregiver availability, budget limits and other available resources.

Payment to a legally responsible person providing in-home aide to a CAP/C participant may be made when any one of the

following extraordinary circumstances is met: a. There are no available certified nursing assistants (CNAs) or personal care assistants in the CAP/C participant's county or adjunct counties through a Home Health Agency, In-Home Aide Agency or under consumer direction due to the impact of infectious viruses, and the CAP/C participant needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.

b. The CAP/C participant requires short-term isolation, 90-days or less, due to experiencing symptoms of infectious viruses extensive to maximal assistance with bathing, dressing, toileting and eating, and the CAP/C participant chooses to receive care in his or her home instead of an institution.

c. The CAP/C participant requires physician-ordered 24-hour direct observation and, or supervision specifically related to symptoms of infectious viruses and the legally responsible person is not able to maintain full or part-time employment due to multiple absences from work to monitor or supervise the CAP/C participant; regular interruption at work to assist with the management of the CAP/C participant's monitoring or supervision needs; or an employment termination.

d. The CAP/C participant has specialized health care needs specific to infectious viruses that can be only provided by the legally responsible person, as indicated by medical documentation, and these health care needs require extensive to maximal assistance with bathing, dressing, toileting and eating to assure the health and welfare of the participant and avoid institutionalization.

e. Other documented extraordinary circumstances not previously mentioned that places the CAP/C participant's health, safety and well-being in jeopardy resulting in an institutional placement directly related to infectious viruses.

A provider's external employment shall not interfere with or negatively affect the provision of services; nor supersede the identified care needs of the CAP beneficiary.

An employee submitting an application for hire under the consumer-directed care program shall not perform services until competencies and trainings are verified or completed.

CAP funding shall not be used to pay for services provided in public schools.

In-Home Nurse Aide Services may not be provided if it duplicates other Medicaid or non-Medicaid services.

Consumer-directed providers shall:

- a. undergo a criminal background and registry check prior to hire; and
- b. demonstrate competencies and skill sets to care for the CAP beneficiary as documented by the consumer-directed participant or responsible party through the self-assessment questionnaire and uploaded to the case file by the case management entity.

Documentation must be provided when specific training and education services are needed and documentation is available to support training needs were met.

Individuals with the following criminal records are excluded from hire:

- a. Felonies related to manufacture, distribution, prescription, or dispensing of a controlled substance;
- b. Felony health care fraud;
- c. More than one felony conviction;
- d. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
- e. Felony or misdemeanor patient abuse;
- f. Felony or misdemeanor involving cruelty or torture;
- g. Misdemeanor healthcare fraud;
- h. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
- i. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
- j. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC.

Waiver service planning is not intended to provide 24-hour care; combining services to provide 24-hour care needs is not permissible. The hours between 12m-5 am are designated as a non-formal time for a parent/primary caregiver/legally responsible person living with the waiver participant who is approved to be the paid worker. These designated hours are intended to prevent burnout and grant an opportunity for the parent/primary caregiver/legally responsible person to sleep/rest. An external direct care worker is hired when a service plan identifies the need for paid support during these hours. Extraordinary circumstances may apply to permit a parent/primary caregiver/legally responsible person to be paid worker during these hours.

Planned and arranged respite must be added to the service plan quarterly for the legally responsible person approved to be paid caregiver to be granted a mental and physical break from the routine 24/7 care to the waiver beneficiary.

A quarterly Home Health visit must be included in the POC for beneficiary directing care using Attendant Nurse Care for continuous access to nursing supplies and equipment. This visit will also provide a quarterly assess of the beneficiary wellbeing.

Waiver beneficiaries receiving PDN from State Plan who have not been able to recruit a nurse as evidence by written documentation from the Home Health agency, PNA services can be temporarily authorized to offer support and assistance with IADLs and monitoring of ADLs when approved the supervising nurse of the HH agency.

The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Direct Staff
Agency	In-Home Aide Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: In-Home Care Aide Service

Provider Category:

Individual

Provider Type:

Direct Staff

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and educational services are needed and documentation is available to support training needs were met. Must be CPR certified.

A legally responsible person, parent, child, sibling, or other relatives is eligible for hire as the employee when requirements are met and warranted by the COVID-19 Care Management Plan. The hiring of a spouse, parent, child, sibling, other relatives shall provide this service only if he or she:

- a. Is 18 years of age or older;
- b. Obtains CPR certification within 30 days of the employee agreement;
- c. Undergoes a registry and statewide criminal background check;
- d. Completes a competency validation, consumer direction training overview in fraud, waste and abuse, abuse, neglect and exploitation and critical incident reporting

Verification of Provider Qualifications**Entity Responsible for Verification:**

It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Frequency of Verification:

initially and annually

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Statutory Service

Service Name: In-Home Care Aide Service

Provider Category:

Agency

Provider Type:

In-Home Aide Providers

Provider Qualifications**License (specify):**

Services are provided by a home care agency licensed by the DHSR under 10A NCAC 13J.
An individual licensed by the NCBON as a Registered Nurse provides supervision of the Nurse Aide as under 10A NCAC 13J.1110.
The Nurse Aide providing direct care is registered as a Nurse Aide I + or Nurse Aide II with DHSR and the NCBON.
Medicare certified home health agency.

Certificate (specify):

The nurse aide providing direct care is certified in CPR. It is recommended that (s)he also be certified in First Aid.

Other Standard (specify):

Staff shall obtain licensure or certification according to all applicable laws and regulations, and practice within the scope of practice as defined by the individual practice board.
NC Medicaid requires the following provider qualifications and training be completed before staff is assigned to provide person care to the CAP beneficiary:

- a. Criminal background checks, which must be repeated every two (2) years, at the time of licensure renewal (refer to Subsection 6.6);
- b. Verification of cardiopulmonary resuscitation (CPR) certification and every two (2) years, coinciding with expiration dates;
- c. Review of trainings and beneficiary-specific competencies at each job performance review as per agency policy;
- d. Pediatric nursing experience or completion of NC Medicaid pediatric training, such as
 1. growth and development
 2. pediatric beneficiary interactions
 3. and home care of pediatric beneficiary

A legally responsible person, parent, child, sibling, or other relatives is eligible for hire as the employee when requirements are met and warranted by the COVID-19 Care Management Plan. The hiring of a spouse, parent, child, sibling, other relatives shall provide this service only if he or she:

- a. Is 18 years of age or older;
- b. Obtains CPR certification within 30 days of the employee agreement;
- c. Undergoes a registry and statewide criminal background check;
- d. Completes a competency validation, consumer direction training overview in fraud, waste and abuse, abuse, neglect and exploitation and critical incident reporting

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV).

Verification of Provider Qualifications**Entity Responsible for Verification:**

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to

care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and education services are needed and documentation is available to support training needs were met.

Frequency of Verification:

The verification of provider qualification is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Respite-Institutional and In-Home

HCBS Taxonomy:

Category 1:

09 Caregiver Support

Sub-Category 1:

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service for a waiver participant that provides temporary relief to the primary unpaid caregiver(s) by taking over the care needs of the participant for a limited time. This service may be used to meet a wide variety of needs, including family emergencies; planned special circumstances when the primary unpaid caregiver needs to be away for an extended period (such as vacations, hospitalizations, or business trips); relief from the daily responsibility of caring for an individual with a disability, or the provision of time for the primary unpaid caregiver to complete essential personal tasks. It can be used as day, evening, or overnight care to meet a range of beneficiary needs such as caregiver relief. Respite care may be provided either in the beneficiary's residence or in a facility licensed to provide the LOC required by the beneficiary (such as a nursing facility or hospital). Institutional Respite is a service for CAP beneficiaries that provides temporary support to the primary caregiver(s) by taking-over the care needs for a limited time. The provision of this service takes place in a Medicaid-certified nursing facility or a hospital with swing beds. Institutional respite is computed on a daily capitation rate per the current Medicaid

Fee Schedule.

Respite In-Home is for a CAP/C beneficiary to provide temporary support to the primary unpaid caregiver(s) by taking over the tasks of that person for a limited time. This service may be used to meet a wide range of needs, such as family emergencies; planned special circumstances (such as vacations, hospitalizations, or business trips); relief from the daily responsibility and stress of caring for an individual with a disability; or the provision of time for the caregiver(s) to complete essential personal tasks.

Respite, total to 720 hours per fiscal year, can be used for the following two purposes:

- a. CAP/C beneficiary or primary caregiver needs physical time away from home; or
- b. Caregiver personal time for emotional, physical or psychosocial balance.

The request for respite must fall within the guideline and definition of respite. When weekly or daily requests are made for respite, a service plan revision may be required if the needs of the beneficiary have changed.

Each day of institutional respite counts as 24 hours towards the annual limit.

Respite In-Home hours can be used to approve extra hours that are needed during the service plan week,

- a. a change in the beneficiary's condition resulting in additional or increased medical needs;
 - b. caregiver crisis (illness or death in the family);
 - c. coverage for school holidays if the caregiver works outside the home and there is no other caregiver available, and
 - d. occasional, intermittent work obligations of the caregiver when no other caregiver is available;
- caregiver relief during a scheduled family vacation in which a CAP/C beneficiary is participating.

Respite In-Home can also be used for school days off, sick days or adverse weather days.

The request for respite must fall within the guideline and definition of respite. When a respite request is made weekly/daily, a service plan should be considered as the care needs of the child/family has changed.

Each day of institutional respite counts as 24 hours towards the annual limit.

Respite hours can be used to approve extra hours that are needed due to:

- a. a change in the beneficiary's condition resulting in additional or increased medical needs;
- b. caregiver crisis (illness or death in the family); and
- c. occasional, intermittent work obligations of the caregiver when no other caregiver is available.

Respite hours will not be approved to provide oversight of additional minor children or to relieve other paid providers.

Any hours not used at the end of the fiscal year are lost. Hours may not be carried over into the next fiscal year. It is the joint responsibility of the case manager, respite provider agency, and family to track the respite hours used to ensure the beneficiary remains within the approved limits.

Respite hours are indicated on the cost summary and service authorization as a "per year" allotment. Families may use as much or as little of their respite time as they wish within a given month, as long as they do not exceed their approved allotment by the end of the fiscal year. Hours may be used on a regularly scheduled or on an as-needed basis. The Business system reconciles respite utilization on quarterly basis.

In-Home respite is subject to the 21st Century Cures Act for Electronic Visit Verification requirements (EVV).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Respite Services, Institutional and In-Home shall not exceed 30 calendar days or 720 hours in one fiscal year (July 1-June 30) for combined use of Institutional Respite Care and In-Home respite care. A day of institutional respite counts as 24 hours towards the annual limit. Any hours not used at the end of the fiscal year may not be carried over into the next fiscal year.

A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide Respite In-Home for a waiver participant. Exclusions apply when (a) there is a staffing shortage in remote areas of the state; or (b) the lack of a qualified provider who can furnish services at usual times during the day because of the complexity of the waiver participant's care needs.

Also refer to C-2 for extraordinary circumstances for a legal guardian to provide this service.

The waiver service corresponding clinical coverage policy may be accessed using this link:

<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The waiver Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Hired workers under participant directed services
Agency	Institutional providers
Agency	Home Care Providers
Agency	Federally recognized tribes

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: Respite-Institutional and In-Home

Provider Category:

Individual

Provider Type:

Hired workers under participant directed services

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The following findings are on their background check:

1. Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
2. Felony health care fraud;
3. More than one felony conviction;
4. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
5. Felony or misdemeanor patient abuse;
6. Felony or misdemeanor involving cruelty or torture;
7. Misdemeanor healthcare fraud;
8. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
9. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
10. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC.

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV)

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite-Institutional and In-Home

Provider Category:

Agency

Provider Type:

Institutional providers

Provider Qualifications

License (specify):

TITLE 10: CH22, 0.0100
 10 NCAC 06B .0101
 Meet Medicare requirements for Tribal Governments

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation
 DHHS fiscal agent (GDIT/NCTracks)
 Tribal Governments

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite-Institutional and In-Home

Provider Category:

Agency

Provider Type:

Home Care Providers

Provider Qualifications

License (specify):

TITLE 10: CH22, 0.0100
 10 NCAC 06B .0101
 Meet Medicare requirements for Tribal Governments

Certificate (specify):

Other Standard (specify):

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV).

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation
 DHHS fiscal agent (GDIT/NCTracks)

Tribal Governments

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite-Institutional and In-Home****Provider Category:**

Agency

Provider Type:

Federally recognized tribes

Provider Qualifications**License (specify):**

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the IHCA, 25U.S.C 1647a, provides that a health program or entity operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law.
--

Certificate (specify):

--

Other Standard (specify):

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV).
--

Verification of Provider Qualifications**Entity Responsible for Verification:**

NC Medicaid

Frequency of Verification:

Initially and five years thereafter by MMIS

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service provided for waiver participant who is directing his or her own care to ensure that consumer-directed funds outlined in the service plan are managed and distributed as intended. Financial managers provide education and training to orient the waiver participant to the roles and requirements of the consumer-directed model of care. Financial managers facilitate the employment of the personal assistant(s) employee and the requirements of the consumer-directed model by completing the following tasks:

- . Serving as the participant's Power of Attorney for Internal Revenue Service's (IRS) processes;
- . Submitting payment of payroll to employees hired to provider services and supports;
- . Providing payroll statements on at least a monthly basis to the personal assistant(s);
- . Ordering employment related supplies and paying invoices for approved waiver related expenses;
- . Deducting all required federal, state taxes, including insurance and unemployment fees, prior to issuing payment;
- . Administering benefits to the personal assistant(s) as directed by the waiver participant;
- . Filing claims for self-directed services and supports;
- . Maintaining separate accounts on each participant's consumer-directed services;
- . Tracking and monitoring individual budget expenditures;
- . Producing expenditure reports as required by the state Medicaid agency; and
- . Completing criminal record history checks, age verification, and health care registry checks on the personal assistant(s).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A monthly reimbursement is provided for financial management services. When financial management services are being shared due to a waiver participant transferring from one FM provider to another in one planning month, an prorated monthly reimbursement is approved.

The waiver service corresponding clinical coverage policy may be accessed using this link:

<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Management Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Financial Management

Provider Category:

Agency

Provider Type:

Fiscal Management Agency

Provider Qualifications

License (specify):

Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications of financial management.

Certificate (specify):

Other Standard (specify):

The FMS shall have a minimum of three (3) years of experience in developing, implementing and maintaining a record management process that includes written policies and procedures for establishing and maintaining current and archived participant, attendant, service vendors and FMS files in a secure and confidential manner and for the prescribed period of time as required by Federal and State rules and regulations, including HIPAA requirements. Internal controls for monitoring this process must be included in the system and described in the policies and procedures. The FMS will also have the capacity to provide Financial Management Services through both the Agency with Choice (AwC) and Fiscal/Employer Agent (F/EA) models. Be authorized to transact business in the State of North Carolina, pursuant to all State laws and regulations. Be approved as a Medicaid Provider for Financial Management Services.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General website to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual-Directed goods and services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service for the waiver participant directing care that provides services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan, and the waiver participant does not have the funds to purchase the item or service or the item or service is not available through another source. This service helps assure health, safety, and well-being when the waiver participant or responsible party does not have resources to obtain the necessary item or service that will aid in the prevention or diversion of institutional placement. Individual goods and services are items that are intended to: increase the waiver participant's ability to perform ADL's or IADL's and decrease dependence on personal assistant services or other Medicaid-funded services. Individual Directed Goods and Services must be documented in the service plan and the goods and services that are purchased under this coverage must be clearly linked to an assessed waiver participant need established in the service plan.

- . The coverage of this service is limited to waivers that incorporate the Budget Authority participant direction opportunity.
- . Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition against claiming for the costs of room and board.
- . The specific goods and services that are purchased under this coverage must be documented in the service plan.
- . The goods and services that are purchased under this coverage must be clearly linked to an assessed participant need established in the service plan.

Types of coverable goods and services:
 The following items are also coverable using this service in addition to other coverable items:
 Items to assist with personal hygiene and bathing, Items to assist with dressing; Items to assist with accessibility in the home; Items to assist with eating; Items to assist with toileting and Items to assist with mobility.
 The listed items are coverable:
 Long handle sponges, Long handle brushes, Elastic shoelaces, Bath tap turners, Button aids, Zipper pulls, Socks aids, Door knob grippers, Wheelchair or walker baskets/bags/caddy, Writing aids, No spill cups straw holder, two-handle mug, Scooper bowls and plates, Plate guards, Bibs, Bottom wipers, Bedside commode cushion, Incontinence disposal system, Protectants for a mattress, chair or car seat to protect against incontinence accidents, and wheelchair canopy.

Additional coverage of good and services may include items listed below and other items that are identified to be necessary and not coverable by the State Health Plan.

- . Sanitation (disinfectant) wipes for direct care workers hired through consumer-directed care;
- . hand sanitizer and disinfectant spray for direct care workers hired through consumer-directed care;
- . thermometer;
- . specific colored trash liners or biohazard disposable bags to be used to manage dirty linen of a waiver participant who has a short-term infection condition to prevent spread;
- . The coverage of a tablet or smartphone for identified waiver participants to promote telephonic/electronic engagements with service providers for telehealth, monitoring, and linkage and is restricted to individuals who do not have access to tablets or smartphones through the state plan. Coverage is approved based on financial need and when determined a necessary.

hypoallergenic pillows and blinds, when determined to necessary consistent with a medical condition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum approved amounts for participant goods and services et.al. shall not exceed \$800.00 total per participant per fiscal year July 1- June 30.

- . Items that are not of direct medical or remedial benefit to the waiver participant
- . Items covered under the Home Health Final Rule
- . Items covered through Medicaid State Plan DME, orthotics, prosthetics, and home health supplies
- . Items that meet the definition exclusions for recreational in nature
- . Items that meet the definition exclusions for general utility to non-disabled individuals
- . Service agreements, maintenance contracts, that are not related to the approved service, and Warranties
- . Equipment used with swimming pools, hot tubs, spas, and saunas that are not approved in the person-centered service plan or included in the exclusion definition
- . Replacement of equipment that has not been properly used, has been lost, or purposely damaged per written documentation or through observation
- . Technology hardware such as computer, laptop, tablet, or smart phone when considered recreational in nature or of general utility per the definition
- . Pharmacy related items that are not approved in the service plan
- . Outdoor monitoring systems that are not approved in the service plan and are included in the recreational in nature or general utility definition

Experimental or prohibited treatments are excluded.

The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
- Provider managed**

Specify whether the service may be provided by (*check each that applies*):

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durabale Medical Equipment Supplier
Agency	Retail Vendor
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Individual-Directed goods and services

Provider Category:

Agency

Provider Type:

Durabale Medical Equipment Supplier

Provider Qualifications

License (specify):

meet all applicable licensure requirements per NC Medicaid Provider Enrollment requirements

Certificate (specify):

Other Standard (specify):

Business approved by the Case management entity or FMS provider to provide the approved service, equipment or supplies of sufficient quality to meet the need for which it is intended.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management entity
 DHHS Fiscal Agent
 State Medicaid Agency
 FMS
 Tribal Governments

Frequency of Verification:

Initially and every five years thereafter by MMIS
 Case management entity to verify prior to service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction

Service Name: Individual-Directed goods and services

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The Retail vendor must hold the applicable business retail requirements to sale or furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Individual-Directed goods and services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Demonstrated ability to render the service to include letters of references.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14031 equipment and technology

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service that provides equipment, physical adaptations, product systems, devices, supplies, monitoring systems, specialized accessibility as identified during the comprehensive assessment, to improve, maximize or enhance the participant's mobility, safety, independence, and integration into the community or address 24/7 participant coverage concerns.

This service shall be used for:

- a. adaptive or therapeutic equipment designed to enable beneficiaries to increase, maintain, or improve functional capacity in performing daily life tasks that would not be possible otherwise;
- b. specialized monitoring systems; and
- c. specialized accessibility and safety adaptations or additions.

The benefit of the specialized monitoring system, as listed above, is used to promote the independent and self-sufficiency of the waiver participant. An assessment of need is completed to identify risks to the waiver participant and a service plan is created to mitigate those risks. During the development of the service plan, the waiver participant is provided information about all services and offered choice of those services. When a request is made for a monitoring system, the waiver participant is counseled and provided detailed information about additional requirements for obtaining the monitoring system which includes the development of a safety plan. The components of the safety plan include the designation of a responsible party that is either on-call or on duty; a back-up plan in the event of system failure; and the timeframe for responding to specific types of emergencies. When a decision is reached that a monitoring system can safety mitigate identified risk(s) to the waiver participant, prior to the installation of the monitoring system, the waiver participant and primary caregiver must develop a safety plan that includes the components listed above. for those eligible, EPSDT should be used for those eligible for all Assistive Technology covered with home health benefit.

There is an assurance that the monitoring system (camera) will not be installed in the bathroom or a location where the waiver participant would dress or undress.

If risks identified in the assessment require the direct assistance from a support staff, the waiver participant is notified and informed of the reasons and concerns of not using a support staff to mitigate the identified risks. Due process is provided if the request for the monitoring system is denied.

This service includes technical assistance in device selection and training in device used by a qualified assistive technology professional, assessment and evaluation, purchases, shipping costs, and as necessary, the repair of such devices.

This CAP service also includes a plan for training the CAP beneficiary, family, primary caregiver, personal aides, or assistants who will assist in the application or use of the device(s).

Repairs of assistive technology are covered as long as the cost of the repairs does not exceed cost of purchasing a new piece of equipment. CAP funding must not be used to replace equipment or devices that have not been reasonably cared for and maintained.

In some cases, the use of assistive technology may reduce the number of hours of personal care that the beneficiary needs. Professional consultation must be accessed to ensure that the equipment or supply meet the needs of the CAP beneficiary.

Each waiver beneficiary will be assessed on a person-centered planning basis. Catastrophic occurrences that may cause the waiver beneficiary to use more services than the established average limits will be assessed on an individual basis. Service requests that meet the catastrophic eligibility criteria may be approved at a limit more than the maximum limit of this service when an assessment of need is confirmed. NC Medicaid will closely monitor the individual and waiver average per capita cost to maintain cost neutrality of the waiver.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The total cost of modifications such as home, vehicle and assistive technology can not exceed \$28,000 per Beneficiary per the life of the waiver, which is renewed every five years.

Entry in the waiver when a home or vehicle modification or assistive technology is requested to return to or remain in the primary private residence that prevents risk of institutionalization (the installation of equipment or modification must be completed within three (3) months of approval.
 The installation of a home or vehicle modification or assistive technology is completed through evidence of an invoice and a prior approval claims submitted to NCTracks.

The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
<input type="checkbox"/> Individual	<input type="checkbox"/> Specialized Therapist
<input type="checkbox"/> Agency	<input type="checkbox"/> Business/Commercial

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Specialized Therapist

Provider Qualifications

License (specify):

Qualified assistive technology professionals, nursing facility (rehab), hospital, or certified home health agency(s), state licensed occupational therapist, physical therapist, and speech therapist can provide this service through consultation, education, repairs, and technical assistance on devices to the beneficiary, family, caregiver, personal aides, and assistance who will assist the beneficiary with application or use of device(s).

Certificate (specify):

Certification- An Assistive Technology Practitioner (ATP) or Assistive Technology Supplier (ATS) certified by RESNA

Other Standard (specify):

Assistive Technology Professionals, Nursing Facility (Rehab), Hospital, or Certified Home Health Agency that are State licensed Occupational Therapists, Physical Therapists or Speech Language Pathologists (Licensure to include certification of clinical competency which is required for augmentative communication evaluations) shall provide assistive technology. Additional provider qualifications may include Assistive Technology Practitioners (ATP) or Assistive Technology Suppliers (ATS) certified by RENSA. Assistive Technologists shall hold a bachelor's degree in a human services field, special education or related degree, and two years of experience working with assistive technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

At time of waiver service provision

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications**License (specify):**

Qualified assistive technology professionals, nursing facility (rehab), hospital, or certified home health agency(ies), state licensed occupational therapist, physical therapist, and speech therapist can provide this service through consultation, education, repairs, and technical assistance on devices to the beneficiary, family, caregiver, personal aides, and assistance who will assist the beneficiary with application or use of device(s).

Certificate (specify):

Certification- An Assistive Technology Practitioner (ATP) or Assistive Technology Supplier (ATS) certified by RESNA

Other Standard (specify):

Assistive Technology Professionals, Nursing Facility (Rehab), Hospital, or Certified Home Health Agency that are State licensed Occupational Therapists, Physical Therapists or Speech Language Pathologists (Licensure to include certification of clinical competency which is required for augmentative communication evaluations) shall provide assistive technology. Additional provider qualifications may include Assistive Technology Practitioners (ATP) or Assistive Technology Suppliers (ATS) certified by RENSA. Assistive Technologists shall hold a bachelor's degree in a human services field, special education or related degree, and two years of experience working with assistive technology.

Verification of Provider Qualifications**Entity Responsible for Verification:**

NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

NC Medicaid MMIS for provider enrollment

Frequency of Verification:

Initially, at time of waiver service provision and every five years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Attendant Nurse Care

HCBS Taxonomy:

Category 1:

05 Nursing

Sub-Category 1:

05020 skilled nursing

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service for a waiver participant who has substantial, complex, and continuous skilled nursing care needs. Attendant Nurse-care is a licensed professional, R.N. or LPN (under the direct supervision of an R.N.) who can pass a registry and criminal background check, in good standing with the Board of Nursing, and Basic Life Support (BLS) certified. Nurse Attendant care is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility or that requires more continuous care than is available through home health services. This level of care must be medically appropriate and medically necessary for the beneficiary to be covered by this service in the waiver. The waiver participants must meet the qualifying criteria listed below to qualify for this service type.

- . A life-threatening medical condition characterized by reasonably frequent periods of acute exacerbation which requires frequent physician supervision or consultation and which, in the absence of such supervision or consultation, would result in hospitalization.
- . Beneficiary need for frequent, ongoing, and specialized treatments and nursing interventions that are medically necessary. and
- . Beneficiary dependency on life-sustaining medical technology such that a reasonable level of health could not be maintained without the technology. PDN service-assisted technology is dependent on a ventilator, endotracheal tube, gastrostomy tube (G-tube), oxygen therapy, cough assist device, chest physical therapy (P.T.) vest, and suction machine or care to compensate for the loss of bodily function.

The conditions must also qualify under the definitions listed below.

Substantial
Substantial means there is a need for interrelated nursing assessments and interventions. Interventions not requiring an assessment or judgment by a licensed nurse are not considered substantial.

Complex
Complex means scheduled, hands-on nursing interventions. Observation in case of an intervention is required is not considered complex skilled nursing.

Continuous
Continuous means nursing assessments requiring interventions being performed at least every two (2) or three (3) hours during the coverage of this service.

The nurse attendant care shall comply with specific requirements listed below that align with the Nurse Practice Act. Attendant Nurse Care differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from private duty nursing in the State Plan. This service is available only for waiver participants enrolled in consumer-directed care.

Assurance: The service under the waiver's Attendant Care is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. For those eligible, EPDST will be used for all mandatory and optional state plan services.

Nurse attendant care is intended to be provided in the home and can be provided in the community to promote community inclusion.

The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the nurse

attendant. Suppose the legally responsible party is the hired caregiver. In that case, there must be a backup caregiver designated who can assist in making judgments on the caregiver's behalf regarding the care of the waiver participant. When the hired worker is an LPN, an arrangement must be made for a supervising registered nurse to provide consultation and guidance of care to ensure the delivery of safe and competent care (NC Board of Nursing). The licensed nurse makes decisions regarding delegating any nurse tasks on a beneficiary-by-beneficiary basis. The nurse attendant shall participate in implementing the health care plan developed by the Employer of Record by performing tasks assigned or delegated by and performed under the supervision or under orders or directions physician licensed to practice medicine, dentist, or other person authorized by State law to provide the supervision. Tasks, amount, frequency, and duration of skilled care must be clearly outlined in the Skilled Declaration Form and the CAP Skilled Level of Care Plan.

Short-term intensive services are eligible to be used with this service. Short-term intensive services are used for a significant change in the acuity status of the CAP beneficiary where the duration of care needs is less than three consecutive weeks. Short-term intensive services are listed in the service plan. Short-term-intensive care is used to approve extra hours needed due to a temporary change in the beneficiary's condition resulting in additional or increased medical needs or a caregiver crisis (significant illness or death in the family).

Unplanned waiver service occurrence requests are eligible to be used with this service. Unplanned waiver services occurrence requests request an adjustment beyond the approved service plan for a particular day(s) due to an unexpected event (such as an accident or flat tire).

The waiver participant can use up to 14 days per year of recreational leave (family vacation) when planned for in the initial and annual person-centered service plan. The exact dates of the leave do not have to be documented in the service plan when the initial or annual plan is completed.

Assistance from the nurse attendant when traveling out of state is allowed when the provision of this service complies with NCBON licensure and certification rules, the service plan, and clinical coverage policy 2A3, Out-of-State Services. An assigned nurse attendant shall accompany or transport (based on the agency's policy) a waiver participant beneficiary and the primary caregiver to a medical appointment, to and from school, or other activities, if documented in the service plan to provide medical care or personal care for the Waiver participant.

Consistent with the Nurse Practice Statement, the nurse attendant shall accept only assignments they: a. are qualified and competent to perform per the Skilled Declaration Form and the CAP Skilled Level of Care Plan;

b. are able to follow the policies and procedures to support safe patient care; and

c. are able to accept responsibility for self-regarding individual nursing actions, which include:

1. Knowing and understanding the statutes and rules governing nursing and functioning within those legal boundaries.

d. Are able to accept accountability for the care provided to waiver participant and all nursing care delegated. -

The nurse attendant hired under consumer direction must consider:

- . Employer expectations for their role, and
- . Determine whether the activities expected in the course of employment are consistent with:
 - . Personal moral values,
 - . Professional, ethical standards, and most importantly
 - . Legal standards of licensure

Attendant Nurse Care can be combined with coordinated caregiving and consumer directed care when special conditions are met. Combining services for a legally responsible (parent) person that are inclusive of the extraordinary conditions is permissible under special conditions when a justification of need documented by the multidisciplinary team is the assessment and service plan.

This service is subject to the 21st Century Cures Act for Electronic Visit Verification requirements (EVV).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A service plan approved for a waiver participant directing their care through consumer-directed services and determined to meet skilled level will calculate nurse care hours using the nursing review criteria outlined in Attachment G in the 3G-2 clinical coverage policy.

Upon requesting a waiver participant to change their care from private duty nursing (PDN) to attendant nurse care through consumer-directed services, the PDN provider agency must notify the assigned waiver case manager to collaboratively work together to create a transition plan, including the transition date for waiver participant. The PDN provider must submit a request to end-date the prior approval for PDN services consistent with the transition plan.

Participation will terminate if the primary caregiver of the employer of record demonstrates the inability to direct care by failure to follow the POC or nurse attendant CAP/C Skilled Level care plan. Failure to hire qualified workers inappropriate approved hours, or other acts of fraud, waste, and abuse will terminate the participation in this waiver service.

Waiver service planning is not intended to provide 24-hour care; combining services to provide 24-hour care needs is not permissible. The hours between 12m-5 am are designated as a non-formal time for a parent/primary caregiver/legally

responsible person living with the waiver participant who is approved to be the paid worker. These designated hours are intended to prevent burnout and grant an opportunity for the parent/primary caregiver/legally responsible person to sleep/rest. An external direct care worker is hired when a service plan identifies the need for paid support during these hours. Extraordinary circumstances may apply to permit a parent/primary caregiver/legally responsible person to be paid worker during these hours.

Planned and arranged respite must be added to the service plan quarterly for the legally responsible person approved to be paid caregiver to be granted a mental and physical break from the routine 24/7 care to the waiver beneficiary.

A quarterly Home Health visit must be included in the POC for beneficiary directing care using Attendant Nurse Care for continuous access to nursing supplies and equipment. This visit will also provide a quarterly assess of the beneficiary wellbeing.

Waiver beneficiaries receiving PDN from State Plan who have not been able to recruit a nurse as evidence by written documentation from the Home Health agency, PNA services can be temporarily authorized to offer support and assistance with IADLs and monitoring of ADLs when approved the supervising nurse of the HH agency.

A live-in family member hired to render the care cannot be paid more than 40 hours per week.

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	R.N. or LPN
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Attendant Nurse Care

Provider Category:

Individual

Provider Type:

R.N. or LPN

Provider Qualifications

License (specify):

Registered nurse

Licensed Practical Nurse

Certificate (specify):

BLS certified

Other Standard (specify):

Consumer-directed care for skilled level participants requirements:

1. Become the employer of record under the consumer direction option to allow the primary caregiver to function in the role of the employer by recruiting, hiring, and overseeing a licensed professional, specifically a registered nurse (R.N.), for the purpose of monitoring orders and health care conditions of a waiver beneficiary who is determined to meet the criteria in

Section 3.0 of the 3G-2 CCP.

2. Be able to collaborate with the primary physician to complete the CAP/C Skilled Declaration Form, which outlines the need for skilled care that must be used to develop a CAP/C Skilled Level care plan.
3. Be able to direct an interested worker in completing a competency skill assessment form and having the skill and ability to evaluate the responses to ensure the worker is qualified to carry out the tasks identified in the CAP/C Skilled Declaration Form and the Skilled Level care plan.
4. Must have one (1) trained primary informal caregiver to provide direct care to the waiver participant beneficiary during the plan and unplanned absence of a qualified worker/licensed professional.
5. When a Licensed Practical Nurse (LPN) is recruited and hired, a Registered Nurse must be contracted to provide guidance and supervision to the LPN.

Must have experience as outlined below:

- . A minimum of 1000 hours of experience in the previous two years in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.
- . A minimum of 2000 hours of experience in the previous three years in an acute care hospital caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.
- . A minimum of 2000 hours of experience in the previous five years, working for a licensed and certified home health agency caring for individuals with the care need(s) of individuals at the levels of care specified in this waiver.
- . A minimum of 2000 hours of experience in the previous five years in an area not listed above, that in the opinion of DHHS, would demonstrate appropriate knowledge, skill, and ability in caring for individuals at one or more of the levels of care specified in this waiver.

Shall comply with specific requirements listed below that align with the Nurse Practice Act.

- Assessing the patient's physical and mental health, including the patient's reaction to illnesses and treatment regimens and reporting those reactions to the employer of record.
- Recording and reporting the results of the nursing assessment.
- Planning, initiating, delivering, and evaluating appropriate nursing acts.
- Participating in teaching, assigning, delegating to, or supervising the Employer of Record and other family members in implementing the treatment regimen.
- Collaborating with other health care providers in determining the appropriate health care for a patient but, subject to the provisions of G.S. 90-18.2, not prescribing a medical treatment regimen or making a medical diagnosis, except under the supervision of a licensed physician.
- Implementing the treatment and pharmaceutical regimen prescribed by any person authorized by State law to prescribe the regimen.
- Providing teaching and counseling about the patient's health.
- Reporting and recording the nursing care given from the care plan and the patient's response to that care.
- Supervising, teaching, and evaluating the Employer of Record and other family members who perform or are preparing to perform nursing functions when the nurse is not available.
- Maintaining safe and effective nursing care, whether rendered directly or indirectly

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV).

Verification of Provider Qualifications

Entity Responsible for Verification:

SMA along with FMS

Frequency of Verification:

annually and during a change in condition of the waiver participant

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Attendant Nurse Care

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License (specify):

Services are provided by a home care agency licensed by the DHSR under 10A NCAC 13J.

An individual licensed by the NCBON as a Registered Nurse provides supervision of the Nurse Aide as under 10A NCAC 13J.1110.

The Nurse Aide providing direct care is registered as a Nurse Aide I + or Nurse Aide II with DHSR and the NCBON.

Medicare certified home health agency.

Certificate (specify):

The nurse aide providing direct care is certified in CPR. It is recommended that (s)he also be certified in First Aid.

Other Standard (specify):

Staff shall obtain licensure or certification according to all applicable laws and regulations, and practice within the scope of practice as defined by the individual practice board.

NC Medicaid requires the following provider qualifications and training be completed before staff is assigned to provide person care to the CAP beneficiary:

- a. Criminal background checks, which must be repeated every two (2) years, at the time of licensure renewal (refer to Subsection 6.6);
- b. Verification of cardiopulmonary resuscitation (CPR) certification and every two (2) years, coinciding with expiration dates;
- c. Review of trainings and beneficiary-specific competencies at each job performance review as per agency policy;
- d. Pediatric nursing experience or completion of NC Medicaid pediatric training, such as
 1. growth and development;
 2. pediatric beneficiary interactions;
 3. and home care of pediatric beneficiary;

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV).

Verification of Provider Qualifications

Entity Responsible for Verification:

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and education services are needed and documentation is available to support training needs were met.

Frequency of Verification:

The verification of provider qualification is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Integration

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17030 housing consultation

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

This service is for an active waiver participant in jeopardy of losing their community placement due to tenancy-related issues. This service may be used in any duration or type, up to the maximum allotted amount through the duration of the waiver approval cycle, to pay for necessary and documented tenancy-related expenses for the waiver participant. The following are allowable activities for Community Integration:

The assistance in Community Integration service enables waiver participants to maintain their housing as outlined in the participant's approved plan of care (POC).

Services must be provided in the home or a community setting. The service includes the following components:

1. Authorizing a community-based organization, housing authority agency, or a legal aide representative to assist the waiver participant in developing a housing plan that identifies preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and the associated support needed to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).
2. Authorizing a community-based organization or legal aide representative to assist the waiver participant in developing an individualized community integration plan that includes securing supporting documents/records, completing/submitting applications, arranging to identify resources to assist with securing deposits, and locating furnishings for the home.
3. Authorizing a community-based organization or legal aide representative to assist with crisis intervention by engaging property housing managers and landlords for eviction risk mitigation efforts related to a waiver participant's disability.

Items and services must be of sufficient quality and appropriate to the needs of the waiver participant. To seek reimbursement, the service vendor shall provide an invoice for each service intervention as described in the service definition.

This service may be used to link to health-related legal support when determined necessary.

This service may be used for housing safety and quality inspection by a certified professional, including the assessment of potential home-based health and safety risks to ensure the living environment is not adversely affecting occupants' health and safety, when applicable.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service does not provide any room or board items such as deposits, housing costs or household furnishings. Room and board fees are excluded

. Ongoing payments for rent are excluded
 . Not to exceed \$2500 per waiver participant for the life of the waiver cycle

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Property Manager
Individual	Retail Supplier

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Integration

Provider Category:

Individual

Provider Type:

Property Manager

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need as verified by the Case management entity. The case management entity does not provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Integration

Provider Category:

Individual

Provider Type:

Retail Supplier

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need as verified by the Case management entity. The case management entity does not provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Community Transition service can be used for individuals transitioning from an institution or provider owned/controlled residence to a private residence for which the individual is responsible for his/her own rent/utilities. This service may be used in any duration or type, up to the maximum allotted amount, at the start of a community transition and up to 1 year after the original transition date to pay for necessary and documented one-time expenses for the waiver participant to establish or maintain a basic living arrangement within one year of the transition to community.

Services for prospective waiver participants transitioning from an institutional setting to a community setting. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Community transition services may cover the following:

- . Essential furnishings, and household products including furniture for the bedroom or living room, window coverings, food preparation items, and bed/bath linens
- . Residential application fees
- . Security deposits required to obtain a lease on an apartment or home
- . Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating)
- . Environmental health and safety assurances, such as pest eradication; allergen control; one-time cleaning prior to occupancy

This service may be used to link to health-related legal support when determined necessary.

This service may be used for housing safety and quality inspection by a certified professional, including the assessment of potential home-based health and safety risks to ensure the living environment is not adversely affecting occupants' health and safety, when applicable.

Items and services (including rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary. The vendor of the service shall provide a receipt for each purchase or invoice to seek reimbursement. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service definition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Room and board fees are excluded
 Payment for rent is excluded
 Not to exceed \$2500 per waiver participant for the life of the waiver cycle
 The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>
 The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail suppliers
Individual	Independent Contractors
Agency	Property Management Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Retail suppliers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provide or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Individual

Provider Type:

Independent Contractors

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected

provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Property Management Agencies

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provide or render this service.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services**C-1/C-3: Service Specification**

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Coordinated Caregiving

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Coordinated Caregiving includes supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community, which provides for such support as adaptive skill development, assistance with activities of daily living (ADLs), and instrumental activities of daily living (IADLs), linkage to health care providers and local resources, social and leisure skill development, protective oversight, and supervision. This service also provides learning opportunities, developing and maintaining skills in the areas of social and recreational activities and personal enrichment. The setting for this service is in the waiver participant's own home or waiver participant's relative/related family/friend's home.

This service is intended to promote the waiver participant's independence and provides in-home supportive services for personal care and basic home management tasks due to the waiver participant's inability to perform these tasks independently due to a disabling condition. Coordinated Caregiving integrates the waiver participant into the usual activities of family and community life.

Coordinated Caregiving is provided by a caregiver who resides in the home of the waiver participant or the caregiver's home. Coordinated Caregiving is provided in a private residence. It affords all the rights, dignity, and qualities of living in a private residence, including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.

The live-in caregivers will receive a monthly stipend.

The Home Environment Requirements:

The home shall provide living arrangements to meet the individual needs of the waiver participants, the supportive staff, and other caregivers.

The home must have a living room, kitchen, dining area, and bathroom.

The home must have operable windows, two exterior doors with locks, fire alarms, a fire extinguisher, and an emergency first aid kit.

Waiver Participant Care Plan

Provider agency shall ensure a care plan is developed for each waiver participant in conjunction with the waiver participant assessment to be completed within 30 days following the service plan. The care plan shall be individualized.

The care plan shall be revised as needed based on further assessments of the waiver participant and caregiver.

The care plan shall include the following:

A statement of the daily care or service to be provided to the participant based on the assessment or reassessment;

A statement of the education and coaching to be provided to the caregiver

The assessor shall sign the care plan upon its completion.

Mail-Waiver participants shall receive their mail promptly. It must be unopened unless there is a written statement that the live-in caregiver is authorized to open and read the waiver participant's mail.

Laundry-Laundry services must be provided to waiver participants without any additional fee.

Telephone - A telephone must be available in a location providing privacy for waiver participants to make and receive a reasonable number of calls of a reasonable length.

Personal Space -Personal space must be provided for the waiver participant to secure his personal valuables.

Management of waiver participant's funds -Waiver participant shall manage their own funds unless a written agreement designates a POA or legal guardian, legal representative, or payee.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The live-in caregiver is paid a stipend to provide the oversight and supervision needed to maintain community placement. An individual serving as the waiver participant's legally responsible party may be eligible to be a provider of coordinated

caregiving when qualifying conditions are met; refer to C-2 for extraordinary circumstances for a legal guardian to provide this service.

The reimbursement rate does not include room and board. Settings such as a foster care setting, an alternative family living setting, or a provider-owned home are prohibited.

A waiver participant receiving coordinated caregiving services shall not receive any of the following services:

- . In-home aide services
- . Pediatric nurse aide services
- . Personal assistance services
- . Attendant nurse care

These services can be combined when special conditions are met for provider-led services. Combining services for a legally responsible (parent) person that are inclusive of the extraordinary conditions is permissible under special conditions when a justification of need documented by the multidisciplinary team is in the assessment and service plan. Because the waiver is not intended to provide 24-hour care, combining services to provide 24-hour care needs is not permissible.

Individuals enrolled in the new service, Coordinated Caregiving does not need to be a RN or an LPN because of the Home Health agency support from the coordinated caregiver agency.

Planned and arranged respite must be added to the service plan quarterly for the legally responsible person approved to the be paid caregiver to be granted a mental and physical break from the routine 24/7 care to the waiver beneficiary.

A monthly contact visit is required from the monitoring agency. A Health visit must be included in the POC for beneficiary directing care using Attendant Nurse Care for continuous access to nursing supplies and equipment. This visit will also provide a quarterly assess of the beneficiary wellbeing.

Waiver beneficiaries receiving PDN from State Plan who have not been able to recruit a nurse as evidence by written documentation from the Home Health agency, PNA services can be temporarily authorized to offer support and assistance with IADLs and monitoring of ADLs when approved the supervising nurse of the HH agency.

A coordinated caregiver for a waiver participant who meets the skill level criteria outlined in the 3G-2 clinical coverage policy must be an R.N. or LPN, and BLS certified.

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCBS approved provider Agencies and Federally recognized tribes
Agency	Home Health Provider of nursing services

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Coordindated Caregiving

Provider Category:

Agency

Provider Type:

HCBS approved provider Agencies and Federally recognized tribes

Provider Qualifications**License (specify):**

none

Certificate (specify):

none

Other Standard (specify):

Must meet the HCBS requirement described in the 3K-1 Clinical Coverage Policy.

Caregiver Qualifications:

Must be at least 18 years of age, in good health, and able to follow written and verbal instructions.

Must pass criminal and registry background check

CPR certified

Provider Qualifications:

Pass a competency validation

Participant in care planning meetings

Agency providers must be enrolled as an NC Medicaid Provider

Agency providers must demonstrate three years of delivering HCBS to elders and adults with disabilities and their caregivers.

Agency providers must develop, implement, and provide ongoing management and support of a person-centered service plan that addresses the waiver participant's level of service needs, including an agreement with caregivers describing their roles and responsibilities for the care and support provided to the waiver participant.

Agency providers must conduct home visits based on the waiver participant's assessed needs and caregiver coaching needs.

Agency providers must provide the caregiver a minimum of 8 hours of annual training that reflects the waiver participant's and caregiver's assessed needs. Training may be delivered during home visits, through secure electronic communication methods, or in another manner that is flexible and meaningful for the caregiver.

Agency providers must provide education and coaching to lay caregivers that are based on the participant's and caregivers' assessed needs, including managing health-related needs; personal care; cognitive, behavioral, and social needs of waiver participants, and including interventions to reduce behavioral problems for waiver participants with mental disabilities and who need restorative services. Training, coaching, and guidance must occur at a minimum monthly.

Agency providers must work with the waiver participant and caregiver to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care and ensure that caregivers understand how to manage medical and other incidents and emergencies as they may occur and report such situations to the provider agency, as soon as possible.

Must have the ability to perform competency evaluation on hired staff

Must perform background checks to include all hired supportive caregivers to validate no finding entered the registry or convictions outlined on the HCBS banned list.

Must assure the health and safety needs of the waiver participant are met in conjunction with the case manager.

Must ensure that coaching to the supportive caregiver includes the importance of providing nutritionally balanced meals and healthy snacks each day to the waiver participant, as dictated by their medical/nutritional needs.

Must engage in regular review of caregiver notes to understand and respond to changes in the waiver participant's health status and identify potential new issues to better assist with the coordination of care to avoid unnecessary hospitalizations or emergency room use

Competency Validation of Caregivers

Provider agency shall assure that each caregiver has the demonstrated competency to perform the personal care activities specified in the CAP service authorization.

Documentation Requirement -Documentation to support service rendered that includes:

Electronic caregiver notes that record and tracks the participant's status, and updates or significant changes in their health status or behaviors and participation in community-based activities and other notable or reportable events

Medication management records, when applicable

Critical incidents

Grievances and complaints

Home visits conducted by provider agency

Education, skills training, and coaching conducted with the caregiver

Multidisciplinary team meetings demonstrate collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers, and other caregivers or individuals important to the waiver participant regarding changes in the participant's health status and reportable events.

Qualified caregivers

Least Restrictive Environment Requirements

The provider agency must ensure that the participants have access to common areas and support available as part of living in the community. A participant's access may be restricted only when the participant's service plan determines the need to assure the participant's safety as documented in the comprehensive assessment.

Transportation. The provider must assure, whenever possible, the provision of transportation by the supportive caregiver for the waiver participants to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping, and recreational facilities, and religious activities of the waiver participant's choice.

The waiver participant is not to be charged any additional fee for this service. Transportation sources may include community resources, public systems, volunteer programs, family members and transportation, and medical and non-medical.

Verification of Provider Qualifications**Entity Responsible for Verification:**

NC DHHS fiscal agent and MMIS (GDIT/NCTracks)
State Medicaid Agency

Frequency of Verification:

Initially and annually during the reevaluation of program participation

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Other Service

Service Name: Coordinatated Caregiving

Provider Category:

Agency

Provider Type:

Home Health Provider of nursing services

Provider Qualifications**License (specify):**

Services are provided by a home care agency licensed by the DHSR under 10A NCAC 13J.

An individual licensed by the NCBON as a Registered Nurse provides supervision of the Nurse Aide as under 10A NCAC 13J.1110.

The Nurse Aide providing direct care is registered as a Nurse Aide I + or Nurse Aide II with DHSR and the NCBON.

Medicare certified home health agency.

Certificate (specify):

The nurse aide providing direct care is certified in CPR. It is recommended that (s)he also be certified in First Aid.

Staff shall obtain licensure or certification according to all applicable laws and regulations, and practice within the scope of practice as defined by the individual practice board.

Other Standard (specify):

NC Medicaid requires the following provider qualifications and training be completed before staff is assigned to provide person care to the CAP beneficiary:

- a. Criminal background checks, which must be repeated every two (2) years, at the time of licensure renewal (refer to Subsection 6.6);
- b. Verification of cardiopulmonary resuscitation (CPR) certification and every two (2) years, coinciding with expiration dates;
- c. Review of trainings and beneficiary-specific competencies at each job performance review as per agency policy;
- d. Pediatric nursing experience or completion of NC Medicaid pediatric training, such as
 1. growth and development;
 2. pediatric beneficiary interactions;
 3. and home care of pediatric beneficiary;

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV), when applicable.

Verification of Provider Qualifications

Entity Responsible for Verification:

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and education services are needed and documentation is available to support training needs were met.

Frequency of Verification:

The verification of provider qualification is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Accessibility and Adaptation

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Home accessibility and adaptation provides equipment and physical adaptations or minor modifications, as identified during an assessment, to enhance the waiver participant's mobility, safety, and independence in the primary private residence. This service often plays a key role in preventing institutionalization.

An assessment of need must be reviewed by a multidisciplinary team in conjunction with a Physical Therapist (PT), Occupational Therapist (OT), Rehabilitation Engineer, or Assistive Technology Professional (for ECUs/EADLs) certifying necessity. A copy of the assessment must be submitted with the request for Home Modifications (with the exception of floor coverings, air filters, and generators). A physician's signed order may be requested to certify that the requested adaptation is necessary. The physician's order and the assessment completed by a PT, OT, Rehabilitation Engineer or Assistive

Technology professional must be on file in the waiver participant's record. When feasible, there must be at least one competitive quote for home modifications to determine the most efficient method to complete the request. An appropriate professional shall provide the modifications or adaptations to the primary private residence.

Assurance: The service under the waiver's Home accessibility and adaptation is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Construction and installation must be completed according to state and local licensure regulations and building codes when applicable. All items must meet applicable standards of manufacture, design and installation.

Home modifications can be provided only in the following settings:

- a. A primary private residence where the waiver participant resides that is owned by the waiver participant or his or her family;
- b. A rented residence when the modifications are portable;

Approval for floor coverings, air filtration, and generators must be based on RN assessment and MD certification.

The following are the covered home accessibility and adaptation modifications:

- a. Wheelchair ramps, stationary or portable, and wheelchair ramps with landing pads;
- b. Threshold ramps, used to allow wheelchairs to move over small rises such as doorways or raised landings;
- c. Grab bars or safety rails mounted to wall, floor or ceiling;
- d. Modification of an existing bathroom to improve accessibility for a disabled beneficiary, such as: installation of roll in shower, low threshold showers, sink modifications (raised, lowered, pedestal, pedal specific for beneficiary), water faucet controls, tub modifications, toilet modifications (such as raised seat or rails), floor urinal adaptations, turnaround space modifications for wheelchair and stretcher bed access, and required plumbing modifications that are necessary for the modifications listed above;
- e. Widening of doorways for wheelchair access, turnaround space modifications for wheelchair access;
- f. An emergency egress door when determined to be medically necessary due to physical limitations of the responsible party;
- g. Bedroom modifications to widen turnaround space to accommodate hospital beds, larger or bulky equipment and wheelchairs (ex. removing a closet to add space for the bed or wheelchair);
- h. Lift systems and elevators that are used inside a beneficiary's private primary residence and are not otherwise covered under DME;
- i. Porch stair lifts;
- j. hypoallergenic home filters to assist with removing dust, pollen, mold and other harmful bacteria and virus from the home.
- j. Floor coverings, when existing floor coverings contributed to documented falls, resulting in injury as evidenced by hospital and emergency room visits, or when those floor coverings are contributing to asthma exacerbations, documented in the health record, requiring repeated emergency room or hospital treatment;
- k. Driving surfaces, when existing driving surfaces leading to the primary private residence pose an access to care issue to the beneficiary with documented gaps in service provision or documented inability to render emergency services contributing to impassable path;
- l. Portable or whole house air filtration system and filters under the following circumstances:
 1. For a beneficiary 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 beneficiary's asthma remains classified as moderate persistent or severe persistent, and a physician has certified that air filtration is of benefit. Ozone generators and electronic or electrostatic or other air filters which produce ozone.
 2. For a beneficiary susceptible to infection, when adequate infection control measures are already in place, yet the beneficiary continues to acquire airborne infections, and when a physician has certified that air filtration is of benefit in preventing infection, a germicidal air filter (with UV light) may be provided.
 3. The smallest unit that meets the beneficiary's needs is covered; , if a beneficiary spends most of his or her time confined to a specific area of the house, then a whole-house system is not covered.
- m. Replacement filters for items covered under the home accessibility and adaptation service;
- n. Portable back-up generator for a ventilator, when the beneficiary uses the ventilator more than eight hours per day, and in the event of a power outage, the beneficiary requires hospitalization, if not for the presence of the portable generator. The coverage of a 220-volt line from a circuit breaker panel in the home to a receptacle installed outside is covered in that instance.

The replacement of a fixture (sink or toilet) or a mirror over the vanity may be replaced using funding through the home accessibility and adaptation service when during demolition the fixture or mirror cannot be preserved as described in the specification document.

Approval of minor plumbing and electrical work when determined necessary during the modification, but not to repair or fix plumbing or electrical problems.

The replacement of storage spaces when original storage place was used to widen an area or modify the area.

Home accessibility and adaptation items that require a physician's order:

- a. Tub replacement; and
- b. A portable generator.

The home accessibility and adaptation service consists of the following:

- a. Technical assistance in device selection;
- b. Training in device use by a qualified assistive technology professional;
- c. Purchase, necessary permits and inspections, taxes, and delivery charges;
- d. Installation;
- e. Assessment of modification by the case manager and by any applicable inspectors to verify safety and ability to meet waiver participant's needs;
- f. 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 participant or his or her family shall own any equipment that is repaired; and
- g. The move of modification or adaptation from one primary private residence to another. An evaluation of the cost for labor and costs of moving modification or adaptation must be approved prior to the move.

The CME authorizes the services through a service authorization and verifies training, technical assistance, permits, inspections, safety and ability to meet waiver participant's needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Home accessibility and adaptation provides a combined vehicle modification and assistive technology waiver cycle benefit of \$28,000 per waiver participant. When the maximum utilization limit is reached, requests for home modification are reviewed separately to determine extreme need.

The vendor of this service or the CME shall file a claim to Medicaid upon the receipt of an invoice for reimbursement of this service. The original invoice must be retained in the waiver participant's record.

Home modification excludes the following:

- a. home modifications that add to the total square footage of the home;
- b. home improvements, renovations, or repairs;
- c. homes under construction;
- d. a dwelling where the owner refuses the modification;
- e. the modification in a rented residence when the requested modification is not portable;
- f. purchase of locks;
- g. service agreements, maintenance contracts, insurance, and extended warranties;
- h. roof repair, central air conditioning;
- i. swimming pools, hot tubs; spas, saunas, or any equipment, modification or supply related to swimming pools, hot tubs, spas, or saunas;
- j. items that have general utility to a non-disabled waiver participant;
- k. replacement of equipment that has not been properly used, has been lost or purposely damaged;
- l. computer desk and other furniture;
- m. plumbing, other than the plumbing described under the covered items in letter(d);
- n. approved vendor shall not be the spouse, parent, primary caregiver or legal guardian of the waiver participant; and
- o. Air filtration that is less than or equal to 50 parts per billion ozone by-products.

A generator with a wattage capacity power of 3kW to 10kW, used only during an emergency to maintain a life-sustaining device. The portable generator is not intended for stand-by power (permanent installed generator with an automatic turn-on).

A portable generator through CAP/C services is primarily used on a short-term, temporarily basis, during an emergency, to ensure the continuous operation of a ventilator, and when applicable, other small medical devices that safe-keep medication and other essential health care items operating.

Funding for home accessibility and adaptation available through the waiver must be shared to meet the needs of the household. Equipment, technology and modification are shared when the disabilities of two or more waiver participants living in the same household are similar.

The total budget for home accessibility and adaptation services is planned per waiver participant and the total budget must be shared between the two parents when a shared custody order is in effect.

A waiver participant who resides in foster care is eligible to receive a home modification when the modification is portable.

A waiver participant who is in a permanent foster care placement, ordered by the court and the placement is intended to last more than three (3) years, is eligible to receive a permanent home modification.

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Home Accessibility and Adaptation

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License *(specify):*

Local business licensure requirement specific to business entity

Certificate *(specify):*

Other Standard *(specify):*

Case Management Entity must approve and authorize the service and the provider.
The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license. Licensed contractors are preferred.

Enrolled Medicaid providers who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer's specifications and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Transportation covered by this waiver is intended to allow waiver participants to gain access the community to obtain medication, food, attend activities and access resources, to meet goals as specified in person-centered service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. This service has maximum utilization limits and does not duplicate NEMT.

The services under the waiver's non-medical transportation are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. For those eligible, EPDST will be used for all mandatory and optional state plan services.

There are no payments other than those directly from Medicaid to the provider of this service.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Transportation of a waiver participant to receive medical care that is provided under the State plan must be billed as a State plan transportation service.

Mile reimbursement - .58 per mile with a maximum radius of 35 miles from the waiver participant's residence. The maximum allowable per trip is \$21.80. The maximum allowable trips per month is three (3).

. Bus tokens- \$2.50 maximum for a day pass or \$45.00 maximum for a month's pass. The maximum allowable per year is \$540.00.

. Taxi rides or share rides - The maximum allowable per trip is \$21.80. The maximum allowable trips per month is three (3).

. Gas Vouchers - .58 per mile with a maximum radius of 35 miles from the waiver participant's residence. The maximum allowable for one gas voucher per trip is \$21.80. The maximum allowable gas vouchers per month is three (3).

The maximum approved amounts for participants goods and services, individual-directed goods and services, pest

eradication, non-medical transportation and nutritional services cannot exceed \$800.00 total per each fiscal year.
 The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>
 The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Vendor
Individual	Individuals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License (*specify*):

Employees must have a valid driver's license

Certificate (*specify*):

Other Standard (*specify*):

The Retail vendor must hold the applicable business retail requirements to sale or furnish one of the listed items under this definition and the company must have liability insurance coverage. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individuals

Provider Qualifications

License (specify):

Must have a Valid Driver's license

Certificate (specify):

Other Standard (specify):

An individual provider of transportation shall have a valid drivers' license, car insurance that covers liability and his or her own.

The individual must demonstration capacity to furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Nutritional Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (*Scope*):

A service for a waiver participant that provides coverage for physician ordered health supplements, vitamin or mineral supplements, herbal preparations and nutritional supplements such as vitamins that are directly related to the primary physical medical condition and are determined medically necessary but are not available under the State Plan. These nutritional supplements such as vitamins are necessary to assist the waiver participant to maintain community placement and for the management of health and safety as identified in the person-centered service plan.

Assurance: The services under the waiver's nutritional supplements such as vitamins are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. For those eligible, EPDST will be used for all mandatory and optional state plan services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is not intended to cover prescription drugs or prescriptions with a rebate.

The cost of this service shall not exceed \$800.00 per waiver participant in a fiscal year (July 1-June 30). Participants goods and services and individual goods and services are excluded when this service is approved and reimbursed to it maximum limits during each qualifying fiscal year.

This service is not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase health supplements, vitamin or mineral supplements, herbal preparations and nutritional supplements such as vitamins and these nutritional services are not available through another source.

The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (*check each that applies*):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (*check each that applies*):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Vendor
Agency	DME

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Nutritional Services

Provider Category:

Provider Type:

Provider Qualifications**License (specify):**

Certificate (specify):

Other Standard (specify):

The Retail vendor must hold the applicable business retail requirements to sale or furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Nutritional Services

Provider Category:

Provider Type:

Provider Qualifications**License (specify):**

meet all applicable licensure requirements per NC Medicaid Provider Enrollment requirements

Certificate (specify):

Other Standard (specify):

business approved by the Case management entity or FMS provider to provide the approved service, equipment or supplies of sufficient quality to meet the need for which it is intended.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Case Management entity
DHHS Fiscal Agent
State Medicaid Agency
FMS
Tribal Governments

Frequency of Verification:

Initially and every five years thereafter by MMIS
Case management entity to verify prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service for the waiver participant who is not directing their own care that provides services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase the item or service or the item or service is not available through another source. This service helps assure health, safety, and well-being when the waiver participant or responsible party does not have resources to obtain the necessary item or service that will aid in the prevention or diversion of institutional placement. Participant goods and services are items that are intended to: increase the waiver participant's ability to perform ADL's or IADL's and decrease dependence on personal assistant services or other Medicaid-funded services.

- . Goods and services purchased under this coverage may not circumvent other restrictions on the claiming of FFP for waiver services, including the prohibition against claiming for the costs of room and board.
- . The specific goods and services that are purchased under this coverage must be documented in the service plan.
- . The goods and services that are purchased under this coverage must be clearly linked to an assessed participant need established in the service plan.

Types of coverable goods and services are specific to items to assist with personal hygiene and bathing, Items to assist with dressing; Items to assist with accessibility in the home; Items to assist with eating; Items to assist with toileting and Items to assist with mobility. The following specific items are approvable using this service:
Long handle sponges, Long handle brushes, Elastic shoelaces, Bath tap turners, Button aids, Zipper pulls,

Door knob grippers, wheelchair or walker baskets/bags/caddy, writing aids, no spill cups straw holder, two-handle mug, Scooper bowls and plates, Plate guards, Bibs, Bottom wipers, Incontinence disposal system, Protectants for a mattress, chair or car seat to protect against incontinence accidents, wheelchair canopy, specialized mixer/blenders.

Additional coverage of good and services may include items listed below and other items that are identified to be necessary and not coverable by the State Health Plan.

- . Sanitation (disinfectant) wipes for direct care workers hired through consumer-directed care;
- . hand sanitizer and disinfectant spray for direct care workers hired through consumer-directed care;
- . thermometer;
- . specific colored trash liners or biohazard disposable bags to be used to manage dirty linen of a waiver participant who has a short-term infection condition to prevent spread;
- . The coverage of a tablet or smartphone for identified waiver participants to promote telephonic/electronic engagements with service providers for telehealth, monitoring, and linkage and is restricted to individuals who do not have access to tablets or smartphones through the state plan. Coverage is approved based on financial need and when determined a necessary.

hypoallergenic pillows and blinds, when determined to necessary consistent with a medical condition.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The maximum approved amounts for participant goods and services shall not exceed \$800.00 total per participant per fiscal year July 1- June 30.

- . Items that are not of direct medical or remedial benefit to the waiver participant
- . Items covered under the Home Health Final Rule
- . Items covered through Medicaid State Plan DME, orthotics, prosthetics, and home health supplies
- . Items that meet the definition exclusions for recreational in nature
- . Items that meet the definition exclusions for general utility to non-disabled individuals
- . Service agreements, maintenance contracts, that are not related to the approved service, and Warranties
- . Equipment used with swimming pools, hot tubs, spas, and saunas that are not approved in the person-centered service plan or included in the exclusion definition
- . Replacement of equipment that has not been properly used, has been lost, or purposely damaged per written documentation or through observation
- . Technology hardware such as computer, laptop, tablet, or smart phone when considered recreational in nature or of general utility per the definition
- . Pharmacy related items that are not approved in the service plan
- . Outdoor monitoring systems that are not approved in the service plan and are included in the recreational in nature or general utility definition

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME
Individual	Individual
Agency	Business/Commercial

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service**Service Name: Participant Goods and Services**

Provider Category:

Agency

Provider Type:

DME

Provider Qualifications**License (specify):**

meet all applicable licensure requirements per NC Medicaid Provider Enrollment requirements

Certificate (specify):**Other Standard (specify):**

A business approved by the Case management entity or FMS provider to provide the approved service, equipment or supplies of sufficient quality to meet the need for which it is intended.

Verification of Provider Qualifications**Entity Responsible for Verification:**Case Management entity
DHHS Fiscal Agent
State Medicaid Agency
FMS
Tribal Governments**Frequency of Verification:**Initially and every five years thereafter by MMIS
Case management entity to verify prior to service delive

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service**Service Name: Participant Goods and Services**

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications**License (specify):****Certificate (specify):****Other Standard (specify):**

Demonstrated ability to render the service to include letters of references.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service

delivery

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Participant Goods and Services

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The Case Management entity must approve and authorize the service.
 The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license. Licensed contractors are preferred.
 Enrolled Medicaid providers who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer's specifications and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years
 NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

Initially and at time of service provision

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Pediatric Nurse Aide Services

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service for a waiver participant who is unable to perform any two of the seven key Activities of Daily Living (ADLs) tasks independently due to a medical condition identified and documented on a validated assessment. This service provides extensive hands-on (not merely set-up or cueing) assistance with at least two ADLs (bathing, dressing, eating, toileting, hygiene, mobility and transfer) in which at least one of the ADLs must be Nurse Aide II (NA II) tasks during the hours of service provision. The need for assistance with ADLs relates directly to the waiver participant's physical, social environmental and functional condition. Pediatric Nurse Aide Services, when medically necessary, must be provided in the community, home, workplace, or educational settings (when not the responsibility of LEA). CAP/C is intended to provide services to children age birth through 20 who need non-age appropriate hands-on assistance with ADLs. A child (0 through 20 years of age) who has not reached the developmental milestones for his or her chronological age for the ADLs, based on the evaluation of a licensed professional, is considered to require non-age appropriate assistance for a specific ADL. The personal care needs must fall within the NA II scope of nursing practice. This service type is substantial. This means that the waiver participant's needs can only be met by certified professional such as an NA I or II. Nurse Aide services could not and shall not be provided by home health aides not registered with DHSR, unless participation in the waiver is through the consumer-directed model of care.

The staff providing the care must be an NAI or the Home Health agency shall have competencies for NA I + 4 tasks Typical Level II tasks will include oxygen therapy, break-up and removal of fecal impaction, sterile dressing change, wound irrigation, I.V. fluid assistive activities, nutrition activities, suctioning, tracheostomy care, elimination procedures and urinary catheters. Typical Level I tasks include paying bills as directed by the participant; essential shopping, cleaning and caring for clothing; performing basic housekeeping tasks such as sweeping, vacuuming, dusting, mopping and washing dishes; identifying medications for the participant; providing companionship and emotional support; preparing simple meals; and shopping for food, clothes, and other essential items. Level I tasks, which consists entirely of home management tasks, are covered only when provided in conjunction with Level II Personal Care tasks.

ADL care for a waiver participant under the age of three (3) years is considered age appropriate and the responsibility of the parent or responsible representative.

Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the State plan. Because this service is different than state plan services in the scope, nature, and supervision requirements, waiver participants between the ages of 18-20 years old are included to receive this service.

Assurance: The service under the waiver's Pediatric Nurse Aide is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. For those eligible, EPDST will be used for all mandatory and optional state plan services.

Pediatric nurse aide services can be provided in the workplace for waiver participants who meet the specified qualifications. Level I tasks, which consists entirely of home management tasks, are covered only when provided in conjunction with Level II Personal Care tasks.

The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the nurse aide. If the regular informal caregiver (parent) is not available, there must be a back-up informal caregiver designated by the parent who can be physically present with the beneficiary and make judgments on the caregiver's behalf regarding the care

of the beneficiary.

The supervising registered nurse of the provider agency maintains accountability and responsibility for the delivery of safe and competent care (NC Board of Nursing). Decisions regarding the delegation of any nurse aide tasks are made by the licensed nurse on a beneficiary-by-beneficiary basis.

The criteria stated below must be met in order for a task to be delegated to unlicensed personnel. The task:

- a. is performed frequently in the daily care of a beneficiary or group of beneficiaries;
- b. is performed according to an established sequence of steps;
- c. involves little or no modification from one beneficiary situation to another;
- d. may be performed with a predictable outcome;
- e. does not involve ongoing assessment, interpretation, or decision-making that cannot be logically separated from the task itself; and
- f. does not endanger the beneficiary's life or well-being.

Tasks, amount, frequency, and duration must be clearly outlined in job duties developed by the CAP beneficiary or responsible party or representative participating in consumer-directed care.

Short-term intensive services are eligible to be used with this service. Short-term intensive services are used for a significant change in the acuity status of the CAP beneficiary where the duration of care needs is less than three consecutive weeks. Short-term intensive services are listed in the service plan. Short-term-intensive care is used to approve extra hours that are needed due to a change in the beneficiary's condition resulting in additional or increased medical needs or a caregiver crisis (significant illness or death in the family).

Unplanned waiver service occurrence requests are eligible to be used with this service. Unplanned waiver services occurrence requests are used to request an adjustment beyond the approved service plan for a particular day(s) due to an unexpected event (such as an accident or flat tire).

The waiver participant can use up to 14 days per year of recreational leave (family vacation), when planned for in the initial and annual person-centered service plan. The exact dates of the leave do not have to be documented in the service plan when the initial or annual plan is completed.

Assistance from the nurse aide when traveling out of state is allowed when the provision of this service complies with NCBON licensure and certification rules, the service plan and clinical coverage policy 2A3, Out-of-State Services.

An assigned nurse aide shall accompany or transport (based on the agency's policy) a waiver participant beneficiary and the primary caregiver to a medical appointment, to and from school or other activities, if documented in the service plan to provide medical care or personal care for the Waiver participant.

Individuals with any one of the following criminal records are excluded from hire:

- a. Felonies related to manufacture, distribution, prescription, or dispensing of a controlled substance;
- b. Felony health care fraud;
- c. More than one felony conviction;
- d. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
- e. Felony or misdemeanor patient abuse;
- f. Felony or misdemeanor involving cruelty or torture;
- g. Misdemeanor healthcare fraud;
- h. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
- i. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
- j. Any substantiated allegation listed with the NC Health Care Registry that prohibits an individual from working in the health care field in the state of NC.

Individuals with criminal offenses occurring more than 10 years previous to the date of the criminal report may qualify for an exemption when the exemption does not violate Medicaid guidelines. The financial manager shall inform the Waiver participant when a prospective employee is within the 10-year rule and the Waiver participant shall have the autonomy to approve the exemption.

The services under the waiver's pediatric nurse aide are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Note: Individuals directing their own care must comply with the U.S. Department of Labor Fair Labor Standards Act.

This service is subject to the 21st Century Cures Act for Electronic Visit Verification requirements(EVV).

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The type, frequency, tasks and number of hours per day of this WAIVER service are authorized by the CME, based on medical necessity of the Waiver participant, caregiver availability, budget limits and other available resources.

A spouse, parent, step-parent, or grandparent, is eligible for hire as the employee when qualifying conditions are met. The employment of a spouse, parent, or grandparent, of the Waiver participant may provide this service only if:

- a. 18 years of age or older; and
- b. Meets the qualifications to perform the level of personal care determined by the WAIVER assessment.

A provider's external employment must not interfere with or negatively affect the provision of services; nor supersede the identified care needs of the Waiver participant.

Waiver funding must not be used to pay for services provided in public schools.

Nurse Aide services must not be provided at the same day or time as Waiver In-Home Aide services or private duty nursing. Pediatric Nurse Aide Services may not be provided if it duplicates other Medicaid or non-Medicaid services. In-Home Aide services, Pediatric Nurse Aide services and Coordinated Caregiving can be combined when special conditions are met for provider-led services. Combining services for a legally responsible (parent) person that are inclusive of the extraordinary conditions is permissible under special conditions when a justification of need documented by the multidisciplinary team in the assessment and service plan

An employee applying for hire under the consumer-directed care program shall not perform services until competencies and trainings are verified or completed.

Waiver service planning is not intended to provide 24-hour care; combining services to provide 24-hour care needs is not permissible. The hours between 12m-5 am are designated as a non-formal time for a parent/primary caregiver/legally responsible person living with the waiver participant who is approved to be the paid worker. These designated hours are intended to prevent burnout and grant an opportunity for the parent/primary caregiver/legally responsible person to sleep/rest. An external direct care worker is hired when a service plan identifies the need for paid support during these hours. Extraordinary circumstances may apply to permit a parent/primary caregiver/legally responsible person to be paid worker during these hours.

Planned and arranged respite must be added to the service plan quarterly for the legally responsible person approved to be paid caregiver to be granted a mental and physical break from the routine 24/7 care to the waiver beneficiary.

Pediatric Nurse Aide Services may not be provided if it duplicates other Medicaid or non-Medicaid services.

An employee submitting an application for hire under the consumer-directed care must comply with all policies and procedures of the consumer-direction program and successful pass a background check.

The waiver service corresponding clinical coverage policy may be accessed using this link:

<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agencies
Individual	Direct Staff

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Pediatric Nurse Aide Services

Provider Category:

Agency

Provider Type:

Home Care Agencies

Provider Qualifications

License (specify):

Services are provided by a home care agency licensed by the DHSR under 10A NCAC 13J.

An individual licensed by the NCBON as a Registered Nurse provides supervision of the Nurse Aide as under 10A NCAC 13J.1110.

The Nurse Aide providing direct care is registered as a Nurse Aide I + or Nurse Aide II with DHSR and the NCBON.

Medicare certified home health agency.

Certificate (specify):

The nurse aide providing direct care is certified in CPR. It is recommended that (s)he also be certified in First Aid.

Other Standard (specify):

Staff shall obtain licensure or certification according to all applicable laws and regulations, and practice within the scope of practice as defined by the individual practice board.

NC Medicaid requires the following provider qualifications and training be completed before staff is assigned to provide person care to the CAP beneficiary:

- a. Criminal background checks, which must be repeated every two (2) years, at the time of licensure renewal (refer to Subsection 6.6);
- b. Verification of cardiopulmonary resuscitation (CPR) certification and every two (2) years, coinciding with expiration dates;
- c. Review of trainings and beneficiary-specific competencies at each job performance review as per agency policy;
- d. Pediatric nursing experience or completion of NC Medicaid pediatric training, such as
 1. growth and development;
 2. pediatric beneficiary interactions;
 3. and home care of pediatric beneficiary;

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV).

Verification of Provider Qualifications

Entity Responsible for Verification:

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and education services are needed and documentation is available to support training needs were met.

Frequency of Verification:

The verification of provider qualification is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Pediatric Nurse Aide Services

Provider Category:

Individual

Provider Type:

Direct Staff

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and educational services are needed and documentation is available to support training needs were met. Must be CPR certified.

Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Comply with the 21st Century Cures Act for Electronic Visit Verification(EVV).

Verification of Provider Qualifications

Entity Responsible for Verification:

It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Frequency of Verification:

initially and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Pest Eradication

HCBS Taxonomy:

Category 1:

Sub-Category 1:

17 Other Services

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service for waiver participants that provides a one-time pest eradication treatment. This service is coverable when the waiver participant is living in his or her own home, when not already included in a lease, and when the eradication is for the management of health and safety as identified in the person-centered service plan. The eradication procedure is limited to one time per year.
 Assurance: The service under the waiver's Pest Eradication is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is not intended for monthly, routine or ongoing treatments.
 The cost of this service shall not exceed \$1600.00 per waiver participant (July-June); \$800.00 maximum for each fiscal year.
 This service is not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase the pest eradication and the treatment is not available through another source.
 The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>
 The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

Specify whether the service may be provided by (check each that applies):

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
<input type="checkbox"/> Agency	<input type="checkbox"/> Retail Vendor

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
 Service Name: Pest Eradication

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The Retail vendor must hold the applicable business retail requirements to sale or furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17990 other

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Supplies that are necessary to avoid institutionalization and promote continuous community integration often prescribed by a physician.

- a. Adaptive Tricycles: A durable medical equipment 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.
- b. Vehicular transport vest: A durable medical equipment for safe transport.
- c. Adaptive car seats: a durable medical equipment for appropriate positioning and safe transport.

Specialized medical equipment and supplies consists of the following:

- 1. The performance of assessments to identify the type of equipment needed by the participant.
- 2. Training the participant or caregivers in the operation and/or maintenance of the equipment or use of the supply.
- 3. Repair of the equipment is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment.

EPSDT should be used for those eligible on home health coverable items.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Service only covers items not available through EPSDT

Adaptive tricycles for individuals: - \$ 3,000 over the cycle of the waiver

Adaptive car seats or vehicular transport for individuals between the ages of 0-20 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. As priced per plan year.

A physician's signature certifying medical necessity for the supply is required.

The waiver service corresponding clinical coverage policy may be accessed using this link:

<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME Supplier

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

DME Supplier

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled as a Medicaid provider as a DME provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years, NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

Initially and every five years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Training, Education, and Consultative Services

HCBS Taxonomy:

Category 1:

13 Participant Training

Sub-Category 1:

13010 participant training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

A service that provides supportive services to the waiver participant, the waiver participant's unpaid primary caregiver, or unpaid support system. The purpose of the supportive service is to enhance the decision-making ability of the waiver participant, enhance the ability of the waiver participant to independently care for him or herself, or enhance the ability of the primary caregiver in caring for the waiver participant. These service activities which include training and counseling services for individuals who provide unpaid support, training, companionship or supervision to waiver participants. All training and education services must be documented in the participant's person-centered care plan as a goal with the expected outcomes. This service may cover conference registration and enrollment fees for classes.

The services under the waiver's training/education and consultative services are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. This service may not be used to provide training to a paid caregiver.

This service will cover training for the direct care worker in PPE specific to the care needs of a waiver participant to prevent the spread of a virus.

This service will advance the cost of CPR classes for the direct care worker to assist the direct care worker become financially stable. The cost for the CPR class will be deducted from the direct care worker's wages.

This service may cover violence intervention training/educational services, when not covered through the State Plan.

Each waiver beneficiary will be assessed using person-centered planning methodology. If a waiver beneficiary's status changes, and requires service units over the average limit, an assessment of needs will be evaluated on an individual basis. Service requests that meet eligibility criteria will be approved at the assessed need, NC Medicaid will closely monitor the individual and wavier average per capita cost to maintain cost neutrality of the waiver.

Medicaid reimburses providers directly and no payments are made to families.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is limited to \$500 per fiscal year. Individuals who are paid service providers cannot be trained or educated using this service.

An organization with a training or class curriculum approved by the SMA including Universities, Colleges and Community Colleges shall provide training and education services.

The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method (check each that applies):

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by (check each that applies):

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial/Educational Settings

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Training, Education, and Consultative Services

Provider Category:

Agency

Provider Type:

Business/Commercial/Educational Settings

Provider Qualifications

License (specify):

- 1) Universities, Colleges, and Community Colleges
- 2) An organization with a training/class curriculum approved by the Division of Medical Assistance.

Certificate (specify):

- 1) Universities, Colleges, and Community Colleges
- 2) An organization with a training/class curriculum approved by the Division of Medical Assistance.

Other Standard (specify):

The case management entity must approve and authorize the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management Entity

Frequency of Verification:

prior to service provision

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Service Definition (Scope):

Vehicle modification is a service for a waiver participant that enables increased independence and physical safety through transport. The intent of a vehicle modification is to adapt, alter, or install controls or services to an unmodified motor vehicle such as an automobile or van that is a waiver participant's primary means of transportation. The vehicle must be owned by the waiver participant or the primary caregiver prior to the initiation of the modification. Vehicle modifications are specified by the service plan as necessary to accommodate the special needs of the beneficiary to enable the beneficiary to integrate more fully into the community and to ensure the health, safety, and well-being. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the modification in the event of an accident. Modifications do not include the cost of the vehicle or lease.

Assurance: The service under the waiver's Vehicle modification is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The following modifications are covered for an unmodified vehicle:

- a. Door handle replacements;
- b. Door modifications;
- c. Installation of raised roof or related alterations to existing raised roof system to approve head clearance;
- d. Lifting devices;
- e. Devices for securing wheelchairs or scooters;
- f. Adapted steering, acceleration, signaling and breaking 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;
- g. Handrails and grab bars;
- h. Seating modifications;
- i. Lowering of the floor of the vehicle;
- j. Transfer assistances;
- k. 4-point wheelchair tie-down;
- l. Wheelchair or scooter hoist;
- m. Cushions;
- n. Wheelchair or scooter transporting mobility devices;
- o. Ramps; and
- p. Devices for securing oxygen tanks.

Vehicle modifications may be approved for a previously modified vehicle when the modification is intended to meet the waiver participant's care needs and allows for physical safety through transport. The service does not cover the purchase or lease of the vehicle itself, but the actual cost of the installed modifications. When a vehicle is a manufactured modification or has been previously modified, the above exhaustive list of items are covered when the items listed in the assessment are specific to the disability. An assessment must be completed by a Physical Therapist or Occupational Therapist specializing in vehicle modifications, or a Rehabilitation Engineer or Vehicle Adaptation Specialist certifying necessity. All vehicles must be evaluated with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications. A copy of the assessment must be submitted with the request for Vehicle Modifications. Upon a determination analysis of a request, a physician's signed order may be required to certify that the requested adaptation is necessary. Obtained physician's signed order must be on file in the waiver participant's record. When feasible, there must be at least one competitive quotes with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications to determine the most efficient method to complete the request.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Vehicle modification is included in a combined home modification and assistive technology budget of \$28,000 per beneficiary per the cycle of the CAP/C waiver, which is renewed every five years. When the maximum utilization limit is reached, requests for vehicle modification is denied. The CME shall track all costs of vehicle modifications billed and paid, to avoid exceeding the \$28,000 limit over the cycle of CAP/C waiver.

The cost of renting or leasing a vehicle with adaptations, service and maintenance contracts and extended warranties and adaptations purchased for exclusive use at the school or home school are not covered. Items that are not of direct or remedial benefit to the CAP/C beneficiary are excluded from this service. The CME shall authorize vehicle modification through

service authorization prior to the initiation of the modification.

A vehicle modification may be considered for an older vehicle or a vehicle with over 80,000 miles when the recommendation from the vehicle modification specification guarantees the vehicle's ability to withstand the modification and the vehicle has a life expectancy of five (5) or more years.

The service reimburses the cost of the depreciated value of a previously modified vehicle, see above, when as assessment of the previously modified vehicle is in good condition. The assessment reports

- a. The age of the previous modifications;
- b. The original price of the modifications;
- c. The current value of the modifications;
- d. The age of the vehicle; and
- e. The current appraised condition and value of the vehicle.

Those items that are not of direct medical or remedial benefit to the beneficiary or are considered recreational in nature are excluded and not authorized by the case management entity. Approval for vehicle modifications is based upon medical need; there is no entitlement of services up to the program limit (\$28,000).

Vehicle modifications are provided and must be installed according to applicable standards and safety codes such as manufacturer's installation instructions, National Mobility Equipment Dealer's Association guidelines, Society of Automotive Engineers guidelines, and National Highway and Traffic Safety Administration guidelines.

Exclusions:

Vehicle modification excludes the following:

- a. Items that are not of direct or remedial benefit to the CAP/C beneficiary;
- b. purchase price or lease of the vehicle itself;
- c. Regularly scheduled upkeep and maintenance;
- d. The cost of renting a vehicle with adaptations;
- e. Service and maintenance contracts and extended warranties;
- f. Adaptations purchased for exclusive use at school; or
- g. Replacement of a vehicle adaptation if the beneficiary or family fails to keep their automobile insurance policy current when the repair would have been covered by the insurance.

The waiver service corresponding clinical coverage policy may be accessed using this link:
<https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

The wavier Service Fee Schedule may be accessed using this link: <https://medicaid.ncdhhs.gov/fee-schedule-index#C>

Service Delivery Method *(check each that applies):*

Participant-directed as specified in Appendix E

Provider managed

Specify whether the service may be provided by *(check each that applies):*

Legally Responsible Person

Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing.
 All vehicles must be evaluated by an adapted vehicle supplier.
 Motor vehicle modifications are provided and installed in accordance with applicable standards and safety codes including manufacturer's installation instructions, National Mobility Equipment Dealer's Association guidelines, Society of Automotive Engineers guidelines, and National Highway and Traffic Safety Administration guidelines.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management Entity, if the case management agency bills for the modifications on behalf of the vehicle adapter.

Frequency of Verification:

Prior to service delivery.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

Not applicable - Case management is not furnished as a distinct activity to waiver participants.

Applicable - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

As a waiver service defined in Appendix C-3. *Do not complete item C-1-c.*

As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option). *Complete item C-1-c.*

As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management). *Complete item C-1-c.*

As an administrative activity. *Complete item C-1-c.*

As a primary care case management system service under a concurrent managed care authority. *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

- a. Criminal History and/or Background Investigations.** Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

No. Criminal history and/or background investigations are not required.

Yes. Criminal history and/or background investigations are required.

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal Background checks are conducted in accordance with GS 131 E255 and NCAC 27G.0202. Criminal background checks and registry checks are conducted on all personnel providing waiver services. For case management staff, the appointed case management entity is required to perform a state background check and a national background check if lived outside of North Carolina within five years. The record of this background check is kept on file at the provider agency and confirms this requirement was met in the CAP Business system. For all personal care assistants who are providing hands-on waiver services, the In-Home Aide Agency or the Home Health Agency is required to perform a criminal background and registry check on all hired employees prior to assignment to a waiver participant. The record of this background check is kept on file at the provider agency and must be produced upon demand by the SMA or its representative. For all Medicaid enrolled providers, the State's contracted vendor, conducts a background check to include an OIG search on all applicants prior to the assignment of a National Provider Number. If the background check is not favorable, the applicant is not granted a Medicaid enrollment status. For direct hire employees, the financial management entity is mandated to conduct a SBI background check on all employees to include a background and registry check. The results of the background check are filed in the waiver participant's file. The verification of criminal history and background check is performed by an approved, licensed Home Health or In-Home provider when the waiver participant is receiving services from a provider. The financial manager is required to verify criminal history and background check of the provider. The verification process is completed annually and when directed by the SMA. The case manager verifies that the checks were completed before waiver services and participation are approved. NC Medicaid conducts annual audits to ensure compliance of waiver assurances and performance measures in regard to criminal history and background checks. The NC Medicaid Program Integrity Unit conducts post audit reviews, criminal history and background investigation are included in their reviews.

- b. Abuse Registry Screening.** Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

No. The state does not conduct abuse registry screening.

Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Division of Health Services Regulation (DHSR) is responsible for maintaining the nurse aide registry. DHSR requires direct care staff to be screened through the Nurse Aide Registry at hire and at least annually. All direct care staff are not nurse's aides, the DHSR conducts a criminal background check on entities monitored by that division. The licensed entities monitored by DHSR are mandated to conduct criminal backgrounds and registry checks on all hired employees to assure health, safety, and well-being of all individuals to mitigate risk. A waiver participant using the consumer-direction model of care selected worker (personal assistant) is required to undergo a health care registry check prior to providing supplement and supportive services to a waiver participant. The health care registry check is completed by the financial management entity during the employment screening process. Health care registry checks are obtained by the NC Health Care Registry and the Office of Inspector General (OIG) U.S. Department of Health and Human Services Exclusion Database. Any findings related to a substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry and or OIG U.S. Department of Health and Human Services Exclusion Database or a finding that restricts the selected worker (personal assistant) from working in the health care field. This procedure is a mandatory responsibility of the financial management entity.

To mitigate risk of abuse, neglect, exploitation of a waiver participant, the State Medicaid Agency has implemented a mandatory requirement of a health care registry check prior to the approval of the authorization to the financial management entity. This approval permits the FMS the ability to submit Medicaid waiver service claim for reimbursement. The selected worker (personal assistant) must receive clearance to provide HCBS through the CAP Business system, e-CAP from the financial management entity by checking a mandatory field. Once the mandatory field is checked, it validates this requirement was met. Random samples are performed quarterly to monitor the performance of the financial management entity

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.

Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

A waiver participant 18 years old and over may have his or her In-home Aide, Respite In-home, Pediatric Nurse aide Services provided by a relative and/or legally responsible person who is an employee of an In-Home Care Agency or directing care through self-directed services. The CME plays a major role, along with the participant and/or representative in assessing and determining need for personal care. The CME also assists in monitoring the service plan, tasks, and time records, when applicable, to assure appropriate provision and utilization of waiver services. Additional safeguards include post-payment reviews conducted by the State Medicaid Agency. The limit is up to 8 hours maximum a day. On a case-by-case review, hours may exceed 8 hours based on assessed and demonstrated need.

The employment of a spouse, parent, child, or sibling of the waiver participant is eligible to provide personal care services and the person providing the care meets the following qualifications:

- a. Is at least 18 years of age;
 - b. Meets the aide qualifications; or deemed competent by the appropriate licensed supervisory professional of the; and
 - c. Does not have other employment that interferes with the needs of the waiver participant regarding time and days.
- A legal guardian, Power of Attorney, Health Power of Attorney of an 17-year-old or younger waiver participant cannot be hired to provide In-home Aide, Respite In-home, Pediatric Nurse aide services, or skilled care to a waiver participant unless extraordinary conditions are met such as (a) when there is a staffing shortage in remote areas of the state; or (b) the lack of a qualified provider who can furnish services at unusual times during the day because of the complexity of the waiver participant's care needs.

When it is determined to be in the best interest of the waiver participant who is 17 years old and younger to have a legally responsible individual to provide personal care services, a physician's recommendation shall be provided to the case manager outlining the specific care needs of the waiver participant and how those needs can only be provided by the legally responsible individual. In conjunction with the physician's recommendation, an analysis of the case record is performed to evaluate the legally responsible individual's compliance with treatment and service plans and to ensure critical incident reports did not implicate the legally responsible individual to be negligent. In addition, the physical health of the legally responsible individual is heavily considered.

Paid care by a legally responsible person may be authorized when extraordinary conditions apply which include the following circumstances:

1. There are no available CNAs in the waiver participant's county or adjunct counties through a Home Health Agency/In-Home Aide Agency due to a lack of qualified providers, and the waiver participant needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
2. The waiver participant requires short-term isolation, 90-days or less, due to experiencing an acute medical condition/health care issue requiring extensive to maximal assistance with bathing, dressing, toileting and eating, and the waiver participant chooses to receive care in their home instead of an institution.
3. The waiver participant requires physician-ordered 24-hour direct observation and/or supervision specifically related to the primary medical condition(s) to assure the health and welfare of the participant and avoid institutionalization, and the legal guardian is not able to maintain full or part-time employment due to multiple absences from work to monitor and/or supervise the waiver participant; regular interruption at work to assist with the management of the waiver participant's monitoring/supervision needs; or an employment termination.
4. The waiver participant has specialized health care needs that can be only provided by the legal guardian, as indicated by medical documentation, and these health care needs require extensive to maximal assistance with bathing, dressing, toileting and eating to assure the health and welfare of the participant and avoid institutionalization.
5. Other documented extraordinary circumstances not previously mentioned that places the waiver participant's health, safety and well-being in jeopardy resulting in an institutional placement.

Self-directed

Agency-operated

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The state does not make payment to relatives/legal guardians for furnishing waiver services.

The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.

Specify the controls that are employed to ensure that payments are made only for services rendered.

A legally responsible individual can only perform personal care tasks for 40 or less hours per week to ensure compliance with Department of Labor requirements. The approved hours are based primarily on the assessed needs identified in the assessment.

A legally responsible individuals of waiver participant under the age of three may not be authorized as the paid caregiver when care needs are within the developmental range.

This waiver allows a spouse or legally responsible individual of a waiver participant who is 18 years old and older to perform personal care services and receive payment when any one of the following extraordinary circumstances occur: 1. The waiver participant is experiencing a cognitive or intellectual limitation and the present of an unfamiliar individual is more disruptive than productive and the waiver participant requires additional assistance with ADLs than ordinary as identified in a service plan.

2. The waiver participant is in an area with limited access to service providers and the assessment of needs identifies that the waiver participant requires five or more hours per day of uninterrupted personal care.

3. The waiver participant has a secondary diagnosis of mental illness or an intellectual disability and the behavior, because of this illness, poses harm to an unfamiliar person or past behaviors have alienated service providers.

The legal guardian will not receive payment for solely performing instrumental activities of daily living tasks solely such as meal preparation, laundry, money management, home maintenance, shopping, and medication management. The performance of ADLs associated with the IADLs are included in the payment for performing personal care tasks.

When the legal guardian is authorized to receive payment for providing in-home aide or pediatric nurse aide services, and skilled care the waiver participant will be enrolled in the coordinated caregiving or self-directed care. The enrollment in these service options will provide quality assurance of the health, safety and well-being of the waiver participant and provides the controls to ensure that payments are made only for the services authorized. The assigned case management entity will perform weekly contacts to include monthly in-person monitoring visits to ensure the services are provided in accordance with the service plan and the waiver participation business requirements, when the waiver participant elects to enroll in self-directed care.

A legal guardian will not be approved to provide personal care services and receive payment because of unwarranted biases to a Home Health Agencies/In-Home Aide Agencies without first attempting to work with those agencies. A legal guardian will not be approved to provide personal care type services or skilled care and receive payment if there are other providers Health Agency/In-Home Aide Agency due to non-complaint or violent behavior exhibited by the waiver participant or the legal guardian.

A comprehensive multidisciplinary assessment is conducted to identify medical, functional, social, and family support needs. The severity of these needs is identified in the assessment and carried over to the service plan. The CME coordinates with the waiver participant and other care professionals to create a plan of care to meet the needs identified in the assessment. Each month, the CME corresponds with the participant and service providers to assure that the services authorized on the POC are adequate in the amount, frequency, and duration. Every three months, the CME is required to conduct a home visit to observe hands-on assistance to assure services approved for the amount, frequency and duration are sufficient for current needs. Adjustments are made upon discovery. Also, the CME is required to review supporting documentations to determine the need for a reassessment when the participant is hospitalized or endures a significant change in status. Another monitoring task the CME performs to assure services are in the best interest of the individual is a quarterly multidisciplinary monitoring team meeting with all services providers.

Other policy.

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Enrollment is available to an interested provider at any time. Providers must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once Medicaid enrollment application is approved, and the provider has completed a managed change request to provide waiver services, the provider is authorized to provide services in the approved catchment area. Each approved provider is required to be listed on the freedom of choice provider form in each catchment area to be eligible to render services to waiver participants.

The CME and IAE will provide each waiver participant a freedom of choice policy in which the waiver participant must sign to acknowledge his or her rights to choose any qualified provider eligible to provide a waiver services.

Case management entities will be approved to serve their designated catchment areas when all qualification requirements are met.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-A1 Number and percent of waiver providers who met the required licensure and/or certification standards and/or adhere to other standards prior to their furnishing waiver services. Numerator: number of waiver providers who met required licensure and/or certification standards and/or adhere to other standards prior to their furnishing waiver services D: number of waiver providers reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and NC Medicaid MMIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> CAP Business system case management system and NC Medicaid MMIS </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 30px; margin-left: auto; margin-right: auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-B1: #/% of all non-licensed/non-certified providers adhere to waiver requirements
N: # of all non-licensed/non-certified providers adhere to waiver requirements
D: # of all non-licensed/non-certified providers reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (<i>check each that applies</i>):	Frequency of data collection/generation (<i>check each that applies</i>):	Sampling Approach (<i>check each that applies</i>):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100%

		Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
Other Specify: CAP Business system	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: CAP Business system	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div style="border: 1px solid black; width: 100%; height: 20px;"></div>

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

QP-C1 #/% waiver participants enrolled in consumer-directed care, for the 1st, who completed the consumer direction training modules before hiring staff N: # waiver participants enrolled in consumer-directed care, for the 1st, who completed the consumer direction training modules before hiring staff D: # waiver participants enrolled in consumer-directed care for the 1st time that were reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other	Annually	Stratified

Specify: CAP Business system and FMS files		Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: CAP Business system and FMS files	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

QP-C2 Number and percent of local agencies that uploaded evidence of completed required training outlined in the waiver CCP Numerator: number of local agencies that uploaded evidence of completed required training outlined in the waiver CCP Denominator: number of local agencies reviewed

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Material will be uploaded in the CAP Business system by the case management entity annually and continuously and ongoing.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> CAP Business system </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

QP-C3: Number and percent of HCBS providers who had uploaded evidence of completed required training before rendering waiver services each waiver participation year N: Number of HCBS providers who uploaded evidence of completed required training before rendering waiver services for each waiver participation year D: Total number of HCBS providers reviewed.

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and NC Medicaid MMIS

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 95% confidence level and +/- 5% margin of error

<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> CAP Business system case management system and NC Medicaid MMIS </div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; width: 100px; height: 30px; margin: 10px auto;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; width: 100px; height: 30px; margin: 10px auto;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; width: 100px; height: 30px; margin: 10px auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; width: 100%; height: 40px; margin-top: 10px;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; width: 100%; height: 40px; margin-top: 10px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CAP Business system evaluates waiver activities. The SMA verifies all Medicaid providers are licensed/certified and properly enrolled as a Medicaid providers by the fiscal agent for each type of service furnished. A rigorous process includes

submitting required documents:criminal complaint, consent order, documentation of license, suspension, penalty notice, and/or final disposition. The provider application has questions that must be answered:Have you ever been convicted of any criminal offense, had adjudication withheld on any criminal offense, pleaded no contest to any criminal offense, or entered into a pre-trial agreement for any criminal offense? Have you or any entity you are or were either an agent, owner, or managing employee of ever had disciplinary action taken against any business or professional license held in this or any other State, including licenses issued by the North Carolina Division of Health Service Regulation and endorsements issued by any Local Management Entity, N.C.G.S. 122C-115.4? Has your license to practice ever been restricted, reduced/revoked in this or any other State, or been previously found by a licensing, certifying, or professional standards board or agency. Have you or any entity you are or were either an agent, owner, or managing employee of ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any State? Have you or any entity you are or were either an agent, owner, or managing employee of ever had payments suspended by Medicare or Medicaid in any State? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had civil monetary penalties levied by Medicare, Medicaid, or other State or Federal agency or program, including N.C. D.H.S.R., even if the fine(s) have been paid in full? Has Medicare or Medicaid in any state ever taken recoupment actions against you or any entity you are or were an agent, owner, or managing employee of? Do you or any entity you are or were either an agent, owner, or managing employee owes money to Medicare or Medicaid that has not been paid in full? Have you ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services? Have you ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? Have you ever been convicted under federal or state law of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct? Have you or any entity you are or were either an agent, owner, or managing employee of ever been found to have violated federal or state laws, rules, or regulations governing North Carolina's Medicaid program or any other State's Medicaid program or any other publicly funded federal or state health care or health insurance program? Applicants must meet all program requirements and qualifications for which they seek enrollment before being enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once participation as a Medicaid provider has been approved, providers are assigned an NPI with an effective date and are notified by mail. Providers may begin submitting claims to Medicaid upon receipt of their NPI. An active Medicaid Provider must be reassessed every five years to ensure the provider's credentials and qualifications continue to meet N.C. standards. In addition to these rigorous state licensure/certification standards, a Medicaid provider must demonstrate competency to perform services. The State Medicaid Agency approves each provider to provide waiver services. After approval to provide the service and before the service may be rendered, each approved provider must complete a Provider CAP Training Overview module.

The CME will initially provide the Medicaid provider with service authorization and, at POC revision, initiate approved waiver services.

Waiver participants have the freedom to choose to receive waiver services from any active credentialed Medicaid provider that serves their county. A waiver participant may switch providers without any restrictions. The only restriction imposed is a 5-day delay to the switch between case management entities within a county. Because of the appointment of a case management entity and the utilization limitation of case management hours annually, when a request is made to switch a case management entity, the case manager will notify the State Medicaid Agency to initiate a root cause analysis to identify the reason, current utilization limits and the performance of the previous and newly selected case management entity. The State Medicaid Agency will provide technical guidance for the approval and transfer of the case management entity. Medicaid providers that provide personal care services and other in-home type services must ensure the following activities to comply with state laws: 1. background checks are completed on all employees; 2. competency evaluations and training are conducted for in-home aide staff; 3. Monitor quality of care; 4. Handle Worker's Compensation; 5. Manage the payment of income and Social Security taxes; 6. Ensure that in-home aides work under the supervision of a Registered Nurse, and 7. Abide by the waiver policy of no seclusion and restraints; 8. Comply with the EVV requirements. FMS will conduct background/registry checks on all direct support staff and ensure the required training is completed. Any direct support staff without a criminal background and registry check will not be allowed to provide services until verification is confirmed that the checks were complete.

b. Methods for Remediation/Fixing Individual Problems

- i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Upon discovering an incomplete or invalid provider application, The State Medicaid Agency appointed fiscal agent notifies the provider via letter and electronically to inform of the return of the provider application. The returned application will highlight the areas of noncompliance and information on how to re-submit the application. The provider must comply with

all required timelines. If the timeline is not met, the provider application will be voided. A provider must document and provide a record of the provision of services before seeking Medicaid payment. The record must provide an audit trail for services billed to Medicaid. Submitting a written explanation in lieu of supporting documentation may result in the denial of the application. Each provider must notify the State Medicaid Agency fiscal agent within thirty (30) calendar days of learning of any adverse action initiated against their license, certification, registration, accreditation, and endorsement of the provider or any of its officers, agents, or employees.

Upon noncompliance with CAP-specific guidelines, the CAP Medicaid provider will be notified via written correspondence detailing the non-compliant area(s). The provider will be given a specified period of time to comply. If compliance is not reached, a referral will be made to Program Integrity with a recommendation of termination or payback, depending on the occurrence.

Upon discovering the noncompliance of the FMS, the State Medicaid Agency notifies the FMS of the noncompliance and gives the FMS 30 calendars days to correct the noncompliance areas. Technical Assistance is provided to the FMS. Persistent noncompliance will result in corrective action. Three incidences of a corrective action will result in an action plan that may lead to termination.

Upon discovering noncompliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within three business days.

Repeated findings of noncompliance by a CAP IT contractor result in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

The State Medicaid Agency will ensure that provider training is conducted in accordance with state licensure/certification requirements, NC Medicaid clinical policy, and waiver requirements. The case management entity staff are required to have mandatory annual training as specified by the waiver. Upon discovering noncompliance, case management entities will be required to attend an ad-hoc mandatory training session in person or by webinar. Persistent noncompliance will result in the suspension of new enrollment until compliance is achieved and maintained. Failure to meet annual training requirements for all staff for two consecutive waiver years will result in provider termination.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

Not applicable- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Applicable - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.

Furnish the information specified above.

Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.

Furnish the information specified above.

Other Type of Limit. The state employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2, HCB Settings Waiver Transition Plan, for a description of how the state will achieve compliance with the HCB settings requirements of the final rule for both residential and non-residential settings.

There are no provider-controlled settings used in this waiver.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person/Family-Centered Plan of Care

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

Registered nurse, licensed to practice in the state

Licensed practical or vocational nurse, acting within the scope of practice under state law

Licensed physician (M.D. or D.O)

Case Manager (qualifications specified in Appendix C-1/C-3)

Case Manager (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

Social Worker

Specify qualifications:

Other

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

An assessment is conducted to initially assess needs and risk indicators to validate eligibility to receive this level of care and HCBS planning. Upon the approval of waiver participation, the waiver participant is required to select a case management entity to assist with the development of a person-centered service plan. The person-centered service plan is individualized and is designated to address risk indicators that were identified. The CME arranges an appointment with the waiver participant and encourages the waiver participant's support system to attend. Prior to the first appointment, the waiver participant is encouraged to identify goals/objectives to address social/health needs. The CME reviews those goals with the waiver participant and relates them to the identified risk indicators to begin the discussion of the person-centered service plan. The CME is also responsible to provide monthly case management to ensure each waiver participant's health/welfare is maintained. The CME may also be approved by SMA to render other waiver services when there is no other qualified entity available, and the CME is the only willing and qualified entity. Safeguards are put in place to mitigate conflict and bias. To prevent conflict of interest and to promote freedom of choice, the SMA has instituted firewalls to safeguard the waiver participant. Two firewalls: 1. Clearly defined definition for COI that is discussed with the waiver participant and signed by both the case management entity and the waiver participant and approved by the SMA. This HCBS waiver arranges conflict-free case management in that a CME must disclose their other lines of business that may pose a conflict and describe the firewalls within their organization. Before the CME is approved to render case management services, a Conflict-of-Interest form must be completed and approved by SMA. If a CME is selected to render a service in addition to case management, a provider assessment is conducted to ensure that the provider is the only provider available in that service region. 2. Initial Assessments performed by a CME or IAE that has no direct or indirect affiliation with the waiver participant. The IAE will be responsible to perform a quality validation of annual eligibility decisions to ensure the service plan is interest free and the waiver participant could fully exercise freedom of choice. As a means of documenting choice was provided to the waiver participant, the case management entity must review and have the waiver participant to acknowledge and sign an agency disclosure form that provides information about COI, free choice of providers or lack of specific service providers in that service region. Disclosure about freedom of choice and interest free case management is provided in four written formats-Participant Disclosure Form, Introductory Letter, Welcome Letter, and a reassessment anniversary letter. Each of these letters are generated in the CAP Business system and mailed either by the CME or IAE. Yet another safeguard is Rights and Responsibilities form. This form clearly outlines the responsibilities of the waiver participant, the IAE, CME and SMA in their responsibilities of assuring freedom of choice and interest free protections. The form must be signed and dated by the waiver participant and uploaded in the CAP Business system prior to the approval of the service plan. The e-CAP Business system performs a quality check of the service plan to validate COI protections were practiced by the CME with all waiver participants. When CME acts in a dual role, safeguards are in place to assure the CME administratively separates the plan development function from the direct service provider functions. Two safeguards are in place to manage potential conflict of interest. The first safeguard is for the services and approval authority to be provided by two distinct units or personnel within that organization. The second safeguard is for the CME to have an independent reviewer to perform quality checks on a quarterly basis to assess concerns of conflict and needs of the waiver participant is adequately met. In instances of agencies in rural eastern, southern, and western communities with limited resources, conflict of interest protections is managed through separation of authority within that agency. The CME/provider agency must administratively separate the plan monitoring function from the direct service provider functions. A safeguard is in place for the monitoring and service rendering staff to be provided by two distinct units/personnel within that organization. A second safeguard is for the CME/provider agency to have an independent reviewer to perform quality checks quarterly to assess concerns of conflict and needs of the waiver participant is adequately met. The case management entity is also required to assess adequacy of provider network quarterly. The SMA identifies in advance the potential agencies that will fall in this threshold through a network analysis quarterly. When an agency is approved to function in this dual role, the SMA monitors those agencies closely by the initial service plan, paid claims, revisions to service plans, monitoring of monthly and quarterly visit summary reports, incident reports and annual surveys. The CME is also required to assess provider network in the service region routinely for available providers and discuss free choice of provider (disclosure form) with the waiver participant quarterly. Entities can only provide both case management services and other waiver services when prior approved by the SMA. The state CAP unit will assist the waiver participant to select different direct service provider when COI is evident. The waiver participant will be offered a dispute resolution process when COI is identified. The waiver participant will be provided a written notice and requested to reply within 10 business days to initiate a dispute.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The waiver participant is supported in the service plan development process. Prior to the official in-home assessment, the waiver participant is provided an Introductory letter or an anniversary letter that informs the waiver participant on how the service plan will be developed and how to access needed waiver services based on risk indicators. Both letters provide detailed information about each waiver service to allow the waiver participant the opportunity to formulate a plan to meet health care needs. The letters also provide information about fair hearing and grievance and complaints. Additionally, while the assessor is in the home conducting the comprehensive assessment, the waiver participant is provided with information about person-centered planning and the need to select a case management entity to initiate the person-centered plan. The assessor informs of risk indicators identified after completion of the comprehensive assessment and provides the waiver participant a list of waiver services that may assist to mitigate those risks. The waiver participant is encouraged to begin identifying person-centered goals and services to meet health care needs in preparation of the service plan development.

Upon the completion of the comprehensive assessment by the assessor, the selected case management entity is provided access to the completed comprehensive assessment along with a summary of findings and recommended waiver services that may aid in mitigating risks for the waiver participant. The case management entity meets with the waiver participant to complete the person-centered plan that includes cultural influences and holistic overview of assessed needs. The waiver participant leads the service plan development process. The waiver participant is granted the authority to include individuals he or she finds to be pertinent to participate in the development of the service plan.

Information provided to the waiver participant to assist with service plan development:

- Waiver benefit package - the names of each waiver service and its definition and how one qualifies for a particular waiver service, the utilization limits and how the services may prevent institutional placement.
- Person-centered planning – information to describe the definition of person-centered planning and how the participant is entitled to determine who should be involved in decision-making and who may attend planning meetings. The participant is also provided information about how to ensure his or her likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity are included in the plan. The participant is also informed about assumed risk when choosing to participate in a home and community-based program.
- Freedom of Choice – information is provided to describe what freedom of choice is and how the participant can exercise his or her freedom of choice when selecting to participate in the waiver, how to select waiver services and providers to provide services which also includes the case management agency for management of the day-to-day oversight during waiver participation. A participant may select a different provider at any time, for any reason.
- Fair hearing- information is provided on how to request an appeal when an adverse decision is made, and the timeline granted to file an appeal.
- Complaints and Grievances- information is provided that describes what is a complaint and a grievance and how to voice a complaint and a grievance. The timeline is provided on how the complaint or grievance is to be managed.
- Abuse, Neglect and Exploitation (ANE) - information is provided on what ANE means, ways to identify concerns and how to report suspensions. This information also states the obligation by State Medicaid Agency, case management entities and service provider to report concerns of ANE to the appropriate officials.
- Resources available in the community- a list of resources is provided to the waiver participant that describes Medicaid services and other community resources potentially available to the participant while the participant completes the eligibility steps.

Fraud, Waste and Abuse - information is provided on what fraud, waste and abuse is and how to report concerns. This information also informs of the obligation of the State Medicaid Agency, case management entity and service providers to report fraud, waste, and abuse when it is suspected.

Service plan development will also include planning for individuals wishing to transition from an institution. The safeguards in place to ensure an appropriate assessment of need is conducted and that a person-centered service plan is developed to adequately address needs in the type, frequency, duration, and amount are identified by the following:

A. Coordination of at least two transition planning meetings are arranged to begin the building of relationships as well as obtaining information to plan for community living. This information will assist to complete the service request form that is required for participation in this HCBS program. At this meeting, educational information about the transition process is effectively communicated to the interested individual and family.

B. During the second transition planning meeting, the assessor will initiate a dialogue about peer supports and social supports, substance addition, behavior support needs and tenancy support needs for preparation of service planning.

C. The assessment of need and the service plan development will be contingent upon various factors, one, in particular, is the confirmation of housing. When housing is secured, the following steps are followed:

1. An assessment is initiated within 2 business days of the arrangement of housing.
2. A service plan is completed within 15 business day or within 5 business days of the arrangement of housing, when a time limit is placed on acquiring the housing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The applicant is sent a notice on the Service Plan Development Process steps. The letter contains information about leading the discussion and inviting others to participate in the service plan development stages. There are three steps involved in developing the service plan. In each step, the applicant leads the process. The LOC is the first determinant of waiver eligibility. Upon the completion of this step, the applicant is encouraged to identify those deemed important to participant in the assessment. The next step is the determination of reasonable indication of need based on functional needs and psychosocial factors identified in a comprehensive assessment. Individuals determined to have reasonable indication of being institutionalized or have a reasonable indication of meeting a nursing facility level of care (LOC) with assessed complexity of needs ranging from low to high skill levels and who do not have available resources to meet immediate needs- medical, psychosocial, and functional. The affirmative results of having reasonable indication of needs leads to the last step of eligibility, the service plan development. The service plan development stage is where person-centered goals are discussed and where the applicant is assisted through coaching to lead the service plan discussion. The case manager is trained in person-centered thinking and planning and health, safety, well-being, and individual risk agreements, which aid in coaching the applicant to lead the service plan discussion.

Breakdown of each step:

First step is the health information gathering and consultation with the primary physician to decide of level of care (LOC) using a physician's worksheet and paid claims and analytic to create a service request form. Upon the approval of the LOC and the assignment of a slot, the CME or IAE initiates the second steps of eligibility which is the comprehensive assessment that assesses the following functional areas:

Contact information, Diagnosis, and history; Caregiver information; Medication and precautions; Skin; Neurological; Sensory and communication; Pain; Musculoskeletal; Cardio-Respiratory; Nutritional; Elimination; Mental Health; Informal support; Housing and finances; and Early Intervention and Education

If the individual needs indicate gaps in service provisions or the individual is assessed to be at-risk of community displacement (institutionalized), and reasonable indications of gaps in service provision, the individual is mailed an approval letter titled "Welcome Letter" that provides supportive information about the waiver. The letter also introduces the waiver participant to home and community-based planning; the roles and responsibility of State Medicaid Agency and the case management entity, freedom of choice and services available to him or her while participating in the waiver. The individual or current approved waiver participant is requested to select a case management entity for the assignment of a case manager to assist with the develop of a person-centered service plan. The waiver participant may request individuals he or she prefers to participate in the service plan development phase. The case management entity or the State Medicaid Agency does not place restriction of who may participate in the service plan development unless there is an obvious conflict of interest.

The development of a person-centered service plan is triggered by risk indicators of medical, behavioral, social, and functional needs identified by the independent multidisciplinary assessment team. The case manager supports the applicant in completing the service plan by listening actively, allowing the applicant to take lead in the discussion and asking questions about their preferences, likes and dislikes to identify person-centered goals and incorporate in the service plan along with informal and formal supports. These identified needs will auto-populate to the service plan worksheet, for consideration and planning.

Once the assessment is completed, the service plan must be initiated within 5 business days by the case manager. The service plan must be completed and approved by the 5th day of the anniversary month for an active waiver participant and within 30 calendar days of the home visit to complete the comprehensive assessment for new individuals entering the waiver. The plan is approved for 12 months and can be updated at any time due to a change in status or request for a new or expanded need. Pediatric nurse aide can temporarily be approved for a skilled-level child while a nurse is being recruited in service areas with a shortage of nurses. This service will offer assistance with IADLs and supervision.

The assessment team meets with the potential waiver participant/primary caregiver and others at his or her request in his or her primary residence, to initiate the multidisciplinary comprehensive assessment that includes a historical overview of interested individual or waiver participant's life. The assessment team collects and enters the data in the CAP Business system to initiate the analysis of health care needs. During this process, the assessment team collaborates with current providers and the primary physician, when applicable, to confirm assessed needs to further validate functional level.

Upon the completion of the comprehensive assessment as described above, the CAP Business system provides the assigned case manager an overview of assessed needs and areas that are critical to consider during the service plan development phase. The assigned case manager meets with the potential waiver participant/primary caregiver and others at his or her request, to review the findings of the assessment, to begin the discussion of a person-centered plan, the potential waiver participant/primary caregiver uses this information to begin the construction of a person-centered service plan. The case manager collaborates with the waiver participant to develop the plan of care that will consist of both waiver and non-waiver services. The assessment must be completed and approved within 14 business days for initial and 7 business days for an annual when assigned to an independent assessor. This timeline is tracked by the CAP Business system. Once all needs are identified and the data analysis is received, the file is transferred to a selected case

management entity to initiate the service plan.

The service plan development consists of:

a. A multidisciplinary comprehensive assessment lead by the applicant that identifies the waiver participant's preferences, strengths, needs, and ability to live safely in the community; and

b. an approved person-centered service plan that was developed in conjunction with the applicant and their informal supporters that clearly identifies cultural influences, likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity and services in the amount and duration of the complexity of need. The services documented on the service plan must address the needs identified in the assessment. An annual, every 12 months, reassessment is required during the month of the original waiver entry date. The annual reassessment is called a Continued Need Review (CNR) assessment. The CAP Business system tracks all Continued Need Review and reassessments. The CAP IT system provides monthly alerts to CME or IAE, when applicable, of when annual reassessments are due.

The annual service plan must be approved by the end of a month to have an effective date to start the first day of a given month. When all qualifying conditions are met, the annual service plan will have an effective period that will be consistent from year to year to prevent gaps in services provisions. The service plan is effective for the first day of the month and expires one year later.

Changes and revisions to the Service plan are initiated by the assigned case manager as the waiver participant's needs change. Changes to the service plan are submitted in the CAP Business system within 30-days of identified needs and approved within five (5) business days. The assigned case manager determines whether to revise the service plan when there is a change in the waiver participant's needs. A service plan revision is required when a waiver or Medicaid State Plan service is added, reduced, increased, deleted or when there are changes in amount, duration, or frequency of a waiver service. A service plan update is required for a change in provider agency, but the change is not considered a revision.

The case manager will obtain a signed agreement from the waiver participant or the responsible party consenting to the change in providers.

Service plan revisions are approved by an approval authority of the Case management entity. Revisions may be approved retroactively for up to 30 calendar days for specific services prior to the date that the plan is revised. The waiver participant or the primary caregiver shall agree to and sign the service plan. The CAP Business system places prior approval limits on all authorized waiver services to ensure accurate reimbursement. The assigned case manager monitors the services monthly with the waiver participant and authorized waiver providers to identify deviations of services and review provision of care. If there are consistent deviations and the service is authorized on the service plan, the case manager must review this with the waiver participant and discuss a possible change in providers. If the waiver participant's needs may be maintained at the deviated service level, a service plan revision must be completed.

The Case management entity shall send a written adverse notice in accordance with State Medicaid Agency Due Process policy to the waiver participant or responsible party if a service is denied, reduced, terminated, or if the waiver participant is disenrolled from the program. The service plan will be active on the date of the effective date and all approved services will be rendered regardless of a requested service on the original POC was denied.

When CAP participation is approved, the case management entity will notify the participant in writing of the approval through a Welcome Letter. The Welcome letter outlines the following:

All approved waiver services along with its definition; contact information, information of freedom of choice, conflict of interest, abuse, neglect and exploitation and fraud waste and abuse. Additional information is provided about resources available in the community- a list of resources is provided to the participant that describes Medicaid services and other community resources. The local department of social services is provided an official letter of notification of waiver approval. The notice informs of the CAP effective date and the special coverage code to enter into the eligibility system to ensure the adjudication of all CAP claims that are submitted.

Each service provider is provided an official notice called a service authorization to authorize the waiver service that is listed on the service plan. In addition, Medicaid provider of other Medicaid services are provided a participation letter to acknowledge approval of receipt of other Medicaid services.

The CAP Business system forwards electronic files to the MMIS to validate the prior approval of LOC and the prior approval of waiver services in the amount, duration, and frequency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the

arrangements that are used for backup.

The State has procedures in place to comprehensively assess the waiver participant's needs to identify adverse health, safety and well-being indicators that potentially pose risks and strategies to mitigate those risks. Risk Assessment and Mitigation begins during the multidisciplinary comprehensive assessment. Each waiver participant will be carefully assessed for health and well-being to plan for safe living in the community. An initial assessment is performed on all new enrollees and annual assessments are performed on all active waiver participants. Upon the completion of the assessment, the CAP Business system analyzes the data fields to identify areas that could be a potential risk for the waiver participant. Data from the assessment generated by CAP Business system informs the potential waiver participant/primary caregivers and the assessment team of risk factors to consider during the service plan development to keep the waiver participant safely in the community. The results of the assessment are combined into a composite score. This score identifies the acuity level through a calculation that yields an acuity level of low to moderate needs or high to skilled needs. The composite score consists of:

1. ADL cumulative score;
2. Use of skilled services;
3. Current diagnoses; and
4. Participant/caregiver risk indicators.

Each domain of the composite score is an indicator of fragility or complexity of need. The composite score uses a 100-point scale. A waiver participant with a score between 0-36 is represented to have low acuity needs, while a score between 37-64 is represented as intermediate acuity and a score between 65-100 is represented to have high acuity needs. The results of the assessment are used as a driver to develop a person-centered service plan to mitigate risk, upon initial and annual planning. During the development of the service plan the assigned case manager meets with the potential waiver participant/primary caregiver and other of his or her choice to review assessed risks to develop a plan of action to address each risk factor. Waiver and non-waiver services, assistance from the informal supports system are included in the service plan to aid in mitigating risk factors.

On a quarterly basis, a multidisciplinary team is held to perform a mini-assessment to ensure the person-centered service plan continues to meet the assessed needs of the waiver participant. During the multidisciplinary meeting or at any other monitoring interval, if a determination is made that the current service plan is not meeting the waiver participant's needs, one of two steps is followed: 1. The service plan is revised to add services to meet current needs; or 2. A change of status assessment is performed to conduct a full comprehensive assessment to reevaluate the composite score and risk indicators. Upon the completion of a change in status assessment, a new person-centered service plan is developed to mitigate risk.

Another safeguard the SMA uses to mitigate risk when indicators are present that may potentially jeopardize the health, safety and well-being of the waiver participant or caregivers is an Individual Risk Agreement (IRA). This is an agreement that permits a waiver participant to assume more responsibility for his or her personal choices through surrogate decision making or through planning team consensus. This agreement outlines the risks and course of action. The IRA is primarily used to manage behavioral concerns, non-compliance of the service plan and other well-being concerns that can't be mitigated by a formal service. The individual risk agreement is in conjunction with the service plan and does not replace the service plan. The individual risk agreement is instrumental in creating a think-tank for the case manager and the waiver participant to process risks and identify ways to minimize them and to assume responsibility and accountability of decisions.

Pediatric nurse aide can temporarily be approved for a skilled-level child while a nurse is being recruited in service areas with a shortage of nurses. This service will offer assistance with IADLs and supervision.

During the development of the service plan the assigned case manager meets with the potential waiver participant/primary caregiver and other of his or her choice to review assessed risks to develop a plan of action to address each risk factors. Waiver and non-waiver services, assistance from the informal supports system are included in the service plan to aid in mitigating risk factors. If waiver services, the informal supports system, and regular Medicaid Services are not able to fully address the risk factors, a waiver participant has the discretion to enter an Individual Risk Agreement (IRA) to assume responsibility and accountability of decisions. A risk agreement permits waiver participant to assume responsibility for his or her personal choices through surrogate decision making or through planning team consensus. This agreement in conjunction with the person-centered service plan outlines the risks and course of action. Enrollment and continuous participation in the waiver may be denied based upon a determination that the waiver participant may be unable to participate in the HCBS program despite the implementation of an individual risk agreement. Based on the evaluation of the risk agreement and the assessment of the waiver participant's medical, mental, psychosocial, physical condition and functional capabilities may indicate inability to participate in the waiver when the following conditions cannot be mitigated:

- a. Waiver participant cannot cognitively and physically devise and execute a plan to safety if left alone when over the age of 18 years.

- b. Waiver participant lacks the emotional, physical, and protective support of a willing and capable caregiver, who must provide adequate care to oversee 24-hour hands-on support or supervision, to ensure the health, safety, and well-being of the individual with debilitating medical and functional needs; or
- c. Waiver participant's needs cannot be maintained by the system of services that is currently available to ensure the health, safety, and well-being despite an individualized risk agreement.
- d. Waiver participant's primary private residence is not reasonably considered safe to meet the health, safety, and wellbeing in that the primary private residence lacks adequate heating and cooling system, storage, and refrigeration, plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the waiver participant's safety, and these issues cannot be resolved through waiver services or other means.
- e. The waiver participant's residential environment would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager/care advisor due to: a) the presence of a physical or health threat due to the proven evidence of unlawful activity conducted in the primary private residence; b) threatening or physically or verbally abusive behavior, by the waiver participant, family member or regular visitor or household member in that home; c) more than two incidences of physically and verbally abusive behavior or threatening language; or d) the presence of a health hazard due to pest infestation.
- f. Waiver participant's, legally responsible person or caregiver's safety of self and others is impeded by the participant's, legally responsible person's, or caregivers': a) continuous intrusive and oppositional behavior; b) attempts of suicide; c) behavior that is injurious to self or others; d) verbally abusive or aggressive behavior; e) destruction of physical environment; or f) repeated noncompliance of service plan and written or verbal directives; or g. Waiver participant or primary caregiver or responsible party, continuously impedes the health, safety and well-being of the waiver participant, by refusing to comply with the terms of the service plan, refusal to sign a plan, and other required documents; when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal), refuses to keep the case manager or care advisor informed of changes in the status of the waiver participant, or the participant's, caregiver's, or other resident's behavior makes it impossible to staff aides to provide the required assistance h. Waiver participant chooses to remain in a living situation, where there is a high risk, or an existing condition of abuse, neglect, or exploitation as evidenced by a Child Protective Services or Adult Protective Services assessment or care plan or the parent or responsible party refused to comply with Child or Adult Protective Services where there is a high-risk factor of existing conditions of abuse, neglect, or exploitation.

For new individuals with any of the listed conditions addressed above, an acknowledgement agreement for a 90-day conditional waiver participation period may be implemented. During this 90-day period, an evaluation can be made to determine waiver participation is an option for that individual and risks can be reasonably mitigated to ensure health and welfare. If not, disenrollment may be initiated.

For an active waiver participant, three (3) failed individual risk agreements for any one of the listed reasons may result in a disenrollment when a waiver participant willingly chooses to not follow care plan or IRA.

When a serious risk of harm is imposed upon a hired worker (in-home aide, respite worker, case manager or other professional), this serious threat may result in an immediate recommendation for disenrollment from the waiver if a plan cannot be created to assure the safety of the hired worker.

In addition to Risk Assessment and Mitigation Plan, each waiver participant will be required to have an emergency/disaster backup plan. The emergency/disaster plan is created by the waiver participant with the assistance of the case manager.

This plan specifies who will provide care when key direct care staff cannot provide services or tasks as indicated in the current service plan. Because both personal and home maintenance tasks are essential to the well-being of the participant, the case manager is responsible for ensuring that an adequate emergency and disaster plan is in place. In the event of an emergency or an unplanned occurrence, the plan can include family, friends, neighbors, community volunteers and licensed home care agencies when possible. An emergency and disaster plan is necessary for times when the personal care aide or personal assistant is unavailable during regularly scheduled work hours or when the unpaid informal support is unavailable for the balance of the remaining 24-hour coverage period. The emergency and disaster plan is also necessary to document and outline what the care needs are required to be maintained during a disaster.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Each waiver participant is supported in selecting their providers through information and education during each step of waiver entry process (referral, LOC, assessment, and service plan development). The CAP Business system generates letters at each step to inform the waiver participant about freedom of choice. This information informs of the right to choose any provider to render waiver and non-waiver services listed on the plan of care. When the waiver participant meets the criteria for waiver participation and is at the point to be assessed, a freedom of choice form is signed by the waiver participant to identify available providers of choice including choice of a case management entity. Each waiver participant is provided notices about informed choice of providers through a Participant disclosure letter, Waiver Introductory letter, Welcome Letter, and a Waiver Anniversary Letter. Each letter clearly identifies what informed choice of providers is and how to make a complaint if choice is restricted or when there appears to be a conflict of interest. The waiver participant is supported through this process by making available to him or her listings of available qualified providers and information about the providers. A resource /customer service line is available for the waiver participant to call and seek guidance. The case manager also supports the waiver participant to select a provider of his or her choice by linking the waiver participant to a qualified provider to engage in an interview or request additional information.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

On an ongoing basis, the State Medicaid Agency selects a representative sample of service plans completed by case management entities and assessments completed by the case management entities and the independent assessment entity for review and auditing to assess compliance. This sampling is performed quarterly. The representative sample consists of .95 confidence interval with a margin of error of 5%.

A quality assurance (QA) review will be conducted quarterly. Each case management entity is required to maintain a 90% compliance rate in service plan development. When a case management agency is performing less than 90% of compliance, the State Medicaid agency will provide technical assistance for 30- calendars days. Technical assistance will include a retraining, review of non-compliant areas, questions and answers sessions and monitoring. After the 30-day technical assistance time, an assessment of performance is measured. If the performance continues to be less than 90%, a corrective action plan is implemented that includes corrective steps negotiated by the case management entity and approved by the State Medicaid Agency. The corrective action plan will have a duration period for six (6) months that includes monthly over-the-shoulder monitoring by the State Medicaid Agency. Adjustment to the corrective action plan will be made as needed. If after the six (6) month's corrective action period, the case management entity compliance rate remains 89% or less in-service plan development, the State Medicaid Agency will implement a transition plan to remove this responsibility from the case management entity.

The person-centered plan must include the following:

1. Have the required signatures on or before services begin;
2. Plan effective date;
3. Identification of services by name and in the amount, frequency and duration;
4. Have person-centered goals to meet care needs;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems;
7. Include a schedule of coverage over a 24-hour period;
8. Have a completed emergency and disaster plan

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

Every six months or more frequently when necessary

Every twelve months or more frequently when necessary

Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

Medicaid agency

Operating agency

Case manager

Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The service plan implementation and monitoring are performed at the local case management entity's level. The appointed case management entity initiates a person-centered service plan with the waiver participant and monitors the plan. The State Medicaid agency ensures interest-free case management through checks and balances managed by State staff. Conflict of interest firewalls only apply when that condition has first been met. An independent assessment entity completes the initial eligibility steps of waiver consideration and validates the developed service plan to assist with ensuring interest free protections and appropriateness of care needs. As a safeguard, each case management entity is required to disclose potential conflicts of interest to the waiver participant and provide guidance of how conflict will be managed and resolved. Case management entities are not permitted to render HCBS in conjunction with case management services. The only condition in which an individual can have the same entity perform service planning and actual services is when the entity is the only willing and qualified entity available to the individual. A network adequacy assessment is performed on the service planning entity to ensure that entity is the only entity in that geographical area that can provide the actual services.

Upon the approval of waiver participation, the day-to-day ongoing case management needs are provided by a case management entity the waiver participant/primary caregiver selects through freedom of choice. Upon an approved service plan, the case management entity authorizes or acknowledges the waiver and non-waiver services within 5 business days to qualified Medicaid providers in the amount, duration and frequency listed in the service plan. Prior to authorizing or acknowledging waiver services to a Medicaid provider, the assigned case manager confirms that the provider can provide the services within a reasonable timeframe (within five days to initiate the care plan). Each waiver participant is contacted monthly by the case management entity to undergo an assessment of his or her care needs and changes to medical condition, functioning level, and social support system. Quarterly multidisciplinary team meetings are held with the waiver participant and all care providers to review the service plan, person-centered goals, and desired outcomes to ensure the health and well-being of the participant. If during these scheduled times, a need is identified to revise the service plan or to conduct a new assessment of needs, the case management entity will initiate that process. The waiver participant also has the autonomy to reach out to the assigned case management entity, State staff or a representative from a provider to inform of concern(s) or a change in status to assure health and safety. The State Medicaid Agency has access to data that informs of hospitalizations, ER visits and APS referrals which is monitored regularly to allow for quick intervention to avert health and well-being issues.

Monitoring tasks include assessing, planning, referring, linkage, and follow-up. Upon the implementation of waiver services, the assigned case manager monitors the delivery, effectiveness, and efficiency of all waiver services monthly with the waiver participant /responsible party. Quarterly and as needed, the assigned case manager conducts home visits and on-site agency visits to monitor and observe the provision of waiver services. During these monitoring visits, the assigned case manager assesses medical, social, behavioral, and functional areas to identify a change in status which may warrant a services plan revision.

The CAP Business system provides the quality assurance for service plan implementation and monitoring. Monthly reports and alerts are provided to the case manager to ensure appropriate implementation of the service plan as per policy. Real time reports and data are made available to the State Medicaid Agency to monitor the compliance rate and performance of all case management entities to ensure services are implemented within 5 business days of a services plan approval. The QIS is monitored monthly to ensure the safety and well-being of each waiver participant. The data analytic of service utilization, risks factors, incident reports and complaints and grievances for the CAP QIS framework also allows for quick remediation.

A home visit must be conducted at least quarterly. However, a waiver participant with moderate to high risk indicator scores as identified in a completed assessment must have a face-to-face visit as indicated per risk and monthly multidisciplinary team meeting. This visit is conducted in waiver participant's primary residence to ensure health and well-being.

The CME will observe the home environment for the provision of services by paid caregiver(s). Annually, a home visit must be conducted to perform the annual service plan or more frequently when needed.

- Make a monthly or as needed visit, based on risk indicators with the participant/responsible party to review the health and care needs, satisfaction with services, and assess the provision of all services/supplies to confirm their continued appropriateness.
- Hold a quarterly multidisciplinary treatment team meeting with providers receiving a service authorization/participation notice to review the provision and continued appropriateness of the service plan.
- Document changes in medical, functional, and psychosocial status.
- Review quality assurances reports monthly to remedy any identified issues.
- Contact the waiver participant/responsible party following the construction/installation of home modifications to confirm that the modifications safely meet the waiver participant's needs.
- Contact the waiver participant/responsible party within 2 business days of learned discharge from a hospital/rehabilitation facility to assess health status and changes in needs.

- Ensure that services offered to a waiver participant do not duplicate other services.
- Locate and coordinate sources of assistance from informal sources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal supports.

Case Manager should complete monthly contact via telephone or other secured means of contact with the participant. Case Managers shall make sufficient (more than quarterly) face-to-face contact contingent to the risk factors and other factors that may jeopardize their health safety and wellbeing.

Face-to-face contact can be completed by Facetime, Skype, Video chat, Remote Patient Monitoring system. These types of monitoring tools must be secured and permission to use such devices granted by the waiver participant. If these methods are used the participant will show the aide is present, and a virtual walk through will be completed either by the participant /aide/caregiver directing the device/camera throughout the home environment. The type of monitoring may only occur twice in the quarterly monitoring regiment which begins after the completion of the initial or annual assessment. Take for example, the first quarterly visit after the execution of the service plan that incorporates the risk mitigation plan must be face-to-face. The second and third quarterly visits may be conducted through technology when there is no evidence of a critical incident between the two monitoring periods. The fourth quarterly visit must be performed by a face-to-face visit.

The case manager must perform a monthly monitoring activity with the waiver participant and other service providers. During this monthly visit, the case manager can identify concerns with the service plan or other indicators that may jeopardize the waiver participant's well-being. If by routine monitoring, the case manager determines the service plan is not meeting the current and newly identified needs of the waiver participant, an ad-hoc multidisciplinary meeting must be scheduled within 15-day of awareness to discuss the concerns and to create a plan to mitigate risk and monitor care needs. These types of monitoring tools must be secured and permission to use such devices granted by the waiver participant.

Additional monitoring requirements includes completion of critical incident reports, completion of monthly and quarterly monitoring templates, upload of information in a communication log and technical assistance support from SMA. Each case manager is required to complete a critical incident report for both Level I and II incidents within the specified timeframe. Completed reports are automatically transmitted to the SMA for monitoring of health, safety, and well-being. The monthly and quarterly monitoring tools are programmed with risk indicators algorithms that provides a summary of risk factors based on the responses to the questions being asked. The summary report is transmitted to SMA for monitoring as well as to the CM. The summary report also provides next steps for the CM to perform to ensure a plan is executed to mitigate the identified risk factors.

b. Monitoring Safeguards. *Select one:*

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.

Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

As a quality assurance to manage the monitoring of the service plan and to reduce conflict of interest for a case management entity that may be considered a dual agency, provider of case management and other Medicaid and waiver services, a clearly defined definition for COI is in place and is a requirement of the CME to follow and adhere and specific restrictive assurances are carefully monitored by State Medicaid Agency. These restrictive assurances include an analysis of network adequacy in that service region and a phone or mail questionnaire by representatives from the State Medicaid Agency to the waiver participant regarding access to his or her freedom of choice and engagement with the case management entity. As a means of documenting monitoring requirements and ensuring the waiver participant's needs are adequately met, the case management entity must review with the waiver participant information about disclosure of potential conflict of interest. The waiver participant must voice an agreement or provide written information that the person-centered plan continues to meet current health and social status. The CAP Business system has a function called a Local Authority Review which prompts an unbiased reviewer to ensure the monitoring of the service plan is conducted monthly and quarterly. This agreement is approved by the SMA.

When a CME is granted authority to act in a dual role, safeguards are in place to assure the CME administratively separates the plan monitoring function from the direct service provider functions. Two safeguards are placed to manage potential conflict of interest in this area. The first safeguard is for the monitoring staff and the service rendering staff to be provided by two distinct units or personnel within that organization. The second safeguard is for the CME to have an independent reviewer to perform quality checks quarterly to assess concerns of conflict and needs of the waiver participant are adequately met. The case management entity is also required to assess provider network in the service region routinely for available providers and discuss free choice of provider (Disclosure form) with the waiver participant quarterly. The SMA shall provide a quality review of all service plans to ensure the appearance of conflict is not perceived.

The SMA identifies in advance the potential agencies that will fall in this threshold through a network analysis on a quarterly basis. When an agency is approved to function in this dual role, the SMA monitors these agencies closely by the initial service plan, paid claims, revisions to service plans, monitoring of monthly and quarterly visit summary reports, incident reports and annual surveys.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-A1 Number and percent of waiver participants who had a signed service plan that identified person-centered goals and strategies to meet those goals. Numerator:

number of waiver participants who had a signed service plan that identified person-centered goals and strategies to meet those goals Denominator: number of waiver participants reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entity's file.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> CAP Business system </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

SP-A2 Number and percent of waiver participants who had an IRA, when serious health/safety risk factor was identified. Numerator: Number of waiver participants who had an IRA, when serious health/safety risk factor was identified Denominator: number of waiver participants with serious health/safety risk factors identified that were reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and APS and CPS data reports.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval =

		95% confidence level and +/- 5% margin of error
Other Specify: <input type="text" value="CAP Business system and APS and CPS data reports"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

SP-A3: Number and percent of all waiver participants who had a service plan that addressed assessed needs
Numerator: Number of all waiver participants who had a service plan that addressed assessed needs
Denominator: number of all waiver participants reviewed

Data Source (Select one):

Operating agency performance monitoring

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level and +/- 5% margin of error. </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> CAP Business system </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input data-bbox="405 577 799 663" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input data-bbox="868 864 1262 949" type="text"/>

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-C1: Number and percent of service plans that are updated/revised at least

annually Numerator: number of service plans that are updated/revised at least annually
annually Denominator: number of service plans that were reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from CAP Business system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> CAP Business system </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: e-CAP system	Annually
	Continuously and Ongoing
	Other Specify:

Performance Measure:

SP-C2 Number and percent of service plans that are updated/revised when warranted by changes in the waiver participant’s needs. Numerator: number of service plans that are updated/revised when warranted by changes in the waiver participant’s needs Denominator: number of service plans reviewed

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error

Other Specify: <input type="text" value="CAP Business System"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text" value="e-CAP system"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

d. Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-D1 Number of waiver participants whose files were transmitted to the MMIS with PA service limits in the amount, frequency, and duration authorized in the service plan. Numerator: Number of waiver participants whose files were transmitted to the MMIS with PA service limits in the amount, frequency, and duration authorized in the service plan D: # of waiver participants' files reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> CAP Business system </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

SP-D2 Number and percent of waiver participants whose services were delivered in accordance with the service plan, including type and scope
Numerator: Number waiver participants whose services were delivered in accordance with the service plan, including type and scope
Denominator: Number of waiver participants reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, MMIS system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

<p>Sub-State Entity</p>	<p>Quarterly</p>	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level and +/- 5% margin of error</p> </div>
<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>CAP Business system and MMIS</p> </div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (check each that applies):</p>	<p>Frequency of data aggregation and analysis(check each that applies):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>CAP It case management system and MMIS</p> </div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

SP-E1 Number and percent of waiver participants who were afforded choice between/among waiver services and providers
Numerator: number of waiver participants who were afforded choice between/among waiver services and providers
Denominator: number of waiver participant's records reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error
Other Specify:	Annually	Stratified Describe Group:

<input type="text" value="CAP Business system"/>		<input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The State reviews each service plan developed by the case management entity to validate the service planning needs are consistent with assessed needs. The e-CAP system performs a compliance audit monthly to validate each report to monitor compliance and conflict-free. A quality data report is provided to NC Medicaid, and outliers are carefully reviewed and assessed by NC Medicaid for discovery, remediation, and continuous quality improvement.

The CAP Business system for the waiver is designed to evaluate all waiver participants and provider agencies in the implementation and performance of the service plan development, which is a critical component of the health, safety, and well-being of waiver participants. Staff at NC Medicaid reviews each service plan or other waiver activities developed and

created by the case management entity to validate the accuracy of the information. A quality data report is provided to NC Medicaid, and outliers are carefully reviewed and assessed by NC Medicaid for discovery, remediation, and continuous quality improvement.

The CAP Business system has service plan functionality that produces data reports during each stage of eligibility, and, through the implementation of the service, the plan ensures approved waiver services are rendered and billed in the amount, frequency, and duration specified on the service plan of selected providers. A selected provider will receive a service authorization with the amount, frequency, and duration authorized by the case management entity. NC Medicaid fiscal agent will only reimburse the prior approved limits and deny any claims over the approved limits.

The CAP Business system reviews 100% of cases monthly to determine errors in service plan development. These reviews assist in remediating deficiencies that result from failure to accurately complete the care planning assessment tool. Each case management entity has access to these quality assurance reports to track its performance and identify noncompliance areas that may require remediation.

Monthly performance analytics are produced to monitor the benchmarks established for service plan development and execution.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Upon discovering the noncompliance of the case management entity, a corrective action plan is developed to remediate the noncompliance with a completion date within 30 days of the discovery. Repeated findings of noncompliance may result in suspensions of accepting new enrollment until compliance is achieved. Staff training and technical support are provided. If the case management entity authorizes waiver services outside of the policy, the contracted vendor or local agencies will be fined the amount of the unauthorized waiver services. Continued noncompliance in this assurance area for three consecutive reporting quarters may result in termination of the provider. A mitigation plan will be implemented to mitigate access to care issues and harm to the waiver participant.

Upon discovering the noncompliance of the contracted vendors, a corrective action plan is developed to remediate the noncompliance with a completion date within three business days. Repeated findings of noncompliance by contracted vendors will result in fines and penalties. When errors cannot be remediated, a recommendation will be made to terminate the contract for the contracted vendor.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The state requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver is designed to afford every waiver participant (or the legally responsible party), the opportunity to elect to direct care using consumer-directed services. The program affords increased participant's choice and independence in meeting home care needs and increasing satisfaction with long term supports. This waiver offers both provider-lead and direct-led service options. Waiver services may be directed by the waiver participant or a legally responsible party of the waiver participant. Waiver services may also be directed by a representative freely chosen by an adult participant or a legally appointed representative.

Description of Consumer Direction for the purpose of this waiver; consumer-direction, waiver participant will be able to:

- Choose (hire), the personal assistant who will provide their care;
- Train, supervise, and evaluate the worker;
- Negotiate the rate of pay and other benefits;
- Release (terminate) the worker should this become necessary;
- Select individual providers and direct reimbursement for several other waiver services (identified previously in Appendix C-1/C-3); and
- Engage in a cooperative working arrangement, with a financial manager who will pay the participant's worker, handle federal and state taxes and other payroll or benefits related to the employment of the worker, and reimburse other service providers under the direction of the waiver participant.

To be eligible for consumer-direction, a waiver participant or designated responsible party must:

Meet criteria to be assessed for HCBS waiver participation (e.g., at risk of institutional care; be eligible for Medicaid); Understand the rights and responsibilities of directing one's own plan of care; be willing and able to self-direct or select a representative who is willing and capable of assuming this responsibility. A self-assessment questionnaire must be completed to assess ability of the waiver participant/primary caregiver to direct care. If there are areas for improvement or additional support, the case advisor works with the waiver participant/primary caregiver to build these competencies. Approval to direct care is not approved until the waiver participant/primary caregiver shows evidence of competencies in all areas.

The State Medicaid agency, case management entities, financial management agencies, waiver service providers and other providers interacts with and participate in the participant's service plan.

The Case management entity provides care advisement to the participant monthly and quarterly. The care advisor is a specialized case manager from a case management entity, with an understanding of consumer direction. The care advisor focuses on empowering waiver participants to define and direct their own direct care worker and services. The care advisor guides and supports the waiver participant, rather than directing and managing the waiver participant throughout the service planning and delivery process. The care advisor provides four core functions of case management (assessing, care planning, referral/linkage, and monitoring/follow-up). These functions are done under the guidance and direction of the consumer-directed participant.

The Fiscal Intermediary (FI), through financial management services (FMS), provides financial services to the waiver participant. Financial management services are provided to ensure consumer-directed funds outlined in the family/person-centered service plan are managed and distributed as intended. The FI files claims through NC Medicaid MMIS and reimburses the direct care workers. The FI deducts all required federal, state taxes, including insurance prior to issuing reimbursement or paychecks. The FI entity is responsible for maintaining, separate accounts on each participant's services, and producing expenditure reports as required by the State Medicaid agency. The FI also provides payroll statements, at least monthly, to the direct care worker and the case management entity. The FI must conduct background checks and age verification on all direct care workers. The FI must also validate the direct care worker has completed requirements for CPR certification and other certification requirements.

The CAP Business system has a knowledge exchange that provides additional education and resource materials about consumer-directed services, which is readily available to the case management entity for self-use and distribution to the waiver participant.

Waiver participants selecting consumer-directed care are able to direct personal care type services and skilled care services and make decisions about goods and services.

Training requirements are required for direct care workers caring for waiver participants who are medically fragile and with special care needs. Training, Education, and Consultative services are waiver services and may be included in the service plan to arrange for mandatory training and certification such as CPR. The direct care worker must exhibit core competencies in the specialized areas, which are checked off by the waiver participant or responsible party and reviewed by the care advisor before services are authorized. When a direct care worker is hired, training can be authorized to build

additional capacities or learn how to care for a change in the participant's status. Training, Education, and consultive services are not intended for a direct care worker who can't be hired because they do not meet the hiring requirements.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver.
Select one:

Participant: Employer Authority. As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.

Participant: Budget Authority. As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.

Both Authorities. The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.

Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

Waiver is designed to support only individuals who want to direct their services.

The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.

The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

The CAP waiver has two options, CAP (provider-led option) and consumer-directed option. A waiver participant has the opportunity to select either option during the initial or annual assessment, or any time during waiver participation. To be eligible for consumer-directed care, a waiver participant, responsible party, or legally appointed representative, must meet the following criteria: 1. Understands the rights and responsibilities of directing one's care; 2. Willing and intellectually capable to assume the responsibilities for directing care, or selects a willing and capable representative to assume the responsibilities to direct the participant's care; and 3. Complete a self-assessment questionnaire and other readiness documents to determine the ability to direct care or identify training opportunities to build competencies to aid self-direction. At any given time, a waiver participant directing his care can request to return to the provider-led option of the waiver. The care advisor will work with the waiver participant for a smooth transition back to the provider-led option.

The following conditions are carefully analyzed prior to approval of consumer-direction:

1. Decline in mental or physical health and/or loss of informal support that would affect the ability of the participant to self-direct. If this occurs, care advisors will reassess the participant's situation, to determine whether the consumer -directed option continues to be appropriate for the individual or if additional supports are needed for continued success. Personal care assistants or attendant nurse, and other direct care workers, who are in touch with the participant on a daily or regular basis, are instructed to report problems in these areas to the care advisor.
2. Consistent misappropriation of previous Medicaid services.
3. Past and present criminal involvement.
4. Previous violation of the Participant Rights and Responsibilities.

The Participant Rights and Responsibilities is listed below:

Participant Rights and Responsibilities

By signing the form, I, as the waiver participant or the responsible party (parent, legally responsible party, or designated caregiver) for [name of waiver participant], MID# [insert MID #] acknowledge my understanding of the Community Alternatives Program (CAP) and my rights and responsibilities as a waiver participant.

I understand:

1. The CAP Waiver is an alternative option to institutionalization. I must meet a nursing facility LOC initially and annually to participate in this program.
2. I agree to select this program as an option to institutionalization.
3. The CAP Waiver waives some Medicaid requirements to allow in-home care services (institutional-like services) to be provided and received in my home and community.
4. This CAP Waiver supplements rather than replaces the formal and informal services already available to me and my family.
5. The CAP Waiver has two service options, provider-lead (in-home aide and home health providers), and consumer-lead (consumer-directed), from which to receive my services. To qualify for and maintain qualification for consumer-directed care, I or my designated representative must be intellectually able and willing to direct my care as evidenced by a self-assessment tool. Quarterly reviews of performance are conducted by the care advisor and financial manager to ensure ongoing competencies.
6. The CAP Waiver provides an array of services, known as waiver services, to meet my assessed needs to keep me integrated in the community.
7. The CAP Waiver allows me the right to select any of the available waiver services to meet my assessed needs and any provider to provide those services.
8. The waiver services I select to meet my needs will be listed on a service plan in the correct amount, frequency, and duration that are consistent with my assessed needs. The service plan will be assessed quarterly and can be revised at any time based on my changing needs.
9. If I have a concern, complaint, or grievance, I can notify my case management entity, State staff or my provider agency to assist with my concerns. I also understand that a grievance or complaint does not result in a fair hearing.
10. If a waiver service I request is denied, reduced, terminated, or suspended, I will be notified in writing and be given instructions on how to appeal the denial.
11. The CAP Waiver requires work verification documentation and a listing of household members to assist in planning for my care needs. Work time and family support must be reported accurately to prevent a program integrity review.
12. If I have a Medicaid spend down, deductible, or premium, I must incur the established medical expenses before my CAP Medicaid is made available. I must also pay my identified providers the cost of these incurred medical expenses to prevent a gap in my care provision.
13. The CAP Waiver allows my waiver services to be provided by individuals and agencies of my choosing. However, waiver participants between the ages of 0-17, the following identified parties cannot directly provide waiver services and receive payment through payroll: a parent; stepparent, parent's spouse/significant other (live-in

or not), foster parent, custodial parent or adoptive parent, sibling under the age of 18, anyone acting as “loco parentis”. The following identified parties cannot directly provide waiver services for waiver participants 0-18 years of age or older and received payment through payroll: an appointed guardian appointed Health Power of Attorney or Power of Attorney or executor the estate.

14. The CAP Waiver is required to protect my health, safety, and well-being, at all times, while I participate in the program, I am able to assume some risks in my decisions making. This assumed risk must be outlined in an Individual Risk Agreement or emergency back-up plan. When choices are made that expose me to abusive situation, cause me to be neglected, abused, or exploited, the IRA may be terminated, and a referral will be made to Adult or Child Protective Services. An assessment of my continued eligibility to participate in the waiver will be conducted.

15. The CAP Waiver may initiate disenrollment from the waiver when any one of the following occurs:

- The participant’s Medicaid eligibility is terminated;
- The participant’s physician does not recommend nursing facility;
- The SRF is not approved for nursing facility LOC;
- DSS removes the CAP evidence code;
- The CAP case management entity has been unable to establish contact with the participant or the primary caregiver(s) for more than 60 calendar days despite two written and two verbal attempts;
- The participant fails to use CAP services as listed in the service plan during a 90 consecutive day time period of CAP participation despite case management coordination;
- The participant’s health, safety, and well-being cannot be mitigated through a risk agreement and other interventions.
- The participant or primary caregiver will not participate in development of or sign the service plan.
- The participant or primary caregiver(s) fail to comply with all program requirements, such failure to arrive home at the end of the approved hours of service, or manipulation of the coverage schedule without contacting the case management entity for approval; or
- The participant demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of CAP as outlined in the “Participant Rights and Responsibilities” form and signed by the CAP participant.

16. I or the primary responsible party must maintain monthly telephone contact and monthly-to- quarterly face-to-face contact with the assigned case manager for the purpose of monitoring health and well-being and coordinating to include referrals, linkage, assessments, and care planning.

17. I or the primary responsible party will receive an annual letter of appointment to complete my annual continued need review for going participation in the waiver program. Failure to comply or keep the arranged appointment may interrupt the provision of my services or initiate disenrollment from the CAP waiver.

18. NC Medicaid has sole approval authority over the administration of the CAP waiver.

I have read and understand the above information. By signing this document, I willingly accept to participate in the CAP Waiver and agree to abide by the policies and procedures of the CAP Waiver. I also understand my rights and responsibility as a waiver participant.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant’s representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case management entity is responsible for providing waiver participant/primary caregivers/legally responsible party sufficient information to ensure informed decision-making and understanding of the consumer-directed service option and the provider-led service delivery option. The information includes the responsibilities and choices individuals may make with the election of the consumer-directed service option. The Disclosure Notice and the Welcome letter include information about consumer-directed care. The assigned case manager also reviews the consumer-directed services option at program enrollment, at least annually, or upon request. This information is provided orally and in writing to the waiver participant, and the legally authorized representative by the case management entity.

The information that is provided includes:

- An overview of the consumer-directed services option;
- Explanation of responsibilities of the individual or individual's legally authorized representative and the consumer-directed service agency in the consumer-directed service option;
- Explanation of benefits and risks of participating in the consumer-directed services option;
- Self-assessment questionnaire requirement for participation in the consumer-directed services option;
- Explanation of required minimum qualifications of service providers through the consumer-directed services option;
- and
- Explanation of employee/employer relationships, that prohibit employment under the consumer-directed services option.

During the initial enrollment in the consumer-directed option, a Financial Management Services (FMS) agency performs financial intermediary (FI) services as listed below:

- Information, training and outreach;
- Information in completing and filing IRS tax forms;
- What are the roles and responsibilities of FI?
- What are the roles and responsibilities of the waiver participant?
- Conducting criminal background checks and explaining the criminal background that is identified during the check;
- Processing referral applications;
- How applicants must complete the employment application;
- How to submit Medicaid personal care claims for reimbursement;
- An explanation of Bill of Rights;
- How to contact a representative of the FI contractor; and
- Access to customer services to submit claims and guidance for technical problems or concerns.

On an ongoing monthly basis, the FMS is responsible for the following:

- Filing Medicaid claims for reimbursement of personal care claims;
- Managing and paying payroll;
- Arranging to reimburse hired assistants when payroll is missed;
- Trouble shooting concerns or problems;
- Conducting criminal background checks on newly hired personal care assistants;
- Maintaining monthly contact with the care advisor; and
- Assuring accessibility to customer service for waiver participants to submit claims and seek guidance for technical problems or concerns.

The FI and the case management entity will monitor the compliance of all self-assessment tools to ensure appropriateness of directing care.

The care advisor will inform roles and responsibilities associated with a consumer-directed care, explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual/representative to modify individual budget. The care advisor will also provide:

- Assessment of individual risk;
- Assessment of health, safety, and well-being of the person as well as the continued appropriateness of services and supports;
- Identification of the need for a representative for the waiver participant, who desires to direct his/her own services and supports, and ensures that the representative, meets established criteria to assist the participant to self-direct their supports/services;
- Quality assurance of the person-centered plan, identifies how emergency back-up services will be furnished for workers employed by the individual, and authorizes the provision of on-call emergency back-up services;
- Report critical incidents; and
- Addresses complaints, grievances, and appeals.

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

The state does not provide for the direction of waiver services by a representative.

The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

Waiver services may be directed by a legal representative of the participant.

Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A representative is appointed when the waiver participant or legal guardian requests assistance or has demonstrated a need for assistance. The financial manager and the case advisor work with the participant to identify an individual who will be appointed as the representative. The legal representative is a neutral party. The care advisor plays a significant role in identifying the need for a representative and ensuring that the representative meets the criteria outlined above. Additionally, as part of ongoing monitoring activities, the care advisor ensures the representative continues to act in the best interest of the waiver participant.

The representative may NOT be the paid hired staff (i.e., personal assistant) for the waiver participant. The following requirements must be met prior to approval of designating a representative:

- Demonstrated knowledge and understanding of the participant's needs and preferences;
- Agreement to a predetermined level of contact with the participant;
- Willingness to comply with program requirements;
- 18 years of age or older; and,
- Agreement by the waiver participant/ primary caregiver for someone to act in that capacity

A parent/legal guardian or significant other to a parent of an individual 0-17 is not eligible to be the representative if deemed inappropriate by a local DSS or the SMA. The representative may be a family member, friend, someone who has power of attorney, income payee, or another person who willingly accepts responsibility for performing tasks that the waiver participant or legal guardian cannot perform. The representative must be at least 18 years old. The representative must be committed to following the waiver participant or legal guardian's needs and preferences while using sound judgment to act on the waiver participant or legal guardian's behalf.

The representative may NOT be paid to be the representative or provide any other service to the participant except guardianship services.

If a representative is identified, the representative will be asked to sign the "Representative Agreement" provided by the FI. This agreement outlines the requirements and expectations of the representative and explains that the representative may be removed for not complying with the agreement. The assigned care advisor monitors the delivery of services monthly and reports any concerns to the FI and the State Medicaid Agency. In addition, any concerns about the well-being of a waiver participant or legal guardian must be reported through a critical incident report.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual-Directed goods and services		
Coordination of Care- case management and care advisement		
Attendant Nurse Care		
Respite-Institutional and In-Home		
Pediatric Nurse Aide Services		
In-Home Care Aide Service		

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

Yes. Financial Management Services are furnished through a third party entity. (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

Governmental entities

Private entities

No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

FMS are covered as the waiver service specified in Appendix C-1/C-3

The waiver service entitled:

Financial Management Services

FMS are provided as an administrative activity.

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Public or private entities are eligible to provide FMS as long as they meet the required credential to enroll as a Medicaid provider of this service. The provider credential is as follows:

The vendor shall have a minimum of two (2) years similar project experience with other departments or divisions of state government, county government, municipal governments, or large corporation employers in North Carolina, or in other States with similar projects. The vendor must be authorized to transact business in North Carolina and be approved as a Medicaid provider.

When additional vendors are needed to support consumer-direct participants, a solicitation for vendors is posted to the NC Medicaid website to procure vendors for this service.

Waiver participants are informed of the providers of this service and given a choice of providers to select.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The payment for FMS is a waiver service that is added to the cost budget in the POC. The FMS submits claims to Medicaid for reimbursement of FMS fees. The case management entity monitors the FMS to ensure payment of the direct care worker is paid in the amount, duration, and frequency listed in the POC. The CAP Business system will also submit prior approval claims directly to NC Medicaid MMIS for reimbursement of FMS and direct care worker services. The case management entity will also monitor customer service to address any concerns, complaints, or grievances the waiver participant may have.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

Assist participant in verifying support worker citizenship status

Collect and process timesheets of support workers

Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance

Other

Specify:

Supports furnished when the participant exercises budget authority:

Maintain a separate account for each participant's participant-directed budget

Track and report participant funds, disbursements and the balance of participant funds

Process and pay invoices for goods and services approved in the service plan

Provide participant with periodic reports of expenditures and the status of the participant-directed budget

Other services and supports

Specify:

Additional functions/activities:

Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency

Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency

Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget

Other

Specify:

--

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS must enroll as a Medicaid provider and meet all provider credentials as established by the State Medicaid Agency. The State Medicaid's Fiscal Agent oversees provider enrollment to ensure enrollment is consistent with the State's policies and procedures. The fiscal agent conducts OIG checks regularly to ensure good standing with Medicare and Medicaid. A provider application recertification is required every five(5) years.

The State Medicaid Agency and the case management entities closely monitor the execution of FMS services to ensure the health, safety, and well-being of the waiver participant. The case management entity reviews monthly budget summary sheets provided by the FMS and also addresses concerns of service utilization, both over and under.

The CAP Business system provides the case management entity and the State Medicaid Agency with real-time reports to assist in the monitoring of the FMS to ensure criminal and registry background checks are conducted and enrollment paperwork is completed, and the rate is within the approved Medicaid limits.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Waiver participants and family members are provided information on the SMA, the care advisor, and the FI about their roles and responsibilities in consumer-directed care. Information and assistance are available to support the waiver participant when participating in consumer-directed care. This support is provided by the SMA, care advisor, and the financial management agency. Upon request by the waiver participant, the SMA can arrange to link them to an outside source to resolve grievances and to receive additional education and support. The case advisor is trained in the consumer direction model and acts in the role of primary supporter of the waiver participant to ensure information and assistance are provided regularly and as requested in a person-centered process. The care advisor's role is to empower the participant to define and direct their care and identify needs and supports. The support offered by the care advisor assists waiver participants in making informed decisions about what will work best for them, services consistent with their needs, and reflecting their individual circumstances. Supportive services offered to waiver participants also assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing gaps and other training needs. Care advisor offers practical skills training to enable waiver participants and primary caregivers to remain independent while knowing who and when to contact for additional support. The case advisor meets monthly with the waiver participant/primary caregiver to access support needs, concerns, and areas that are working well.

The care advisors provide information and assistance in the following areas:

- Explanation of the methodology for resource allocation, the total dollar value of the allocation, and mechanisms available to the individual/representative to modify their individual budget.
- Assessments of individual risks.
- Assessment of the waiver participant's health, safety, and well-being as well as the continued appropriateness of services and supports.
- Identification of the need for a representative for the participant who desires to direct their own services and supports, and ensures that the representative meets established criteria to assist the participant to self-direct their supports and services
- Assurance that the Person-Centered Plan identifies how emergency back-up services will be implemented and how and when to authorize the provision of on-call emergency back-up services.
- Assessment of critical incidents and completing necessary reports and referrals
- Assistance with grievances and appeals
- Assist and support the waiver participant/primary caregiver in transitioning to the provider-led services when the waiver participant/primary caregiver decides that they no longer desire to continue to self-direct; or for those participants who have been unable to maintain budget authority.
- Notification of any concerns with implementation and ongoing utilization of the consumer-direction option.

This waiver will provide financial management services as a waiver service for a waiver participant choosing to direct their care. This service will be included in the waiver benefit packet as a fee-for-service item.

Waiver Service Coverage.

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Training, Education, and Consultative Services	
Community Integration	
Individual-Directed goods and services	
Financial Management	
Vehicle Modifications	
Coordination of Care- case management and care advisement	
Pest Eradication	
Attendant Nurse Care	

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Community Transition	
Assistive Technology	
Respite-Institutional and In-Home	
Nutritional Services	
Pediatric Nurse Aide Services	
Specialized Medical Equipment	
Participant Goods and Services	
Non-Medical Transportation	
Coordinated Caregiving	
Home Accessibility and Adaptation	
In-Home Care Aide Service	

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

No. Arrangements have not been made for independent advocacy.

Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Waiver participants choosing consumer-directed care are provided information on opportunities to access independent advocacy. This information is provided during screening and referral for support planning and during the enrollment process for ongoing support. The Division of Vocational Rehabilitation Services provides education, information, and training in consumer-directed care and how to arrange and access services in the community efficiently. The Department of Health and Human Services (DHHS) has a Customer Service Center to provide information, referrals, education, and outreach to individuals choosing to direct their care. The DHHS Customer Service Center can be reached by dialing 888-245-0179. The DHHS Customer Service Center is available 24-hours, 7-days per week, and includes interpretive services for non-English speaking callers. Vocational Rehabilitation Services are available Monday-Friday from 8 am -5 pm for direct assistance in person, writing, or by telephone. There is no fee for accessing and using these advocacy programs. Waiver participants seeking legal guidance can access services from NC Legal Aide Services.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

i. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A waiver participant selecting consumer-directed care may withdraw from the option at any time by notifying the assigned care advisor. The assigned care advisor prepares a revision to the service plan, so provider-led services are authorized for the waiver participant with no service lapse.

The following steps are followed:

- (1) Participant or legally responsible party requests that the assigned care advisor terminates the consumer-directed option and returns the participant back to the traditional waiver services.
- (2) Care advisor asks the participant or legally responsible party to select a provider and updates the service plan to reflect the termination of the consumer-directed option and the provider agency selected by the participant or legally responsible party to provide provider-led services.
- (3) The legally responsible person signs the service plan, and the care advisor uploads it to the CAP Business system.
- (4) The CAP Business system analyzes the service plan for accuracy, and the case management entity or the State Medicaid Agency approves the service plan, authorizes provider-led services, and terminates consumer-directed services.
- (5) The assigned case manager sends a letter to the participant or legally responsible party and all providers notifying them of the termination of consumer-directed care per the request that includes the date of the termination of payroll for all direct care workers. The letter is copied to the care advisor.
- (6) The Employer of Record or financial management agency notifies staff that they are no longer employed under consumer-directed care.

A Care advisor works with the waiver participant to transfer to regular waiver services or other State plan service(s) and monitors health and safety until the new service is fully implemented.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

This waiver will allow for both provider-led and direct-led services. Provider-led services are referred to as the traditional agency oversight. If a waiver participant is not successful in directing care and continues to need support from this waiver, arrangements will be made to transition the waiver participant to a provider-led agency for waiver planning. Upon the transition, the participant will receive all services from a provider agency, and the assigned case management entity will take a more active role in directing the care needs of the waiver participant.

When a waiver participant demonstrates the inability to self-direct waiver services, whether due to misuse of funds, consistent non-adherence to program rules, or an ongoing health and safety risk, he or she will be required to select a representative to assist them with the responsibilities of consumer direction, if a waiver participant refuses to select a representative or if waiver participant loses a representative and cannot locate a replacement, the waiver participant will be required to transfer to provider-led services for closer oversight. The care advisor will assist the waiver participant with the transition. Waiver participants are given Due Process rights for any changes, termination, or removal of a service or program.

The State Medicaid Agency will initiate an involuntarily termination from consumer-directed care under the following circumstances:

- (1) Immediate health and safety concern including maltreatment of the waiver participant;
- (2) Repeated unapproved expenditures and misuse of waiver funds;
- (3) No approved representative available when deemed necessary;
- (4) Refusal to accept the necessary care advisement and training service when deemed necessary;
- (5) Refusal to allow care advisor to support and monitor the health and well-being of the waiver participant;
- (6) Refusal to participate in mandatory monthly and quarterly monitoring requirements, state or federal monitoring;
- (7) Non-compliance with individual and family supports, Financial Supports Agency, Agency with Choice, or employee support agreements; and
- (8) Inability to implement the approved service plan or comply with waiver requirements despite reasonable efforts to provide additional training assistance and support.

The State Medicaid Agency will dis-enroll a waiver participant from consumer-directed care when the same major mistakes occur more than three times in twelve months. However, the recommendation to terminate consumer-directed care may occur immediately if the waiver participant’s health and safety are at risk or if there is suspected misuse of funds. For example, an incident of substantiated abuse by a paid employee could lead to termination if a plan cannot be implemented to ensure health and safety.

Before considering a termination from consumer-directed care, the case management entity will report concerns and allegations of major problems with implementing consumer-directed care to the State Medicaid Agency. The State Medicaid Agency consultant investigates the concerns or allegations. The consultant will review all available plans of correction and documentation.

The termination date from the consumer-directed care will occur on the last day of a given month. When the termination is due to a threat to the waiver participant’s health and safety, such as physical abuse, termination occurs immediately, and traditional waiver participation resumes immediately.

If the employer disagrees with the decision of the State Medicaid Agency, the employer may file a reconsideration request or a grievance.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="1000"/>
Year 2	<input type="text"/>	<input type="text" value="1200"/>

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 3	<input type="text"/>	<input type="text" value="1400"/>
Year 4	<input type="text"/>	<input type="text" value="1600"/>
Year 5	<input type="text"/>	<input type="text" value="1800"/>

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

Participant/Co-Employer. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

Recruit staff

Refer staff to agency for hiring (co-employer)

Select staff from worker registry

Hire staff common law employer

Verify staff qualifications

Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

Associated costs for staff recruitment, hiring, and verification of qualifications may be compensated by the participant's goods and services budget or training, consultative, or education services. Staff criminal history and background verification are reimbursed to the FMS agency by Medicaid through the waiver service, Financial Management Services.

Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

None

Determine staff duties consistent with the service specifications in Appendix C-1/C-3.

Determine staff wages and benefits subject to state limits

Schedule staff

Orient and instruct staff in duties

Supervise staff

Evaluate staff performance

Verify time worked by staff and approve time sheets

Discharge staff (common law employer)

Discharge staff from providing services (co-employer)

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

Reallocate funds among services included in the budget

Determine the amount paid for services within the state's established limits

Substitute service providers

Schedule the provision of services

Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3

Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3

Identify service providers and refer for provider enrollment

Authorize payment for waiver goods and services

Review and approve provider invoices for services rendered

Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Each waiver participant is provided a Welcome Letter initially, and annually that identifies the average per capita cost. The case management entity also provides training and orientation to the waiver participant about the budget and budget management when directing care. Information about the budget methodology is made available to the public by posting current and updated Fee Schedules and communication from the state Medicaid Agency and financial management agencies.

Budgets will be calculated based on the methodology currently in place for the waiver. The process involves:

- An assessment to identify needs.
- Development of person-centered goals based on identified needs.
- Agreement on the type and amount of services needed to meet the goals.

The estimated monthly cost of each waiver service is calculated using the maximum Medicaid limits listed on the current Fee Schedules. The costs of waiver and non-waiver services cannot exceed the average per capita expenditure as established for this waiver. The financial manager informs the waiver participant about the IRS process, how taxes and insurance are calculated, and how those taxes need to be considered when negotiating a rate. The waiver participant is also informed of the need to set the rate at a medium range. Still, not less than minimum wage, to plan for unexpected changes and plan rate increases to compensate for the worker's longevity or tasks requiring extensive assistance.

A rate fee range is provided to the waiver participant for hire consideration. The waiver participant is counseled by the care advisor and the FI on how to set that rate that allows for flexibility and maximal utilization of waiver services.

The waiver participant is also provided:

- Information and education about the Department of Labor Final Rule regarding overtime pay
- Maintaining task sheets
- Assigning pay wages at or above minimum wage

The state has a goal to pay all direct care workers a minimum of \$15.00/hr. Employers are encouraged to offer their direct care workers that rate.

This information is available to the public by accessing the Division's website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Upon approval of waiver participation, a waiver participant is provided a Welcome Letter that informs of the waiver services, resources, and utilization limits provided under the waiver. The waiver participant is informed of the acuity level they are assessed based on the comprehensive assessment results. The acuity level identifies the average per capita cost of service provision based on assessed needs. When developing the service plan to ensure budget management, the care advisor and the financial manager assist the waiver participant in strategizing and structuring services at a negotiated rate. This budget is based on the number of support hours needed during the day, the utilization of other waiver and non-waiver services, and the hourly wages to be paid to the employee. The FI takes this information and creates a budget to ensure the services and pay rate are within the average per capita cost. The pay rate, including all taxes, insurance, and overtime, is within the Medicaid maximum reimbursement. Upon completing the budget, the FI reviews and explains to the waiver participant for understating and agreement. The approved budget by the waiver participant is shared with the care advisor to finalize the service plan. If an adjustment is needed during the annual participation in consumer-directed care, the waiver participant can negotiate additional services using the same methods described above while ensuring expenses remain within the budget allotted.

A change to the waiver participant's status may warrant a change in the acuity level of care, thus changing the average per capita cost of their needs. The participant, the care advisors, physician, or provider agencies can request a change in status assessment to identify an adjustment in the care needs. If the acuity level increases, the waiver participant has more negotiation power and resources to plan care. If the acuity level decreases, the care advisor and financial manager assist the waiver participant in realigning their service needs to ensure service provision is within the average per capita cost of their needs. The care advisor assists the waiver participant in developing a 90-day transition plan to align waiver services so as to not create a health and safety risk factor. Each waiver participant is given a total of 6 months to align within the average per capita cost established for this waiver upon the discovery of exceeding the average per capita cost. When the discovery is made, the waiver participant is informed, and the case advisor works with the participant to identify other formal or informal services to align with the average per capita cost of their needs. If, after the third month of intervention, the cost of care is significantly over the average per capita cost of the waiver and the cost of care will not align because of the severity of care needs, a transition plan will be created for a three-month transition to traditional Medicaid services and other community services where an average per capita cost is not a factor in planning the care needs. The waiver participant is provided Due Process rights through a participant change notification letter. The notification letter clearly describes what has changed, when the change will take effect, and the timeframe for the waiver participant to appeal the adverse decision. Medicaid participants or their personal representatives have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 et seq. and N.C.G.S. §108A-70.9.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

Modifications to the participant directed budget must be preceded by a change in the service plan.

The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

A change to the waiver participant's status may warrant a "change in status assessment" to reassess needs, level of acuity, and the consumer-directed budget. This reassessment may change the maximum average per capita cost of the budget. When a change in status is identified or a request to reevaluate the service plan is made, the care advisor meets with the waiver participant to assess needs and to determine the validity of revising the service plan. Evidence to support the reassessment or a revision to the service plan prepares the care advisor to initiate the process with the waiver participant. This information is documented in the participant service record by the case management entity.

If an unexpected situation occurs, the waiver participant has the autonomy to utilize unauthorized waiver services by notifying the care advisor and financial management agency.

The care advisor, the FI, and the CAP Business system must be notified by the employer of record and the waiver participant within 24 hours of the unauthorized service. If the service was a short-term intensive intervention, the service plan would not be updated. The care advisor would give written approval to the financial manager to reimburse the one-time short-intensive service, and the CAP Business system will send a prior approval record to NCTracks for approval of reimbursement. If the service is ongoing, the service plan and service authorizations must be updated and disseminated to all authorized providers. The care advisor would update the service plan and notify providers.

Prior approval of services would be required for short-term intensive interventions with a longer duration and when the waiver participant requested a pay increase for their direct care worker.

All changes that are made to the consumer-directed budget are documented on the service plan that is electronically stored in the CAP Business system. The service plan identifies all waiver and non-waiver services in terms of the amount, frequency, and duration. The service plan provides a comprehensive overview of the person-centered plan and how services needs will meet care needs.

The FI provides the waiver participant a budget that only identifies the services that are self-directed and the total average budget per month and annually. When changes occur, the budget is updated and shared with the waiver participant and the care advisor. The case advisor uploads the updated budget in the supporting documents in the CAP Business system.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards that are in place to prevent the premature depletion of the participant's budget include:

1) monthly budget analysis reports provided directly to the waiver participant and the care advisors, and 2) quarterly data reports from the CAP Business system provided to NC Medicaid and the case management entity that informs of the average per capita cost of each waiver participant.

The waiver participant is provided a Welcome Letter that informs of the utilization limits of the waiver and an explanation of how the cost of care should fall within the average per capital cost of their assessed needs. The care advisor meets monthly with the wavier participant to assess expenditures and other concerns. The case advisor also reviews the expenditure reports submitted by FI and discusses any concerns with expenditures when warranted.

The case management entity performs post-approval and post-payment reviews using data from the CAP Business system and FMS.

The care advisor, the FMS, and the CAP Business system will continually monitor the service plan and service provision to ensure needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the care advisor works with the waiver participant to resolve them. If the problem cannot be resolved, the care advisor and case management entity will consult with NC Medicaid Program Consultants before taking any adverse action toward the waiver participant.

If changes impact the consumer-directed budget, the waiver participant is provided written information about the impact and the need to address the impact with the care advisor or the FI. The care advisor and financial manager provide counsel and guidance to the waiver participant about maintaining care needs within the average per capita cost while assuring health, safety, and well-being.

The financial manager provides monthly aggregate budget reports that clearly identify authorized expenditures and actual expended costs. If the waiver participant has reached or is near to reaching the authorized expenditure, the financial manager will notify the waiver participant and the care advisor. The care advisor will assist the waiver participant in realigning spending.

Another safeguard is the transmittal to NCTracks of prior approval limits of all waiver services. The CAP Business system automatically transmits the approved limits to the Medicaid management system for claim reimbursement when a service plan is approved. Claims submitted over that prior approved amount will be cut back and denied.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In accordance with Due Process, the State Medicaid Agency ensures the waiver participant, legal representative(s), or both are provided written notice of all adverse decisions. A waiver participant whose SRF is denied or whose waiver services are denied, suspended, terminated, or reduced, has the right to appeal.

Examples of appealable decisions are:

- a. denial of initial or continued participation in the waiver program;
- b. denial of increase, or reduction, of waiver services included in the service plan; or
- c. Disenrollment from the waiver program.

Only actions initiated by the State Medicaid Agency and appointed case management entities may be appealed. The following decisions may not be appealed:

- a. A provider's refusal to serve a waiver participant;
- b. A physician's level of care recommendation; or
- c. A physician's order.

A waiver participant will not be given the opportunity to a fair hearing by NC Medicaid when a physician does not recommend the LOC. The State Medicaid agency's policy states that a recommendation of a LOC decision must be rendered and fully documented by the treating physician to demonstrate medical necessity. When the physician cannot document medical necessity to make a level of care recommendation, the individual must dispute that decision directly with the physician. The individual will have the opportunity to present additional information directly to the physician that supports the institutional level of care. The physician's decision will impact the initial level of care determination as the CAP Business system and Case management entity will not be able to process the assessment without an established LOC recommendation. The individual is provided a referral list of other community resources available to meet needs.

Each waiver participant will receive a copy of their rights at the eligibility screening for home and community-based waiver services. In addition, each waiver participant will be provided appeal rights when a CAP service is denied, reduced, or terminated or when the waiver participant is dis-enrolled from the waiver. The CAP Business system will manage and create adverse notices for the Independent Assessment Entity or the Case management entity to use when an adverse decision is reached.

The adverse notice will contain information on:

- The right to a Fair Hearing;
- The method for obtaining a Fair Hearing;
- The rules that govern representation at Fair Hearings;
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the individuals may use to file a Grievance, complaint, or request assistance; and
- Rights, procedures, and timeframes for voicing or filing Grievances and Appeals or recommending changes in policy and services;
- Information and instruction on how to request an expedited hearing.

The requirements of the appeals process must be consistent with the fair hearing established at 42 CFR Part 431, Subpart E, and NC Gen. Stat. § 108A-70.9A.

An approved waiver participant will be granted a fair hearing when dis-enrolled from the waiver or for any waiver service that is denied, reduced, terminated, or suspended. When an incomplete application is submitted, the waiver participant and family are informed of missing information or incompleteness of the application. Technical assistance is provided to collect the missing information to make an informed decision about the appropriateness of the request. The CAP Business systems will not generate an appeal notice when any of the conditions listed below are presented: 1. The Community Alternatives Program (CAP) special coverage codes/CAP evidence have not been entered or have been removed from the eligibility system, which indicates the individual has not been approved or is no longer approved to receive Medicaid (the Medicaid Eligibility Unit will provide the appeal notice); 2. The HCBS Service Request Form is incomplete or denied due to technicality that did not result in enough information to process the request; 3. The waiver participant's Medicaid eligibility is terminated (a hearing will be offered to the participant by the Medicaid eligibility department); Waiver participants who misappropriate assets invoke a violation of Medicaid rules which places them in a sanction period. This sanction period temporarily deems the waiver participant ineligible for Medicaid; and 4. The waiver participant's Medicaid coverage is in deductible status or requires payment of the patient monthly liability. Individuals participating in the waiver are afforded deeming of income which waives resources and assets over the established poverty limit. The calculation of income and assets may impose a monthly patient monthly liability (PML), or a spend down; the waiver participant must pay the PML or incur before the effective date of Medicaid. A provider agency is accessed the PML when applicable. In incidences a waiver participant has a deductible, and the deductible is not met, the participant is informed of the amount of medical expenses that are needed to incur the deductible. Technical assistance is provided to the waiver participant to identify if expenses were incurred for a specific month. Errors in calculating incurred expenses are shared with the Medicaid eligibility unit for follow-up.

Under the provision of the CAP waiver, if an adverse decision is made due to Medicaid eligibility reasons, a waiver participant must grieve to the Medicaid eligibility department to allow the CAP services to continue as authorized. A waiver participant must be fully authorized for Medicaid in the categories of Medicaid for the Blind(MAB) and Medicaid for the Disabled (MAD)-ABD, Medicaid for Children Receiving Adoption Assistance (I-AS), Medicaid for Children Receiving Foster Care Assistance (H-SF) to use the services listed in the service plan/POC.

The State Medicaid Agency and case management entity are primarily responsible for educating the waiver participant about their rights to appeal an adverse decision. When an adverse decision is reached, the SMA, Independent Assessment Entity, or the case management entity will provide the waiver participant a trackable adverse notice of the decision to deny a requested service. This adverse notice will cite the reason(s) for the denial, provide policy citations, and guide how to file an appeal against the adverse decision. The waiver participant is given instructions on how to file the appeal within the NC Medicaid State Plan guidelines. When an appeal is filed, the participant is granted an option to mediate as the first attempt to come to an agreement between the requestor of service and NC Medicaid. If the adverse decision cannot be resolved in mediation, the waiver participant is entitled to a hearing in front of the Administrative Law Judge (ALJ). The waiver participant or the initiator of the adverse decision must adhere to the final decision of the ALJ.

The CAP Business system will manage all adverse decisions to ensure accuracy of notice dates, appropriateness of maintenance of service, and compliance to the final decision. The case management entity uploads the adverse notice to the State's data warehouse (Public Consulting Group). The Office of Administrative Hearing will monitor this data bank to initiate and follow through with all appeal requests.

When a referral is made for waiver participation under the consumer-directed option, the waiver participant/responsible party is provided educational information about consumer-directed care and their right to request a fair hearing when a choice of provider is denied. The Case management entity and FMS are responsible for explaining to the waiver participant why a selected provider will be denied. The CAP Business system and Case management entity are responsible for providing additional education to the waiver participant/responsible party regarding the procedures once a request for a hearing is made. When the waiver participant has met eligibility to participate in the waiver and consumer-directed care, the CAP Business system is programmed to request a copy of the signed and dated self-assessment questionnaire that describes consumer-directed care and the agreed-upon terms. Before the approval and initiation of waiver services, the CAP Business system validates the file as complete to ensure the waiver participant has completed the self-assessment survey and exercises freedom of choice.

For direct care workers, the waiver participant will also be informed if the requested provider met any one of the lifetime bans and employment could not be offered. The lifetime ban includes:

- Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
- Felony health care fraud;
- More than one felony conviction;
- Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd, or 3rd degree), fraud or theft against a minor or vulnerable adult;
- Felony or misdemeanor patient abuse;
- Felony or misdemeanor involving cruelty or torture;
- Misdemeanor healthcare fraud;
- Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
- Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
- Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the State of NC.

In addition to the above, the waiver participant/responsible party also receives information about participant's rights that pertains to:

- All providers on the freedom of choice list that have met specific NC Medicaid criteria for enrollment to provide the particular service.
- How to explore the possibility of a provider not listed, yet desired by the waiver participant/ responsible party, to be enrolled with NC Medicaid.
- A statement to inform the waiver participant/ responsible party that a provider, not currently enrolled with NC Medicaid would need to meet specific criteria to be enrolled with NC Medicaid, before the provider could be authorized to provide service and be reimbursed by Medicaid for services rendered.
- Information on how to contact the NC Medicaid consultant if problems are not resolved at the local level or by CAP Business system. and
- How to change agencies or lodge a complaint or grievance if unhappy about the care provided or the person rendering the care.

Appendix F: Participant-Rights

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

No. This Appendix does not apply

Yes. The state operates an additional dispute resolution process

- **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Do not complete this item.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

No. This Appendix does not apply

Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

- **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

NCDHHS

- **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The case management entity provides the waiver participant training and orientation about the CAP program. This training and orientation provide definitions and explanations about grievances and complaints. The waiver participant is given information about the appeal process. This information is also outlined in the Disclosure Notice, and the Welcome Letter mailed to the waiver participant initially and annually.

Constituents who contact their governmental representatives or any human service professional with complaints concerning concerns are referred to the NC DHHS. When a complaint is received, the Office Constituent Relations staff serves as a liaison between the complainant and the NC Medicaid program specialist. NC DHHS staff ensure that complaints are thoroughly examined and investigated. Staff determines the most appropriate parties to contact and work with to resolve the situation. Feedback is provided to elected officials regarding constituents' concerns. Ensuring that consumers have the proper channel for addressing concerns is key to this program. Steps are taken to resolve the complaint or concern, and time is spent with the person to educate them on the process and help them understand why the situation was handled in a certain manner.

There is a three-day timeline to address grievances and complaints. Grievances and complaints may consist of customer service concerns, missed timelines, provider treatment, and access to providers. Filing a grievance or complaint is not a prerequisite or a substitute for a Fair Hearing. Waiver participants are notified of the differences between the two. The CAP Business system is also equipped to receive and manage complaints and grievances initiated by the waiver participant, primary caregiver, or other service providers. The case management entity has three days to address the complaint.

The State Medicaid agency reviews the complaint and the resolution by the case management agency for quality assurance and improvement.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The state operates a Critical Event or Incident Reporting and Management Process (*complete Items b through e*)

No. This Appendix does not apply (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

To safeguard the health and welfare of each approved waiver participant, the State Medicaid Agency, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation (ANE) and other critical incidences. To assure each waiver participant's health, safety, and well-being, the case management entities (CMEs) shall engage in a multidisciplinary treatment team (MDT) meeting with each participant quarterly and ad hoc when needed. To mitigate the waiver participant's health and welfare when a critical incident occurs, all case management entities must complete a critical incident report and investigate the incident each time a waiver participant has been involved in a critical incident that jeopardizes his or her health, safety, and well-being. Upon knowledge of the critical incident, a report must be completed within three business days. Each case management entity is provided access to the critical incident report (CIR) developed by the State Medicaid Agency (SMA).

The Critical Incident Form has automatic fill-in responses through drop-down box options. The form is accessible through the CAP Business system. The CAP Business system will track receipt of all critical incident reports to assure the timeline is adhered to. State Medicaid Agency staff will also follow up to assure the identified waiver participant is receiving the necessary services as identified through the recommendation of the incident report.

Two incident levels manage the level of reporting: Level I and Level II.

Incident reports, including follow-up action requirements, are defined as one of two levels.

Level I incidences must be reported within three business days in the CAP Business system. These incidences include: hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered.

Level II incidences must be reported within three business days to State Medicaid Agency. These incidences include APS/CPS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, falls requiring hospitalization or resulting in death, traumatic Injury, medication administration that results in Injury or hospitalization, wandering away from home, homicide/suicide, and media related events.

Incidences of abuse, neglect, and exploitation must be reported to the appropriate authority and carefully followed to assure services are adequately met to keep the waiver participant safe in the community.

Level I Critical Incidents Accident or Injury (LEVEL I)

An accident or Injury is defined as an incident resulting in the need for medical services beyond first aid (e.g., fractures, some falls, burns, lacerations/wounds, etc.) and/or patterns of injuries that may potentially indicate an immediate or serious risk of participant safety. This could include a pattern of repeated falls.

Deaths by Natural Causes – Explained Death (LEVEL I)

Death caused by a long-term illness, a diagnosed chronic medical condition, serious acute illness, or other natural/expected conditions resulting in death.

Emergency Room Visit (LEVEL I)

Emergency Room visit means an emergency room visit for an assessment or for the management of an unstable health condition or high-risk behavior that does not result in a hospital admission.

Hospitalization (LEVEL I)

Hospitalization means an overnight admission, whether scheduled or unscheduled, but not expressly for psychiatric issues.

Inpatient Psychiatric Hospitalization (LEVEL I)

Inpatient psychiatric hospitalization means an emergency, overnight admission for assessment or management of an unstable psychological condition or high-risk behavior that require management by a physician.

Level II Critical Incidents

Abandonment (LEVEL II)

Abandonment is defined as the desertion of a participant by an individual who has the responsibility for providing care for that participant, or by a person with physical custody of that participant. This may include desertion of a participant at a hospital, nursing home or other location.

Abandonment may need to be reported as neglect.

Abuse (LEVEL II)

Abuse can be physical, sexual, emotional, or verbal.

1. Physical Abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include but is not limited to such acts of violence as: striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, or burning. Additionally, use of physical restraints, force feeding, and physical punishment of any kind are examples of physical abuse.
2. Sexual Abuse is defined as non-consensual sexual conduct of any kind with a participant. It includes, but is not limited to, exposure to unwanted sexually explicit material or verbal harassment of a sexual nature, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.
3. Emotional or Psychological Abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse may include, but is not limited to verbal assaults, threats, intimidation, insults, humiliation, and harassment. In addition, treating a participant in a manner not appropriate for their age, isolating

participant from his/her family, friends, or regular activities, giving a participant the "silent treatment," and enforcing social isolation are examples of emotional/psychological abuse.

4. Verbal abuse is defined as the use of any oral or gestured language that includes disparaging or derogatory terms to participants, or within their hearing distance, regardless of the participant's age, ability to comprehend, or disability.

Death – Unexplained Deaths (LEVEL II)

Death means the end of life. ALL DEATHS MUST BE REPORTED in as much detail as possible. The reportable event must describe the circumstances surrounding a participant's death. Unexplained deaths need to be differentiated from deaths that are explained deaths (meaning they were expected or considered a result of natural causes). An Unexplained Death is defined as a death suspected to have resulted from other than natural causes, potentially due to abuse or neglect or such as an occurrence of medical error by others. The circumstances surrounding an unexplained death must document fully all available information about the death including contributory events and a clear explanation of why the death is considered unexplained (resulting from other than natural causes). If autopsy, protective services, or police reports are available, they should be uploaded into the Critical Incident form.

Exploitation – Financial/Theft (Immediate Jeopardy) (LEVEL II)

Exploitation means taking advantage of a waiver participant for personal gain by manipulation, intimidation, threats, or coercion. It involves the misuse of a vulnerable participant's funds, property, or person. Examples may include, but are not limited to:

- alleged fraud,
- use of participant funds for purchases without providing and maintaining itemized receipts
- cashing an individual's checks without authorization or permission, forging a participant's signature,
- misusing or stealing a participant's money or possessions,
- destruction of a participant's personal property,
- withholding a participant's funds,
- coercing or deceiving a participant into signing any document, or
- improper use of conservatorship, guardianship, or power of attorney.

Injuries of unknown source (Level II)

An injury should be classified as an "injury of unknown source" when both of the following criteria are met:

- The source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one point in time or the incidence of injuries over time.

Missing Person (LEVEL II)

Missing Person / Elopement is defined as a participant whose whereabouts are unknown and he/she is considered missing. A missing person does not include a participant who is able to leave the facility to pursue activities, shop or visit with friends or relatives, unless the participant cannot be located after a reasonable time has elapsed without contact. A missing person report is not needed for a participant who lives with unpaid caregivers or housemates (such as natural family) unless the families have requested assistance locating the missing person or while the participant was receiving a waiver service. Even if the participant has been located, a completed Reportable Event form is required.

Neglect (Immediate Jeopardy) (LEVEL II) Neglect is defined as the refusal or failure to provide a participant with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, medical care, personal care, comfort, personal safety, supervision, and other essentials included in an implied or agreed-upon responsibility to a participant. Self-neglect is characterized as the behavior of a participant that threatens his or her own health or safety including substance abuse and dangerous behavior. Self-neglect generally manifests itself as a refusal or failure to provide himself or herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

Restraints / Seclusions (LEVEL II)

Restraints / Seclusions are defined as physical, chemical, or involuntary seclusion. Physical restraint means any manual method, physical device, material, or equipment attached or adjacent to a participant's body, that: a participant cannot remove easily, • restricts freedom of movement or access to the participant's own body, or • is used for discipline or convenience.

Physical restraint may include but are not limited to a device or garment that interferes with freedom of movement or withholding assistance or mobility device to a dependent participant for interfering with the participant's free movement. Chemical restraint means the administration of drugs with the intent of significantly curtailing the normal mobility or normal physical activity of a participant.

Involuntary seclusion means the separation of a participant from others such as in a locked room, or from the participant's room or against the participant's will or the will of the participant's guardian/representative. Involuntary seclusion does

not mean separating the participant from other individuals on a temporary and monitored basis.

Suicide (combine with death) (LEVEL II)

Suicide is the act of taking one's own life voluntarily and intentionally.

Suicide Attempt (LEVEL II)

Suicide attempt is the act of deliberately harming oneself with the intention of causing death.

Treatment and Medication Errors (LEVEL II)

A treatment error involving medication is defined as any medication management event that results in participant requiring medical services beyond first aid. This would include any preventable event that may cause or lead to inappropriate medication uses or omission or harm while the medication is in the control of the health care professional, family member, or participant. This may also include mistakes by prescribers or pharmacists regarding type of medication, labeling, dosage, or packaging.

Other treatment errors may include but are not limited to the improper delegation of a task or the inadequate or poorly performed actions of a delegating nurse or personal assistance aide.

Other Incident Types (Level II)

Other incident types may include, but are not limited to:

- Infectious diseases,
- Insect infestations,
- Any unusual incident, which may involve law enforcement or may attract media attention, emergency closure of a participant's home or program facility for one or more days, or
- Bankruptcy or loss of lease by program

The critical incident report has fields that identify the participant demographic information, description of the incident, participant's response, action taken/prevention/disposition, notification/reported to other authority, recommendation by the case manager or care advisor of how to mitigate future incidences and the recommendation by the State Medicaid Agency against the data report and action taken.

Each case management entity is provided annual training in critical incident reporting approved by the state Medicaid agency. The case management entity is responsible to educate and inform waiver participants/responsible parties and service providers on 1) types of critical incidences, 2) how to make a report, and 3) the timeframe to make a report. The case management entity must provide training and education initially, quarterly, annually, and as needed to all waiver participants.

For incidences of abuse, neglect and exploitation, the state has prescribed guidelines to react to a report and create an action plan.

To assure the health, safety and well-being of waiver participants, the goal is to report a critical incident immediately when it happens. However, for incidences that the case management entities are not immediately aware, upon the knowledge of the incident the case management entity is expected to file a report and follow through to assure the health, safety, and well-being of the waiver participant. The report must be submitted through CAP Business system within 72 hours.

When the case management entity is notified of an incident, notification or report to other providers or entities must occur within 72 hours of the reported incident.

The types of events that warrant notification to state Medicaid agency are reports of abuse, neglect and exploitation that are referred to the local DSS Adult or Children Protective Services.

Article 6, Chapter 108A of the North Carolina General Statutes requires that county departments of social services perform certain activities for disabled individuals alleged to be abused, neglected, or exploited and in need of protective services. In accordance with its authority under N.C.G.S. 143B-153, the North Carolina Social Services Commission has established rules and regulations for the provision of Protective Services for Adults and Children. The Tribe jurisdiction of Article 6, Chapter 108A. The Eastern Band of Cherokee Indians (EBCI) Tribal Code, Article II, Section 108 outlines requirements, inclusive of reporting for tribal members on trust lands.

The County Departments of Social Services must accept all reports alleging abuse, neglect, or exploitation of a disabled individual who needs protective services. This includes anonymous reports.

North Carolina has a mandatory reporting law. Any incidents containing allegations of abuse, neglect or exploitations must be immediately reported to the local Department of Social Services responsible for investigation of abuse, neglect, or exploitation allegations. Any person having reasonable cause to believe that a disabled individual needs protective services shall report such information to the director of the county Department of Social Services, or his representatives, where the disabled individual resides or is present. Other reports may be required by law, such as reports to law enforcement.

The report may be made orally or in writing. The report shall include the name and address of the disabled individual; the name and address of the disabled individual's caretaker; the age of the disabled individual; the nature and extent of the disabled individual's injury or condition resulting from abuse or neglect; and other pertinent information. (G.S. 108A-

102) and (Tribal Code, Article II, Section 108).

North Carolina conducts a comprehensive functional assessment (evaluation) to determine whether there is a need for protective services in situations where it is alleged that a disabled individual has been abused, neglected, or exploited. Protective Services are those services provided by the State or other government or private organizations or individuals that are necessary to protect the disabled individual from abuse, neglect, or exploitation. (G.S. 108A-101 and Tribal Code, Article II, Section 108) North Carolina General Statutes require that any director receiving a report that a disabled individual needs protective services shall make a prompt and thorough evaluation to determine whether the disabled individual needs protective services and what services are needed. The evaluation shall include a visit to the disabled individual and consultation with others having knowledge of the facts of the particular situation. A thorough evaluation of a protective service report shall include identifying indicators of abuse, neglect, or exploitation and the disabled individual's strengths and limitations by assessing physical health, mental health, social support, activities of daily living, and instrumental activities of daily living,

financial support, and physical environment. Other reports The State Medicaid Agency is provided "need to know information:" to assure the appropriate planning of all waiver participants from the DHHS-Division of Aging and Adult Services. The case management entities and the DSS-APS/CPS workers consult with one another about the facts of a situation for appropriate care planning and referrals.

Natural disasters such as hurricanes are considered critical events. Every locality/county must have a disaster plan in place and shelters available that can provide care for individuals and families, including those with special needs, who must evacuate their homes. Each waiver participant is required to have an emergency plan that covers disaster planning.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Initially an annually each waiver participant is provided information about abuse, neglect, and exploitation and how to make a report when concerns arise. The multidisciplinary assessment captures information about informal support systems and their burden of care that identifies potential risk factors for abuse, neglect, and exploitation. Additional information is provided when requested or when the case management entity is concerned about abuse, neglect, and exploitation.

During the waiver enrollment process, the individual is given information about the waiver through a participant disclosure letter, an Introductory letter and a Welcome letter that includes information about ANE. This information describes signs of ANE, contact information and mandatory reporting requirements. The following statement is included in the letter "If you think that you are not safe or have any concerns about abuse, neglect, or exploitation you can call your local Department of Social Services for assistance with Adult and Children Protective Services. You can also call your Case Management Entity or the Independent Assessment Entity" (after May 2020) to provide guidance to the waiver participant if he or she feels abused, neglected, or exploited. In addition, During the planning for the agreement of the Participant Rights and Responsibilities, the Case Management Entity, and the Independent Assessment Entity (after May 2020) educate and provide information to participants, families, and legal representatives. Participants sign the Participant Rights and Responsibility form indicating that they have received information about incident reporting.

Each member of the case management entity is required to have annual mandatory training that includes what constitutes abuse, neglect, and exploitation; and how to complete, assess, report, and mitigate critical incidences of waiver participants. The State Medicaid Agency provides a high-level training in ANE in supporting waiver participants. The DHHS-Division of Aging and Adult Services provides semi-annual training in ANE to the case management entities. In addition, providers are required to provide on-going training to direct service staff in how to recognize abuse, neglect, and exploitation, and where to go for help.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When a waiver participant experiences a critical event or incident, the case management entity is responsible to receive the details of the event or incident to complete a critical incident report using the CAP Business system. The report is designed to document: who the report is from; the type of event or issue; the date and time of the event/issue, if applicable; the location of the incident (participant's home, etc.); details of the event; involved parties; the source of the information.

individuals who have first-hand knowledge of the event; whether the attending physician was notified; and the name, address and phone number of the physician and any other agencies or individuals that were also notified. The specific nature of an event or issue will determine if notification to others is warranted, e.g., APS/CPS, DHHS and law enforcement.

The Critical Incident Form has automatic fill-in responses through drop-down box options. The form is accessible through the CAP Business system. The CAP Business system will track receipt of all critical incident reports to assure adherence to timelines. State Medicaid Agency staff will also follow-up to assure waiver participant with a level II critical incident report is receiving the necessary services as identified through the recommendation of the incident report.

The State Medicaid Agency has trained each case management entity on how to detect and accept critical incident reports (CIR). Upon the knowledge of an incident, each case management entity is required to submit a CIR via CAP Business system within 72 hours. The CAP Business system will compile all critical incident reports to assure accuracy of policy compliance and that the incident was clearly followed-up. Each incident is placed in a data query to track the frequency of each incident to identify trends.

Level of reporting is managed by two incident levels: Level I and Level II.

Level I incidences must be reported within 3 business days the CAP Business system. These incidences include: hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered.

Level II incidences must be reported within 3 business days to State Medicaid Agency. These incidences include, APS/CPS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, falls requiring hospitalization or results in death, traumatic injury, medication administration that results in injury or hospitalization, wandering away from home, homicide/suicide, and media related events.

Incidences of abuse, neglect and exploitation must be reported to the appropriate authority and carefully followed to assure services are adequately met to keep the waiver participant safe in the community.

To assure the health, safety and well-being of each waiver participant, the case management entities shall address remediation efforts that mitigate the waiver participant's health and welfare when a critical incident occurs. It is mandatory for all case management entities to evaluate each report to identify the best course of action for waiver participant. When an event or incident occurs, the case management entity must respond to the following bulleted items that are associated with the event to evaluate the validity and concern listed in the report and to ensure the health, safety, and well-being of the waiver participant.

- The waiver participant or family member is considered at risk of health, safety, and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a personal emergency response system.
- The waiver participant lacks the emotional, physical, and protective support of a willing and capable caregiver who must provide adequate care to oversee 24-hour hands-on support or supervision to ensure the health, safety, and wellbeing of the individual with debilitating medical and functional needs.
- The waiver participant's needs cannot be met and maintained due to unwillingness or uncooperativeness by the system of services that is currently available to ensure the health, safety, and well-being.
- The waiver participant's primary private residence is not reasonably considered safe to meet the health, safety, and wellbeing in that the primary private residence lacks adequate heating and cooling system, storage, and refrigeration, plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the waiver participant's safety, and these issues cannot be resolved.
- The waiver participant's primary private residence presents a physical or health threat due to the credible allegations of unlawful activity conducted; verbal abusive behavior, threatening or physically or verbally abusive behavior, presence of a health hazard due to pest infestation, hoarding of animals, or animal excretion and evidence of ANE; or
- The waiver participant's continuous intrusive behavior impedes the safety of self and others by attempts of suicide, physical abuse or injury to self or others, verbal intimidation, destruction of physical environment, or repeated noncompliance of service plan and written or verbal directives.
- The waiver participant's primary caregiver or responsible party continuously impedes the health, safety and wellbeing of the waiver participant by refusing to comply with the terms of the plan of care, refusal to sign a rights and responsibilities form and other required documents, refusal to keep service providers informed of changes and status

changes, refusal to implement or follow-through with an individual risk agreement to remove or lessen the risk or refusal to necessary waiver services approved in the service plan; or

- The waiver participant chooses to remain in a living situation where there is confirmed, abuse, neglect, or exploitation as evidenced by an APS/CPS assessment or care plan.

When an event/issue is identified by, or reported to the case management entity, a Critical Incidents Report form is completed, and the case management entity arranges an investigation for a Level II critical incident within 5 calendar days.

The case management takes the following steps to investigate the report information:

- Contact with reporter, if provided to discuss the event/incident or concern.
- Contact with involved service providers listed on the POC to discuss waiver participant 's care needs and any concerns related to the incident report
- Home visit with the waiver participant to conduct a risk assessment of needs against the incident report
- Review of past incident reports, hospital visits and ER visits and other data elements to identify trends
- Contact with pertinent individuals or formal agency to identify concerns.

The case management entity also evaluates the following areas during the investigation:

- Human factor (staffing levels, knowledge, training, and competency)
- Prior addressed risk factors
- Equipment-related factors (maintenance)
- Environmental factors (lighting, noise, clutter)
- Communication factors (training and adequate tools)

A plan of protection or assurance of health, safety and well-being is put in place when the case management entity conducts the investigation of the event/ incident. The case management entity collects all this information to complete a root cause analysis report to assist with closing out the investigation to decide about the best course of action for the waiver participant. The following questions are asked:

- Was the incident preventable?
- If staff was involved, did they respond to the incident appropriately?
- If family was involved, did they respond to the incident appropriately?
- Were resources utilized in an appropriate and cost-effective way?
- Did the Case Manager/Care Advisor handle the incident appropriately?

The answers to the questions lead to the remediation plan for the waiver participant such as a risk of dignify declaration form, a revision to the service plan, additional support from formal and informal support systems or disenrollment from the HCBS program when health, and safety cannot be met or mitigated regardless of tried attempts. The state Medicaid agency will make the final remediation plan based on the nature of the incident and the findings in the investigative report. The data query generated by the CAP Business system is reviewed by the State Medicaid Agency on a quarterly basis

and compared against the data query generated by DAAS. These two reports are used to identify trends and strategies to mitigate future occurrences. The waiver participant or the primary caregiver and other pertinent individuals are notified about the results of the root cause analysis (investigation) within 5 business days of the closure of the case.

The case management entity shall initiate an investigation within 5 business days of a Level II incident report to ensure health, safety, and well-being of waiver participant. The waiver participant must be notified of the recommendation of the investigations within 15 business days of the incident.

The Department of Social Service, APS/CPS section is responsible for evaluating all cases of abuse, neglect, and exploitation.

The Adult and Children Protective Services unit has a prescribed timeframe of 24, 48 and 72 hours to investigate a report of ANE. The reporter is provided a disposition of the results of the initial home visit to investigate the allegations of ANE within 30-45 days, depending on the allegation type. APS/CPS have specific guidelines of evaluating a case to determine if a waiver participant is at risk and needs protection. The assigned Adult or Child Protective Service Worker evaluates the waiver participant cognitive skills to determine capacity to make decision and the need for supportive care. If waiver participant is deemed not to be able to make appropriate cognitive decision, APS/CPS will provide an order of protection.

The state has an agreement with the state aging and adult agency (Division of Aging and Adults Services-DAAS) to provide quarterly data query of waiver participants reported to be abused, neglected, or exploited. The data query provides the date of the report, the alleged perpetrator, and the disposition of the case confirmed or substantiated. The report is compiled by county, the waiver program, type of report, disposition decision, and the number of reports received on a given waiver participant. The local DSS trains the APS/CPS workers on how to capture and complete the needed information on the report. A planning meeting is scheduled quarterly with the NC Medicaid staff and the DAAS staff to

review and analyze the data query to identify trends and implement strategies to mitigate future occurrences.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The State Medicaid Agency is responsible for overseeing the operation of the incident management system for this waiver population.

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each waiver participant are identified as part of the intake and assessment process. The CAP Business system generates reports of risk indicators identified in the comprehensive assessment for use by the case management entity for continuous care planning of health, safety, and well-being. These data elements of risk indicators assist the case management entity to proactively identify services and supports to mitigate potential risk(s) that may lead to an unfavorable event or incident for the waiver participant.

When a waiver participant encounters an event or incident, a Critical Incident Report is filed through the CAP Business system. This system aggregates the data on the critical incident report and sends alerts regarding needs and recommendations to the case management entity and the State Medicaid Agency. The reports provide information about the incidents, who were involved in the incident and recommendations made regarding the incident. The State Medicaid Agency reviews these reports quarterly to identify trends and strategies to reduce similar occurrences in the future.

Questions that are

posed when reviewing the data consist of the following:

- How can the State Medicaid Agency prevent this from happening again with this individual/family?
- How can State Medicaid Agency prevent some of these incidents from happening again on a statewide program level?
- Are waiver resources utilized in an appropriate and cost-effective way?
- Were there signs or indications that may have prevented this event/incident?
- Are the staff and family members adequately trained on how to manage health condition?
- Is the waiver participant fully aware of health care needs and how to follow care plan requirements?

A Critical Incident committee meets quarterly to track and trend Level II incidences. The committee reviews summary of care history, age and gender of the participant, date of enrollment in the program, the significant diagnosis, participant's extent on formal and informal supports, summary of events, contributing factors, participants enrollment/action surrounding the event, immediate action taken, participant status, identification of risk points and potential contribution to the event.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The state does not permit or prohibits the use of restraints

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established

concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

This HCBS program prohibits limited use of restraints and restrictive interventions for all settings approved in this waiver. The intended care provided to these individuals should be non-invasive and free from restraints and seclusion, including personal restraints, drugs used as restraints or mechanical restraints, when included in the service plan. For this HCBS program, restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to a waiver participant's body that the waiver participant cannot remove easily, which restricts freedom of movement or normal access to one's body. For this HCBS program, seclusion involves placing a waiver participant alone in a room or other area from which exit is prevented. This may or may not include use of locking mechanism.

The use of unauthorized restraints or seclusion with a waiver participant indicates an immediate need to reassess the waiver participant and his or her plan of care to determine if there are unmet medical or functional needs; whether the waiver participant's caregiver can appropriately deliver the required services while managing stress; and whether the HCBS program remains an appropriate choice for the waiver participant. Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to detect unauthorized use of restraints.

If a waiver participant is determined to be restrained or secluded, the case management entity or the service provider (if the service provider is not the offender) is required to contact law enforcement, children/adult protective services or the Department of Health Services Regulation (DHSR) to report the event. Observed unauthorized use of restraints is referred to CPS/APS and Division of Health Services Regulation (DHSR), to investigate and to send a report on their findings. The case management entity is responsible for follow-up on the investigation and findings to assure the health, safety and well-being of the waiver participant. The State Medicaid Agency will also monitor the status of the report to ensure the critical reporting system is working as designed.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

The case management entity is primarily responsible for detecting the unauthorized use of restraints through two required face-to-face visits and two other required visits that may be conducted using technology. However, if a concern is voiced or identified, the case management entity is required to make an unannounced visit to evaluate the concern and when necessary, call an ad-hoc multidisciplinary meeting to assess the unauthorized use of restraints. A critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery. The case management entity will initiate referrals and investigatory steps within 2 business days of notification.

Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to oversee unauthorized use of restraints.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

- b. Use of Restrictive Interventions.** (*Select one*):

The state does not permit or prohibits the use of restrictive interventions

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

If a waiver provider or CAP Program consultant observes or learns that unnecessary and authorized restrictive interventions are being used, an incident report must be completed within 3 days of discovery.

This waiver program permits authorized restrictive interventions that restrict waiver participant movement when listed and approved in the service plan, such as such as bed rails, Gerri chair, lift chair, safety straps on wheelchairs. Activities that employ aversive methods to modify behavior, unless provided for a waiver participant for whom it is not used as a restraint, but for safety is prohibited. The person-centered plan must document any type of restriction and the less stringent types attempted.

Restrictive interventions are not authorized for restricting the waiver participant's:
Access to other individuals, locations, or activities.
Rights.

If the State Medicaid Agency determines unauthorized use of restrictive interventions or the use of the restrictive interventions is out of compliance with the service plan and physician's orders (bed rails, Gerri chairs, lift chairs, or safety straps on wheelchairs as a safety precaution), the appropriate law enforcement and children/adult protective services will be contacted on the day of discovery to report the event. Unauthorized use of restrictive interventions is referred to law enforcement and CPS/APS/federally recognized Tribes for investigation. The State Medicaid Agency is responsible for monitoring investigations and findings to ensure the health, safety, and well-being of the waiver participant.

The use of unauthorized restrictive interventions on the participant indicates a need to reassess or complete a root cause analysis of the incident to allow review of the waiver participant's current medical and functional needs, caregiver's ability, and stress level to determine appropriateness of CAP services (safety and well-being, ability to self-direct). The findings of the root cause analysis will inform the need for a plan revision, risk agreement or additional support to the child and family. The report will identify the participant's needs, caregiver's ability, and stress level to determine appropriateness for CAP services (safety and well-being, ability to self-direct).

When a waiver provider or CAP Program consultant observes or learns restrictive interventions are being used, an incident report must be completed on the date of discovery and submitted to the State Medicaid Agency on the same date. The State Medicaid Agency will initiate referrals and investigatory steps within 2-days of notification.

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

The case management entity is primarily responsible for detecting the unauthorized use of restrictive interventions through two required face-to-face visits and two other required visits that may be conducted using technology. However, if a concern is voiced or identified, the case management entity is required to make an unannounced visit to evaluate the concern and when necessary, call an ad-hoc multidisciplinary meeting to assess the unauthorized use of restrictive interventions. A critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery. The case management entity will initiate referrals and investigatory steps within 2 business days of notification.

Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to oversee unauthorized use of restrictive interventions.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The state does not permit or prohibits the use of seclusion

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State of North Carolina does not permit the use of seclusions including personal restraints and drugs for any waiver participant. All waiver services and regular State Plan services must be provided in accordance with all requirements specified in this waiver and the State's governing clinical coverage policy; all applicable federal and state laws, rules, and regulations; the current standards of practice; and provider agency policies and procedures. Each case management entity must have a policy on seclusion that complies with the definition of seclusion as stated in the June 22, 2007 memo to State Survey Agency Directors, Ref S&C-07-22, and re: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Refer to: <http://www.cms.gov/surveycertificationgeninfo/downloads/SCletter07-22.pdf>

When evidence is received that unauthorized use of seclusion is out of compliance with the service plan, a critical incident report must be completed by the case management entity on the date of discovery. The case management entity must notify the appropriate law enforcement and child protective services to report the occurrence. The State Medicaid Agency will follow-up within 2-days of notification to ensure incident is correctly mitigated.

The use of seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

No. This Appendix is not applicable (*do not complete the remaining items*)

Yes. This Appendix applies (*complete the remaining items*)

- **Medication Management and Follow-Up**

Do not complete this section

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

Not applicable. (*do not complete the remaining items*)

Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (*complete the remaining items*)

- **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- **Medication Error Reporting.** *Select one of the following:*

Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).

Complete the following three items:

- (a) Specify state agency (or agencies) to which errors are reported:

- (b) Specify the types of medication errors that providers are required to *record*:

- (c) Specify the types of medication errors that providers must *report* to the state:

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1,*

2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-A1 Number/percent of waiver participants who were screened for ANE where an appropriate action plan was implemented to address risk factors within 45 days of the report. N: number of waiver participants who were screened for ANE where an appropriate action plan was implemented to address risk factors within 45 days of the report D: number of waiver participants screened for ANE

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="CAP Business system,"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>

	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	
--	---	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

HW-A2 Number and percent of waiver participants who received SMA generated information on ANE, and how to report a concern of ANE
Numerator: number of waiver participants who received SMA generated information on ANE, and how to report a concern of ANE
Denominator: number of waiver participants reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

<p>Sub-State Entity</p>	<p>Quarterly</p>	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<p>Other Specify:</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">CAP Business system</div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (check each that applies):</p>	<p>Frequency of data aggregation and analysis (check each that applies):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">CAP Business system</div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. *Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-B1 Number and percent of critical incident trends where systemic intervention was implemented
Numerator: number of critical incident trends where systemic intervention was implemented
Denominator: number of critical incidents reviewed

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, APS and CPS data.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 5px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 5px; width: fit-content;"> Business system, APS and CPS data </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify:

		<input type="checkbox"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

HW-B2 Number and percent of critical incidents where root cause was identified

Numerator: number of critical incident where root cause was identified

Denominator: number of critical incidents reviewed

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review

Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = 95% confidence level and +/- 5% margin of error.
Other Specify: CAP Business system	Annually	Stratified Describe Group:
	Continuously and Ongoing	Other Specify:
	Other Specify: 	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: CAP Business system	Annually
	Continuously and Ongoing
	Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

Performance Measure:

HW-B3 Number and percent of death incident reports for unexplained deaths that had a root-cause analysis narrative summation. Numerator: number of death incident reports for unexplained deaths that had a root-cause analysis narrative summation Denominator: number of death incident reports for unexplained deaths

Data Source (Select one):

Mortality reviews

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and APS and CPS data reports.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/>
Other Specify: <input type="text" value="CAP Business system and APS and CPS data reports"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other	

	Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 0 auto;"></div>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; padding: 5px; width: 80%; margin: 0 auto;">CAP Business system and APS and CPS data reports</div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 30px;"></div>

c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-C1 #/% of providers with an approved policy by SMA prohibiting unauthorized restrictive interventions (restraints, seclusions) for waiver participants. Numerator: number of providers with an approved policy by the SMA prohibiting unauthorized restrictive interventions (restraints, seclusions) for waiver participants. Denominator: number of providers reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> Business system </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: auto; margin-right: auto;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

Performance Measure:

HW-C2 #/% of participants with a critical incident (CI) for unauthorized restraints/restrictions that were mitigated in the required timeframe. N: # of participants with a CI for unauthorized restraints/restrictions that were mitigated in the required timeframe. D: # of participants reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text"/> 95% confidence level and +/- 5% margin of error
Other Specify:	Annually	Stratified Describe Group:

<div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system</div>		<div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>	Annually
	Continuously and Ongoing
	Other Specify: <div style="border: 1px solid black; width: 100%; height: 20px;"></div>

d. Sub-assurance: *The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to

analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

HW-D1 Number and percent of waiver participants who completed recommended annual preventative/wellness appointments. Numerator: number of waiver participants who completed recommended annual preventative/wellness appointments Denominator: number of waiver participants reviewed

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px;"> 95% confidence level and +/- 5% margin of error </div>
Other Specify: <div style="border: 1px solid black; padding: 2px;"> Business system and Provider Portal network data system </div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 20px;"></div>
	Other	
	Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

HW-D2 Number and percent of waiver participants who were assigned and connected to a medical health home(PCP). Numerator: number of waiver participants who were assigned and connected to a medical health home(PCP) Denominator: number of waiver participants reviewed

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample

		Confidence Interval = 95% confidence level and +/- 5% margin of error
Other Specify: MMIS and provider portal informatics	Annually	Stratified Describe Group: []
	Continuously and Ongoing	Other Specify: []
	Other Specify: []	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: []	Annually
	Continuously and Ongoing
	Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="text"/>

Performance Measure:

HW-D3 Number and percent of waiver participants who had a scheduled visit with their primary care provider on at least an annual basis. Numerator: number of waiver participants who had a scheduled visit with their primary care provider on at least an annual basis Denominator: number of waiver participants reviewed

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <input type="text" value="95% confidence level and +/- 5% margin of error"/>
Other Specify: <input type="text" value="CAP Business systems and NC Medicaid MMIS"/>	Annually	Stratified Describe Group: <input type="text"/>
	Continuously and Ongoing	Other Specify: <input type="text"/>
	Other Specify:	

	<input style="width: 80%; height: 20px;" type="text"/>	
--	--	--

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

Performance Measure:

HW-D4 #/% of waiver participants who report overall health and well-being was adequately assessed and planned for in their person-centered service plan.

Numerator: number of waiver participants who report overall health and well-being was adequately assessed and planned for in their person-centered service plan.

Denominator: number of waiver participants responding to the survey that were reviewed

Data Source (Select one):

Analyzed collected data (including surveys, focus group, interviews, etc)

If 'Other' is selected, specify:

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review

<p>Sub-State Entity</p>	<p>Quarterly</p>	<p>Representative Sample Confidence Interval =</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>95% confidence level and +/- 5% margin of error</p> </div>
<p>Other Specify:</p> <div style="border: 1px solid black; padding: 5px; width: fit-content;"> <p>CAP Business system</p> </div>	<p>Annually</p>	<p>Stratified Describe Group:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Continuously and Ongoing</p>	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

<p>Responsible Party for data aggregation and analysis (check each that applies):</p>	<p>Frequency of data aggregation and analysis(check each that applies):</p>
<p>State Medicaid Agency</p>	<p>Weekly</p>
<p>Operating Agency</p>	<p>Monthly</p>
<p>Sub-State Entity</p>	<p>Quarterly</p>
<p>Other Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	<p>Annually</p>
	<p>Continuously and Ongoing</p>
	<p>Other Specify:</p>

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<div style="border: 1px solid black; width: 100%; height: 40px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The system design allows for quick remediation when noncompliant areas are discovered. Real-time data reports of programmed performance measures and the ability to run ad-hoc reports external to programmed performance measures allow the State Medicaid Agency to evaluate the effectiveness of its system and promote continuous quality improvement measures. Data analysis from the CAP Business system assists with monitoring the health and welfare of all waiver participants. This analysis allows the case manager to ensure that the service plan is kept current and updated continuously with the waiver participant’s changing needs. When the case manager discovers a waiver participant is at risk, the potential risk must be addressed immediately or within 72 hours. This may include calling a team meeting to address the issue, getting medical advice for the waiver participant, or seeing that the waiver participant is removed from imminent danger, risk, or an unsafe environment. If the case manager or care advisor discovers that the waiver participant has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must discuss this issue with the team to implement a comprehensive safety plan. If it is found that the critical incident was not reported to CPS/APS, the case manager or care advisor must immediately submit a report to CPS/APS.

If it is found that the critical incident was not reported timely, technical assistance will be provided by the State Medicaid Agency; the Case management entity must submit a corrective action plan to reduce future occurrences of untimely critical incident reports to CPS/APS.

Upon discovering noncompliance in ensuring the health and well-being of a waiver participant through regular monitoring and planning, the State Medicaid Agency notifies the responsible agency and assists in structuring a monitoring schedule and areas to monitor.

The agency must develop a corrective action plan within three days of notification to submit to the State Medicaid Agency. The Medicaid Agency reviews the corrective action plan, makes a final decision, and publishes directives for the agency to follow. The corrective action plan is monitored, and progress or concerns are tracked and discussed monthly with the case management entity. Repeated findings of noncompliance by the agency will result in the termination of new enrollment of waiver participants until the successful completion of the corrective action plan.

The State Medicaid Agency will provide staff training and technical guidance to ensure success. If the corrective action plan is not remediated within 90 days, a recommendation may be made to terminate the agency as a waiver services provider.

If the case manager or care advisor discovers the waiver participant has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must address this with the team to implement a root cause analysis of multiple incidents.

Upon discovering the noncompliance of the contracted vendor, a corrective action plan is developed to remediate the noncompliance with a completion date within three business days.

Repeated findings of noncompliance by the contractor vendor result in fines and penalties. If the errors cannot be remediated, the recommendation may be made to terminate the contract.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The system design allows for quick remediation when noncompliant areas are discovered. Real-time data reports of programmed performance measures and the ability to run ad-hoc reports external to programmed performance measures allows the State Medicaid Agency to evaluate the effectiveness of its system and promote continuous quality improvement measures. Data analysis from the CAP Business system assists with the monitoring of health and welfare of all waiver beneficiaries. This analysis allows the case manager to ensure that the service plan is kept current and updated on a continuous basis with the waiver beneficiary’s changing needs. When the case manager discovers a waiver beneficiary is at risk, the potential risk must be addressed immediately or within 72 hours. This may include calling a team meeting to address the issue, getting medical advice for the waiver beneficiary, or seeing that the waiver beneficiary is removed from imminent danger, risk or an unsafe environment. If the case manager or care advisor discovers that the waiver beneficiary has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must staff

this with the team to implement a comprehensive safety plan. If it is found that the critical incident was not reported to CPS, the case manager or care advisor must immediately submit a report to CPS. If it is found that the critical incident was not reported timely, technical assistance will be provided by the State Medicaid Agency; the Case management entity must submit a corrective action plan to reduce future occurrences of untimely critical incident reports to CPS.

Upon discovery of non-compliance of ensuring the health and well-being of a waiver beneficiary through regular monitoring and planning, the State Medicaid Agency notifies the responsible Case management entity and assist in structuring a monitoring schedule and areas to monitor. The Case management entity must develop a corrective action plan within 3 days of notification to submit to the State Medicaid Agency. The Medicaid Agency reviews the corrective action plan, makes a final decision and issues directives for the Case management entity to follow. The corrective action plan is monitored and progress or concerns are tracked and discussed with the case management entity monthly. Repeated findings of non-compliance by a Case management entity will result in termination of new enrollment until successful completion of the corrective action plan. The State Medicaid Agency will provide staff training and technical guidance to ensure success. If corrective action plan is not remediated within 90 days, a recommendation may be made to terminate provider enrollment status as case management entity.

If the case manager or care advisor discovers the waiver beneficiary has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must address this with the team to implement a root cause analysis of multiple incidents.

Upon discovery of non-compliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within 3 business days. Repeated findings of non-compliance by a CAP IT contractor results in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State Medicaid Agency has developed a quality management plan that integrates, analyzes, measures, and processes data and responds to information from multiple sources across functions within the waiver operation systems (CAP Business system, MMIS, and IAE/CME) to ensure waiver assurances are met. The primary system used to monitor the compliance to the waiver assurances and measure the quality of the waiver's performance is the CAP Business system. The CAP Business system is the hub for all waiver activities. Information about all the waiver assurances is entered into the CAP Business system by the State Medicaid Agency (SMA). The CAP Business system correlates this information to align with the waiver business workflow to allow the SMA to aggregate and analyze trends and areas that may need remediation. The data elements in the system are real-time, which promotes immediate discovery and quick implementation of remediation steps. The CAP Business system generates data on all six waiver assurances, allowing the SMA to perform daily and ad-hoc analyses of the waiver's performance.

To assist in managing the waiver's performance, the CAP Business system is programmed to manage the workflow for this waiver based on the requirements and deliverables for each assurance drawing from several data sources, including:

1. The web-based case management and business process tool
2. On-site audits and reviews;
3. Desktop audits and reviews
4. The Medicaid Fiscal Contractor
5. NC Division of Health Services Regulation for licensure/certification records;
6. NC Medicaid Program Integrity Unit for audits, reviews, and investigations;
7. Experience Surveys; and
8. Stakeholder's input

The system tracks compliance using mandatory fields, time limits, and workflow interruptions when the correct steps are not followed. The users are provided alert notifications and messages to promote cQuarterly, the State Medicaid Agency conducts a comprehensive analysis of data reports to review trends, compliance to timelines, and utilization in the areas of LOC, service plan, administrative authority responsibilities, financial accountability and health and welfare, qualified providers to measure the effectiveness of the CAP Business system in assuring each waiver assurance is met. This analysis identifies strengths and opportunities for improvement and identifies areas to prioritize. During this comprehensive analysis, discovery methods are used to ensure that staff, processes, data systems, and reporting mechanisms are working as intended to meet minimum standards and desired outcomes of the waiver quality improvement system. As a first step, identified areas of weak performance are brought up to minimum standards through an understanding of the problem. Remedial action is taken to correct the root causes of the problem to improve performance in the weak area to prevent similar problems in the future. During analysis review, if a trend is identified that requires more focus or remediation, the case management entities, independent assessment entity, or HCBS provider is informed of the quality improvement focus within 15 business days of discovery. Depending on the focus of the trend, training/technical assistance is performed, and a remediation plan is put in a plan to either enhance what is working well or re-train to improve efficiency and compliance. If the identified trend requires remediation, a 3-month QIS period is implemented, including re-training and direct technical guidance. The State Medicaid Agency may impose a suspension of specific activities until the issue is remediated for quality improvement. This QIS quarter is provided to all CMEs and IAEs; however, the out-of-compliance entities must complete a corrective action plan for review and approval to initiate steps to align to waiver assurances. If compliance is not achieved, a "non-eligible provider transition plan" is developed.

Prioritization of noncompliance areas is made when access to care barriers or gaps in services provision are presented. These gaps may include HCBS providers not receiving timely authorization to render approved services, prior approval records that prohibit reimbursement of services, and workflow that restricts the ability to document the receipt of a request for a fair hearing.

A dashboard is updated daily in the CAP Business systems that display the performance of the waiver. An announcement queue is used to communicate quality improvement information.

To validate the efficiency and capacity of each responsible entity, the CAP Business system measures its performance monthly. Each entity must maintain a 90% quality compliance rate.

The CAP Business system is assessed daily to measure the ability to manage this HCBS QIS and waiver compliance. The assessment of the system is monitored through:

1. Audits and reviews;
2. MMIS;
3. Experience Surveys;
4. Stakeholder's input

5. Scope of the work; and
 6. Weekly discussion and tracking meetings.
 When areas of noncompliance are identified, the CAP Business system is informed of the concerns and required to complete a root cause analysis. A corrective action plan is implemented that includes timeframes and any identified system change requests. Refer to H-1bi. This system is in the process of being certified. Through planned stakeholder engagement meetings, stakeholders are notified quarterly about waiver trends and performances. Stakeholders can voice concerns or provide recommendations on how the systems may be more efficient or methods to implement and manage waiver assurances and QIS. compliance with the programmed workflow.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Quality Improvement Committee	Annually
Other Specify: <input type="text"/>	Other Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

A quarterly assessment of the functionality of the CAP Business system is conducted to monitor the performance and wavier specification per the approved scope of work. A State Medicaid representative reviews data reports and conducts testing to assess the effectiveness of the waiver functionality and its reliability to design. One hundred percent of the data must be processed and made available to the State Medicaid Agency when requested. However, the State Medicaid Agency gathers and reviews the data in the aggregate quarterly. The data must be able to drill down to the minimal sub-assurances and individual participants or case managers. Upon discovering out-of-compliance areas, a meeting is held with the vendor to address concerns, identify causes, and assist with implementing a corrective action plan. If the system is functioning as designed, but the waiver functionality is incongruent with processes or workflow, a change request is made to amend the scope of work or contract. The vendor must submit specifications for approval to the State Medicaid agency that addresses the new functionality. After the approval of the specification, a user acceptance test is performed to ensure the updated functionality is working as designed. Upon completing this process, the State Medicaid agency ensures the system is functioning as designed through observation and review. If the system is not functioning as designed, the vendor will have five business days to correct the area(s) of concern or provide a proposal that includes timelines.

- ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

Based on language approved in the Appendix K amendment associated with this waiver, due to the COVID pandemic, a quality review report was not completed for the previous waiver cycle. Additionally, 372 reports due during the emergency have not been submitted. Upon expiration of the Appendix K amendment, the state will gather data and submit the quality review in addition to any outstanding 372 reports as quickly as the required information can be gathered and analyzed. If necessary, the state will submit waiver amendments based on identified deficiencies in the quality review report and/or 372 reports within 90 days up to 6 months of receiving the final quality review report and 372 report acceptance decision.

A safeguard implemented by the State Medicaid Agency (SMA) to continuously evaluate the Quality Improvement Strategy (QIS) for this HCBS program is through data analysis. The State Medicaid Agency requires the CAP Business system vendor to generate daily reports on all workflows directly connected to the six waiver assurances. The CAP Business system must also maintain history files. Quarterly, and when a concern arises, an analysis of the reports is performed to evaluate the system's performance. Data from this system is cross-referenced, when applicable, to MMIS to validate compliance or issues of concern. This analysis allows a whole system review to identify areas that are working as designed and areas that need improvement. System improvements are implemented when areas of weakness are identified or when the system warrants. Another safeguard implemented by the SMA to evaluate the QIS is the recommendations made by the Home and Community Care Quality Management committee. This committee meets quarterly to evaluate the QIS.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one*):

No

Yes (*Complete item H.2b*)

b. Specify the type of survey tool the state uses:

HCBS CAHPS Survey :

NCI Survey :

NCI AD Survey :

Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The oversight of the waiver financial integrity and accountability (FIA) is performed by the SMA with data reports received from the CAP Business system (CBS) and the MMIS. The SMA does not require an independent audit of provider agencies specific to this waiver. The FIA oversight consists of the Office of Compliance & Program Integrity (OCPI) and contracted vendor to conduct post/pre-payment reviews of providers that deliver Waiver services, both provider-led and consumer-directed. The OCPI and its authorized vendors conduct announce/unannounced on-site and desk post-payment review audits and investigations of providers. Onsite post-payment reviews may be triggered from complaints which may include insufficient staff to render care/proper care, lack of required or trained staff, falsification of records, not providing treatment or delivering services, misuse of beneficiary's funds, solicitation and/or kickbacks; or identified anomalies in billing. Reviews do not differ by service types. These complaints come from internal/outside agencies & beneficiaries. The SMA's IT System receives PAs from utilization reviews and documented and archived authorizations in MMIS. The MMIS has edits/audits programmed to allow claims to adjudicate before payment. PCS is audited the same as other service claims. The weekly Aide Log captures the service approved on the POC & documents deviation from the approved POC. After the service has been provided, both Aide/beneficiaries are required to sign to confirm PCS services were provided. The OCPI uses the Fraud and Abuse Management System (FAMS), Java-Surveillance and Utilization Review System (JSURS), and Advantage Suite to detect over/underutilization of services, and improper/aberrant billing practices. FAMS and JSURS can identify providers billing practices/behaviors outside the norm of peers. On a 90-day basis, post-payment review samples with a 95% confidence level & 5% margin of error are sent to the SMA from each of the assigned reviewers that were completed during the previous quarter. For the SMA, the post-payment review process occurs daily during business days. Data Analysis meetings are conducted bimonthly, and a case review meeting is held to determine whether a provider should be recommended for post/pre-payment review. Reasons why a provider would be placed on post/pre-payment include: credible allegations of fraud; Identification of aberrant billing practices because of investigations; Aberrant Data analysis results; Failure of the provider to timely respond to a request for documentation. A Data Analytics Team within the SMA identifies data leads for audit and investigation based on the reasons for post/pre-payment placement, as listed above. Advantage Suite has the capacity to identify over/under utilization of services. When providers are identified through data analytics, a Data Analytics Report is created and assigned to an investigator to conduct further research and make a recommendation to refer a provider for post/pre-payment review. Post-payment reviews are conducted to determine if the provider delivered services in accordance with the policies, rules, and regulations for the claim billed. Post-Payment reviews may include a review of service requests, assessments, service plans, prior authorizations, staff qualifications, and claims paid. Prepayment claims review may include review of service requests, service orders, assessments, staff qualifications, service plans, and claims prior to payment. A provider placed on prepayment claims review must obtain a 70% accuracy rate for three consecutive months to successfully complete the program. Providers may stay on prepayment claims review for up to 24 months. The provider is provided the audit tools and instructions in the initial notice letter, and TA/support is given throughout the prepay process. If the provider does not meet this standard within six months of being placed on prepayment review, SMA may implement sanctions, including termination of the provider's Medicaid Application. The provider is notified of appeal rights. Pursuant to § 108C-7(b) and federal regulation, providers are not entitled to payment prior to claims review. To ensure that claims presented by a provider for payment meet the requirements of Federal/State laws, regulations and medical necessity criteria, a provider may be required to undergo prepayment claims review. The accuracy rate is determined by the total number of claims and detail line items (from all service locations operating under the NPI number) and determined as approved/denied within each month in which the claims are submitted for payment. 70% of all claim detail lines submitted must be identified by the designated vendor as containing no error(s). A single claim may contain one or more procedures billed on the same/different DOS. In this prepayment review process, the methodology for calculating a provider's accuracy rate is to take all claim detail lines with no identified errors divided by the total number of claim detail lines submitted for review. All the details of the statute are followed to assure that the provider successfully completes the program including the number of claims per month is no less than 50% of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review. There are approximately 90,000 NC Medicaid providers and less than 1% have been placed on pre-payment review. There is no time frame for how often a provider would be placed on pre-payment review. However, a determination can be made during the bimonthly Data Analysis Workgroup meetings. Terminations are the only actions that have been taken for providers failing pre-payment review. An access of care analysis is conducted prior to a pre-payment action being initiated.

SMA provides oversight and monitoring (case referrals, special initiatives, provider performance reports, quality assurance reports) of the contracted vendors' performance to ensure contract compliance and quality performance. All vendors are invited to participate in joint training sponsored by SMA and The Medicaid Fraud Control Unit on an annual basis to receive understanding of the OCPI monitoring and oversight requirements.

The CBS contains algorithms with logic that can interpret information from the Service Request Form (SRF) and the assessment that results in the development of a service plan. The assessment tool has key indicators to identify risk factors in the areas of sensory and communication, mental and behavioral health, informal supports, housing and finance, safety and well-being, and medical and diagnostic functioning. Upon the completion of the assessment, the CAP Business system, analyzes the data gathered and provides the case manager a report that contains risk indicators and suggestions on the

types of services the waiver participant would need to maintain health, safety, and well-being in the community. The case manager reviews those risk indicators along with the waiver participant to develop the service plan. The CBS also monitors services as listed on the service plan through monthly and quarterly documentation the case manager is required to complete in the CBS. The case manager gathers information about waiver participation and health and welfare during contact with the waiver participant and providers as well as from the review of paid claims. Key responses entered by the case manager populate to the service plan, the participant profile, and a risk indicator section to aid in assessing if the waiver participant's needs are adequately addressed and met. The case manager is required to respond to probing questions in the monthly and quarterly monitoring assessment that analyze if services are provided as planned and if these services are meeting needs in the amount, frequency and duration as identified. The CAP Business system provides a summary of each waiver participant which is referred to as "participant at a glance". This summary provides an overview of all care needs, services approved, risk indicators, ADLs composite score and caregiver involvement and availability. If the analysis by the CBS reveals that needs do not appear to be met or there are concerns of risk, the case manager is prompted to complete a change in status assessment, a plan of care revision or a risk agreement. The SMA consultant reviews this information and provides guidance to the case manager. Level of care determination is generated by the CAP Business system. When the assessment is approved which determines the participant reasonable indication of need and appropriate to participate in this HCBS program, the CAP Business system automatically transmits the prior approval (PA) to SMA's MMIS. When the service plan is completed by the case manager that identifies the service types in the amount, duration and frequency, the CAP Business system automatically transmits the service types in the amount, frequency, and duration to SMA's MMIS for adjudication of claims. SMA's MMIS will adjudicate claims up to the amount transmitted by the CAP IT system. SMA's contract administrator is responsible to ensure the CAP Business system is transmitting level of care PAs and service limit PAs to SMA's MMIS system timely and correctly. The contractor administrator will review all PAs transmitted to SMA's MMIS and will run data queries each week to assure claims adjudicated per the PA. The CAP Business system reviews 90% cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from consistent failure to comply with service plan. The Office of State Auditor (OSA) is responsible for conducting the periodic independent audit of the waiver program to include consumer-direction under the provisions of the Single Audit Act. Payment Error Rate Measurement (PERM) and recipient eligibility cases are completed every three years to determine whether medical record documentation supports services/products billed and whether the services/products were paid correctly. Post-payment reviews of all Medicaid providers conducted by the SMA look at the complete audit trail including the approval of the service plan; the authorization to the provider that rendered approved services, service provision and service documentation; the authorization for claims submission and actual claims data. The results of monthly monitoring are reviewed by the system and the SMA. The findings are shared with the CME. The findings enable the agencies to improve the way financial integrity and accountability are operated. The QA review process is not a negative process, but one that leads to the continuous quality improvement. Additionally, PA limits are placed on services to assure claims data is billed as planned in the SP. The waiver unit reviews claim data monthly to identify outliers/unusual occurrences. Outliers/unusual occurrences are analyzed to assure financial soundness and integrity. Concerns are referred to SMA's PI unit for an official investigation and follow-up. In addition to this process at the state level, the CME reviews paid claims routinely to ensure accuracy of service provision and reports concerns to SMA for follow-up. Program Integrity Section is tasked with multiple responsibilities. These responsibilities include resolution of provider fraud, abuse and administrative over-payments; determining the accuracy of Medicaid eligibility determinations; performing reviews of claims filed to identify problem areas; assisting in claim payment audits; conducting periodic reviews with providers who bill for payments; and referring cases of possible fraud to the Attorney General's Medicaid Investigations unit. The EVV is not a part of the Prepayment Review program, refer to I-2-b on the state's EVV plan.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
 (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-A1 Number and percent all claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. Numerator: number of all claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered Denominator: number of claims reviewed

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

The source of these reports are from CAP Business system and NC Medicaid MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">95% confidence level and +/- 5% margin of error</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content; margin: 5px auto;">CAP Business systems and NC Medicaid MMIS</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px auto;"></div>
	Continuously and	Other

	Ongoing	Specify: <input type="text"/>
	Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

FA-B1: Number and percent of rates that remain consistent with the approved rate methodology
Numerator: Number of rates that remain consistent with the approved rate methodology
Denominator: number of rates reviewed

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
State Medicaid Agency	Weekly	100% Review
Operating Agency	Monthly	Less than 100% Review
Sub-State Entity	Quarterly	Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% confidence level and +/- 5% margin of error</div>
Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Business system and Medicaid MMIS</div>	Annually	Stratified Describe Group: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Continuously and Ongoing	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>
	Other Specify: <div style="border: 1px solid black; width: 100px; height: 20px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly

<i>Responsible Party for data aggregation and analysis (check each that applies):</i>	<i>Frequency of data aggregation and analysis (check each that applies):</i>
<i>Operating Agency</i>	<i>Monthly</i>
<i>Sub-State Entity</i>	<i>Quarterly</i>
<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<i>Annually</i>
	<i>Continuously and Ongoing</i>
	<i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CAP Business system for this waiver is designed to evaluate all waiver participants and provider agencies in the processing and performance of waiver activities. As a safeguard for the financial accountability assurance, the State Medicaid Agency has programmed in its MMIS functionality to place prior approval limits on all waiver services. These limits are electronically transmitted to the State’s MMIS to inform claim reimbursement. These prior approval limits will prevent overpayments of Medicaid claims processing. The prior approval limits will also prevent providers from submitting Medicaid claims before the effective date of service implementation. The Medicaid Fiscal Agent ensures that waiver claims are paid correctly. All services are appropriately coded, and audits and edits are placed within the system to ensure claims are paid correctly. Audits have been tested to ensure claims for the waiver services will process as per Medicaid guidelines. In conjunction with the CAP Business system, the case management entities monitor service authorization against paid claims to ensure they are coded and paid correctly and that these paid claims correspond with the approved services in each waiver participant’s service plan. The CAP Business system, in conjunction with the Medicaid waiver services unit, monitors expenditures to ensure monthly benefit limits are not exceeded, and the program stays within its approved budget. NC Medicaid Office of Compliance and Program Integrity (OCPI) and/or its agents conduct post-payment reviews of providers that deliver Medicaid Waiver services. The NC Medicaid MMIS receives prior authorizations from utilization review, and authorizations are communicated, documented, and archived in the system’s portal known as NCTracks. NC Medicaid MMIS has edits and audits programmed to allow claims to process appropriately before the provider is paid. NC Medicaid Office of Compliance and Program Integrity uses robust data analytic tools that include the Fraud and Abuse Management System (FAMS), Java-Surveillance and Utilization Review System (JSURS), and Advantage Suite to identify and detect over-utilization and underutilization of services, as well as improper or aberrant billing practices by providers. FAMS and JSURS have the capacity to identify providers billing practices or behaviors outside the norm of their peers. Advantage Suite has the capacity to identify overutilization and underutilization of services. When providers are identified through data analytics, a Data Analytics Report is created and assigned to an investigator to conduct further research and make a recommendation to refer a provider for post-payment review or prepayment review. Post-payment reviews are conducted by the Office of Compliance and Program Integrity (OCPI) and/or its authorized agents to determine if the provider delivered services in accordance with the policies, rules, and regulations for the claim billed. Post-Payment reviews may include a review of service request forms, assessments, family/person-centered service plan, prior authorizations, staff qualifications, and claims paid.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Upon discovering noncompliance, a root-cause analysis is completed to identify the source of the systems error. If an NC Medicaid MMIS issue is discovered, a Medicaid Policy Memo (Change Service Requests) is generated to identify and resolve the issue.

Upon discovering noncompliance, the state’s fiscal agent contacts the provider to alert the paid claim error and requests a proposal on repayment, including recoupment of payment and/or adjustment to future provider payments. When trends or patterns are revealed of continued noncompliance, an audit is conducted, which may result in further sanctions or disbarment as a Medicaid-enrolled provider.

Whenever provider paid claims spike for various reasons or failure to substantially comply with previous requirements in an audit, the provider may be considered for prepayment claims review.

Prepayment claims review may include reviewing service request forms, service orders, assessments, staff qualifications, family/person-centered service plan, and claims before payment. A provider placed on prepayment claims review must obtain a 70% accuracy rate for three consecutive months to complete the program successfully.

Providers may stay on prepayment claims review for up to twelve months. Should a provider not meet the 70% accuracy rate, NC Medicaid may terminate the provider from the Medicaid program.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
State Medicaid Agency	Weekly
Operating Agency	Monthly
Sub-State Entity	Quarterly
Other Specify: <input type="text"/>	Annually
	Continuously and Ongoing
	Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group

services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The State does not have a defined timeframe for rebasing of rates. From a review perspective, the State does interact and solicit feedback from the stakeholder community on an ongoing basis including the feasibility of the current fees in place. A formal review/rebase of waiver rates was conducted in SFY 2017-2018. Generally, the State determines rates through a fee-for-service fee schedule methodology. For fee schedule rates, the State has historically solicited data from providers to inform the rate development process. The following components are typical considerations in the State fee development:

- Staffing Assumptions and staff wages
- Employee-related expense (e.g., benefits, employer taxes)
- Non-direct program expenses (e.g., supplies, training and supervision)
- Provider administrative overhead
- Direct staffing hours – this considers the training and other non-billable activities that practitioners are involved in.

The fee schedule for this waiver is statewide and does not vary geographically. The statewide approach is consistent with all other DHHS fee schedules, and in prior rate reviews, have not identified provider feedback to support geographic variation.

Rates are set to reimburse reasonable cost as defined in section 1861(v) of the Social Security Act. Service rates are developed using various methodologies; Medicaid historical fee schedules, Medicare, historical cost to providers, cost modeling and Medicare established fee schedules; and, in some cases, providers are invited to participate in forums related to rate setting. At any time, re-evaluation of reimbursement rates are considered as warranted based upon provider inquiries, service access considerations and budgetary considerations. DHHS monitors the number of providers delivering each waiver service, reviews participant complaints regarding ability to select/find a qualified provider, and considers participant feedback on service quality. Rate increases are determined by the State based on the outcomes of the periodic rate reviews performed by the State and available budget appropriations. DHHS performed an exhaustive review of all waiver service rates in SFY 2017/2018 and more recently rate increases were implemented in March 2022 in response to direct care worker wage increases.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The waiver participant is provided information about the waiver and payments when a referral is made and during the initial assessment process and annually thereafter. The State requires all participants be offered the opportunity to self-direct their services. The method of rate determination does not differ in any way from the methodology that is utilized when service is provider managed.

North Carolina establishes reimbursement rates applicable to services provided by providers and facilities. The rates are based on the costs incurred and reported by the providers with certain limits. Rates are generally set for the rate period based on the historical costs of the facility for a prior year (adjusted for inflation), rather than on the actual costs of providing the services for which the rate is claimed.

The General Assembly in North Carolina authorized legislation and funding to support the increase in provider rates for services delivered by direct care workers with the intention of supporting increased wages of these workers. Senate Bill 105 did not provide specific authority to enforce providers to pass on a percentage of the rate to the direct care worker., Based on the legislative intent of the rate increases, NC Medicaid strongly encouraged providers to distribute no less than 80% of funds received to increase wages of direct care workers identified using the criteria defined by the department within the next practicable pay period, not to exceed 45 days. This wage increase is intended to be in addition to the rate of pay each employee was receiving as of Oct. 1, 2021 (excluding any temporary wage increases made in response to COVID-19). An announcement to providers on the management of the rate increase can be found in the published Medicaid Bulletin. Rates can be found in the published Fee schedules: https://ncdhhs.servicenowservices.com/fee_schedules.

The State identified the services in the 1915(c) waivers delivered by direct care workers and determined equitable increases to each fee schedule. These increases support an approximate \$1.50-\$2 per hour increase in direct care worker wages. The rate increases were calibrated to a \$0.54 per 15-minute unit equivalent. The \$0.54 was derived by dividing the funding allocated by the general assembly by the historical number of 15-minute equivalent units of direct care delivered across the various HCBS services. For services with unit definitions that differ from 15-minute units (i.e. per diem or hourly services), the \$0.54 was translated into an equivalent rate add-on based on the assumed number of 15-minute units of direct care delivered during the defined unit.

The reasons for the differences in the rates are listed below.

- 1) The \$0.54 increase was developed for 1:1 service. In instances when this was applied to congregate care settings, the increase was adjusted to reflect that one direct care worker may be providing services to more than participant concurrently.

2) *The respite care in home nursing rates were increased in alignment with specific State legislation, which required increases in private duty nursing services from \$9.90 to \$11.25. This change was separate from the direct care worker increases impacting other PCS services. The impacted services and fee increases are identified below and are for FFS providers only. Reimbursement for all providers for the following services is capped:*

- *Home accessibility and adaptation -- \$28,000.00 per occurrence for the lifetime of the waiver*
- *Individual-Directed goods and services has a combined total of \$800.00 per occurrence per fiscal year with non-medical transportation, nutritional services, and pest eradication*
- *Assistive Technology- \$28,000.00 per occurrence per lifetime of the waiver*
- *Community Transition and Community Integration Services- combined \$2,500.00 per occurrence per Waiver beneficiary over the lifetime of the waiver*
- *Training, Education and Consultative Services- \$500.00 per occurrence per state fiscal year*
- *Case management – monthly reimbursement for each waiver participant*
- *Vehicle Modification- \$28,000.00 per occurrence per the lifetime of the waiver*
- *Specialized medical equipment- \$3,000.00 per occurrence per the lifetime of the waiver*

Maximum reimbursement for all providers for the following services is the same per unit rate or occurrence identified on the published fee schedule and is determined at least annually by NC Medicaid:

- *In-Home Care Aide Services to include pediatric nurse aide services, in-home respite services and nursing services per 15-minute increment as approved in the service plan*
- *Attendant Nurse Care per 15-minute increment as approved in the service plan*
- *Respite Care (Non-Institutional) per 15-minute increment as approved in the service plan*
- *Financial Management per monthly occurrence*
- *Care Advisor per monthly reimbursement for each waiver participant*
- *Case Management per monthly reimbursement for each waiver participant*
- *North Carolina establishes per diem rates for the following services for Respite Care (Institutional)*
- *Coordinated caregiving has three rate formulas per daily occurrence as approved in the service plan:*
 - o *Low rate*
 - o *High rate*
 - o *Skilled rate*

The per diem units per users of skilled coordinated caregiving is expected to increase because this is a new service without historical utilization, assumptions. Through the application of utilization trend, consistent with other services, the underlying total annual units per user grows, and without capping it would have exceeded 365 which is not possible since this is only available once per day. So, adjustments were made to the calculation to apply the 365-day cap.

Unit/occurrences and rates can be found in the published Fee schedules:

https://ncdhhs.servicenow.com/fee_schedules.

Refer to Main Section 6-I on how the Medicaid agency solicited public comments. Rate methodology is offered through public comments similar to the proposed waiver renewal changes.

NC Medicaid is in constant communication with providers and their associations through frequent meetings. Consumers may submit complaints by phone, or in writing. NC Medicaid complaints are investigated by Program Integrity who is available to receive complaints from patients, their families, other providers, former employees of a provider, and through federal and state referrals. Program Integrity staff investigates the complaint.

- b. Flow of Billings.** *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The billing flow for waiver services is directly from the providers to the State's claims payment system. The flow of billings for waiver services subject to the Electronic Visit Verification (EVV) under the 21st Century Cures Act is a three-step process. The first step is the collection by providers of EVV visit history data from scheduled in-home visits. The second step is the uploading, by providers, captured visits into the State's aggregator, which is electronically transmitted to the MMIS. The third step is the assigning, by the MMIS vendor, the visit capture data to the rendering provider and Medicaid beneficiary. When a provider bills a claim, the MMIS audits the claim to append the visit history data to the claim. Claims that match the visit history data flow through the claim billing process. Claims that do not match the history data are pended for up to 14 days before the claim processing is denied or suspended. EVV for personal care services (In-Home Care Aide and Pediatric Nurse Aide services) provided to waiver beneficiaries and Medicaid beneficiaries receiving State Plan services was implemented statewide in January 2021. The SMA has been granted a good-faith effort to launch EVV for Home Health at a later date in 2023. Sandata is the state's contracted vendor to manage EVV. The state uses an open vendor model. To ensure the accuracy flow of billings, all providers subject to the EVV mandate must register with the State's EVV solution to report visit history data.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures (select one):

No. state or local government agencies do not certify expenditures for waiver services.

Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.

Select at least one:

Certified Public Expenditures (CPE) of State Public Agencies.

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

Certified Public Expenditures (CPE) of Local Government Agencies.

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

NC Medicaid contracts with a Fiscal Agent (FA) for the management of the MMIS, claim processing and payment. It is the FA's responsibility to process valid claims from enrolled providers in accordance with policies, edits, audits, guidelines, and reimbursement methodologies. Payments are made through MMIS and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers. A PA of LOC and a coverage code is inputted in the MMIS for claim processing. The CMS 64 is adjusted to account for inappropriate payments identified from MMIS. The provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid because Medicaid is the payer of last resort.

Once the provider determines that the invoice is a Medicaid claim, the provider then bills NCTracks for payment. Validation that services have been provided as billed is a function of quality assurance conducted by the CAP Business system and the case management entities. Audits include verification that the services were provided as billed. Additional validation is through desk/onsite audits and PI reviews.

Annually, the NC Medicaid Accountability Team conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of enrolled providers. his review includes monitoring of requirements that addresses staff qualifications, service authorizations, family/person centered plans, service documentation, and billing protocol. For the waiver, a validation of the following is reviewed:

1. Have the required signatures on or before services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and
7. Include a 24-hour schedule of coverage, if warranted.

During and prior to waiver participation the SMA validates the CAP Business system:

- reviews 100% of its cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided.
- reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, different LOC and appeals on a monthly basis to assure accuracy and 100% compliance of authorized services.
- conducts quality assurance reviews that include a review of the family/person centered plan and service documentation for each waiver beneficiary. The reviewer reviews the current service request form, the assessment and the approved family/person centered, service documentation, and paid claims to insure that services were billed appropriately as according to the service plan.
- places prior approval limits on all service plans to identify deviations from the providers and review provision of services monthly. If there are consistent deviations and the service is authorized on the service plan, the case manager must review these with the waiver beneficiary for further validation.

The State Medicaid Agency/CAP Business system will provide each CME with QI reports to validate all authorized services. The case management entities will contact the CAP Business system representatives/State Medicaid Agency when program integrity concerns are present. The State Medicaid Agency will arrange for a program integrity review of the concerns.

The SMA utilizes desk reviews/on-site reviews(audits), reports, and special reviews to ensure program accountability for service plan development and implementation. These desk reviews/on-site reviews occur annually and as needed.

Submitted claims are systematically reviewed by the fiscal agent to ensure that all required information is present.

Completed claims processed through MMIS are run against system edits to verify:

- Services are prior authorized (i.e., level of care); Individual is a Medicaid beneficiary and is enrolled in the waiver (i.e. CAP indicator); Provider is an enrolled waiver provider; Claim is not a duplicate; Claim is paid per the published rates; and the participant was not institutionalized during the time covered.

Payments are made through MMIS and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers.

Validation that services have been provided as billed is a function of quality assurance conducted by the management of prior approvals and assessment by the CME. Additional validation that services were provided as billed is performed during CME and provider on-site compliance monitoring reviews, conducted by the State Medicaid Agency's PI Unit. Validation will also be achieved through participant's surveys by mail or by telephone; education about fraud and abuse and how to report concerns of payment integrity and quality of care. During enrollment and annually thereafter, each waiver participant will be provided education and information regarding financial accountability. In addition, post payment reviews, review of provider records and claims will also be used for validation. Payments for inappropriate billing are recouped after a tentative notice of decision is sent to the provider for identified overpayment. Provider is

given the opportunity to appeal. When the appeal becomes final, the provider has the option to pay with a check or to repay overpayment through future payments. An Accounts Receivable is set -up for the provider to payback overpayment. Those dollars are adjusted and or identified on the Provider's Remittance Advice. The EVV system is not a part of the Prepayment Review Program.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).

Payments for some, but not all, waiver services are made through an approved MMIS.

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are not made through an approved MMIS.

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.

The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.

The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

No. The state does not make supplemental or enhanced payments for waiver services.

Yes. The state makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.

Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Case management entities comprise of various types of entities such as health departments, the department of social services, and county aging departments. These entities are local government entities. These entities are not providers of waiver services such as specialized medical equipment and supplies, home accessibility and adaptation, participant goods and services, and assistive technology. When a waiver service of such is identified as a need, the case management entity assists the waiver beneficiary in identifying a waiver provider based on freedom of choice. When the waiver beneficiary selects a provider, a service authorization is forwarded to the chosen provider by the CME to initiate the provision of that waiver service. When applicable, the case management entity can be a pass-through for claims processing when clearly identified in the service plan and the provider is not specified as an eligible enrollee as a Medicaid provider. The case management entity gets reimbursed for case management services which is a waiver service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.

Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.

Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to

obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.

This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.

If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:

Appropriation of State Tax Revenues to the State Medicaid Agency

Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Other State Level Source(s) of Funds.

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

No. *The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.*

Yes. *Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.*

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

No. *The state does not impose a co-payment or similar charge upon participants for waiver services.*

Yes. *The state imposes a co-payment or similar charge upon participants for one or more waiver services.*

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

Nominal deductible

Coinsurance

Co-Payment

Other charge

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

No. *The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.*

Yes. *The state imposes a premium, enrollment fee or similar cost-sharing arrangement.*

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	35813.52	92105.06	127918.58	114924.79	82366.37	197291.16	69372.58
2	37215.32	95816.89	133032.21	119556.26	85685.73	205241.99	72209.78
3	38682.96	99678.31	138361.27	124374.37	89138.86	213513.23	75151.96
4	40141.83	103695.35	143837.18	129386.66	92731.16	222117.82	78280.64
5	41679.42	107847.27	149526.69	134600.94	96468.23	231069.17	81542.48

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	4000	26	3974
Year 2	4500	29	4471
Year 3	5000	33	4967
Year 4	5500	36	5464
Year 5	6000	39	5961

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for the waiver is 331.8 days. This figure is actual average length of stay for waiver participants from March 1, 2018 through February 28, 2019 as reported in the historical CMS 372. This figure was corroborated using state eligibility data with no notable differences identified. Note that the overall length of stay for the CAP/C waiver is comparable to the average length of stay across the previous CAP/C waiver submission.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

Year 1 Factor D Derivations are estimated based on North Carolina's experience for March 1, 2018 through February 28, 2019 CAP/C waiver users and services as reported in the CMS 372. Additionally, CY 2019 claims data from the State's MMIS was run to factor actual utilization (users and units) of current services during the time period. These two data sources (CMS 372 and claims data) were compared and found to be reasonable and consistent. CMS 372 submissions for the periods of March 2017 – February 2018 and March 2018 – February 2019 were relied upon to develop the utilization trends. New services included in the waiver relied on utilization data (paid expenditures and user counts) from March 2017-February 2019 from similar services (private duty nursing) from our State Plan services and services utilization (data from CMS 372 submissions from March 2017-February 2019) from the CAP/DA waiver, the adult 1915 (c) HCBS waiver in NC.

For services that are new to the waiver as part of this renewal and those that were not included in the noted CMS 372 report (Consumer Directed Nursing, Community Integration, Non-Medical Transportation, Nutritional Services, Pest Eradication and Coordinated Caregiving), no historical utilization was available. Instead, the State reviewed service need and utilization of similar services in other waivers to determine appropriate initial estimates of utilization, users, and average costs.

Utilization was then trended forward to the first year of the waiver using historic utilization trends of 3% based on review multiple years of historical trends as available in the March 2017-February 2019 CMS 372 reports. The service rates utilized reflect the current fee schedule including consideration for legislatively required increases to rates implemented to support increased direct care worker wages and less any COVID rate increases tied to the public health emergency, as it is assumed these will not be effective at the beginning of Waiver Year 1. User penetration rates for each service were evaluated based on historical 2018 and 2019 372 data. These penetration rates were then multiplied by the State's total enrollment estimates for each waiver year to establish estimated users for each service. In instances where historical utilization of a service was not available, the State made estimates based on their understanding of the potential needs of the population.

For Waiver Years 2 – 5, utilization is trended forward at the same 3% annual rate as noted above, along with 1% annual growth in service rates. The 1% annual unit cost trend was included as an estimate of potential future fee schedule unit cost growth during the prospective time period. It is included as consideration for cost of living/inflationary growth to services that are paid based on a standardized preset fee schedule. User penetration rates for each service were evaluated based on historical 2018 and 2019 372 data. These penetration rates were then multiplied by the State's total enrollment estimates for each waiver year to establish estimated users for each service. In instances where historical utilization of a service was not available, the State made estimates based on their understanding of the potential needs of the population.

For services that are paid based on cost rather than a preset fee schedule (Home Accessibility and Adaptation; Training, Education, and Consultative Services; Assistive Technology; Individual-Directed Goods and Services; Participant Goods and Services; Vehicle Modifications; and Specialized Medical Equipment and Supplies), no historic or prospective utilization trend was applied, as it was assumed each average user will utilize the same amount of services. A 1% annual unit cost trend was included for these services in Waiver Years 2 – 5 to account for cost of living/inflationary growth.

For services that are paid based on cost that have little or no historic utilization (Community Transition, Community Integration, Non-Medical Transportation, nutritional services, and Pest Eradication), no utilization or unit cost trend was included, as it was assumed these services will be paid at the approved spending cap for each user.

ii. Factor D' Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Year 1 Factor D' Derivation is estimated based on actual Medicaid expenditures for all non-waiver services (i.e., acute medical, pharmacy and behavioral health) for CAP/C recipients during CY 2019. DHHS reviewed CY 2018 and CY 2019 non-waiver (e.g., acute, pharmacy and behavioral health) claims information for CAP/C waiver enrollees to evaluate the Factors D' trends.

The data was pulled for CY 2019 CAP/C enrollees from the State's MMIS and then trended forward to each waiver year using 4% annual growth in expenditures to align with utilization and unit cost trends observed for the CAP/C waiver spending as summarized in the historical CMS 372 reports. This 4% trend also aligns with medical trends observed by the State in other projections of future medical expenses.

Specific to hospital expenditures, the Medicaid claims experience was adjusted to reflect the new reimbursement methodology the State has implemented effective July 1, 2021. Similar to the Factor D Derivation section above, expenditure data for Factor D' was found to be consistent with CMS 372 information from overlapping time periods.

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Year 1 Factor G Derivation is estimated based on actual Medicaid institutional claims expenditure data for 0- to 20-year-old, non-CAP/C Medicaid recipients residing in nursing facilities and hospitals. These individuals were identified using specific NPIs and age criteria to proxy individuals who would otherwise be eligible for the CAP/C waiver. The data was run for CY 2019 and was trended forward to each waiver year using a 4% annual inflation factor to align with historical growth in utilization and unit cost for these services as observed in the claims information. Institutional claims from CY 2018 and CY 2019 were reviewed for the comparable institutional population to establish Factor G trends.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Year 1 Factor G' Derivation is estimated based on actual Medicaid claims expenditure data for non-institutional services (i.e., acute medical and behavioral health) for 0- to 20-year-old, non-CAP/C Medicaid recipients residing in nursing facilities. These are the costs associated with non-nursing facility expenditures for the recipients identified and measured for Factor G derivation (see above). The data was run for CY 2019 and was trended forward to each waiver year using a 4% annual inflation factor to align with historical growth in utilization and unit cost for these services as observed in the claims information. Specific to hospital expenditures, the Medicaid claims experience was adjusted to reflect the new reimbursement methodology the State has implemented effective July 1, 2021. DHHS reviewed CY 2018 and CY 2019 non-institutional (e.g., acute, pharmacy and behavioral health) claims information for the comparable institutional population to evaluate the Factors G' trends.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.

Waiver Services	
Coordination of Care- case management and care advisement	
In-Home Care Aide Service	
Respite-Institutional and In-Home	
Financial Management	
Individual-Directed goods and services	
Assistive Technology	
Attendant Nurse Care	
Community Integration	
Community Transition	

<i>Waiver Services</i>	
<i>Coordinated Caregiving</i>	
<i>Home Accessibility and Adaptation</i>	
<i>Non-Medical Transportation</i>	
<i>Nutritional Services</i>	
<i>Participant Goods and Services</i>	
<i>Pediatric Nurse Aide Services</i>	
<i>Pest Eradication</i>	
<i>Specialized Medical Equipment</i>	
<i>Training, Education, and Consultative Services</i>	
<i>Vehicle Modifications</i>	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care-case management and care advisement Total:						9651200.00
Care Advisor	per month	828	6.40	377.00	1997798.40	
Case Management	per month	3172	6.40	377.00	7653401.60	
In-Home Care Aide Service Total:						36613878.91
In-Home Care Aide Service	15 min	1698	4409.60	4.89	36613878.91	
Respite-Institutional and In-Home Total:						32127549.06
Institutional Respite	per diem	3	1.10	218.50	721.05	
Non-Institutional Respite	15 min	3029	1500.20	7.07	32126828.01	
Financial Management Total:						914807.52
Financial Management	per month	828	10.80	102.30	914807.52	
Individual-Directed goods and services Total:						10184.00
<p>GRAND TOTAL: 143254073.86</p> <p>Total Estimated Unduplicated Participants: 4000</p> <p>Factor D (Divide total by number of participants): 35813.52</p> <p>Average Length of Stay on the Waiver: 332</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Individual-Directed goods and services	event	16	1.00	636.50	10184.00	
Assistive Technology Total:						942758.72
Assistive Technology	event	152	1.00	6202.36	942758.72	
Attendant Nurse Care Total:						13470311.25
Attendant Nurse Care	15 min	1045	1145.80	11.25	13470311.25	
Community Integration Total:						2500.00
Community Integration	event	5	1.00	500.00	2500.00	
Community Transition Total:						7500.00
Community Transition	event	3	1.00	2500.00	7500.00	
Coordinated Caregiving Total:						3463224.80
Coordinated Caregiving Skilled	per diem	50	348.60	124.77	2174741.10	
Coordinated Caregiving High	per diem	50	290.50	63.55	923063.75	
Coordinated Caregiving Low	per diem	50	174.30	41.93	365419.95	
Home Accessibility and Adaptation Total:						2273883.04
Home Accessibility and Adaptation	event	299	1.00	7604.96	2273883.04	
Non-Medical Transportation Total:						40000.00
Non-Medical Transportation	event	50	1.00	800.00	40000.00	
Nutritional Services Total:						16000.00
Nutritional Services	event	20	1.00	800.00	16000.00	
Participant Goods and Services Total:						10184.00
Participant Goods and Services	event	16	1.00	636.50	10184.00	
Pediatric Nurse Aide Services Total:						40756831.05
Pediatric Nurse Aide Services	15 min	1394	5102.50	5.73	40756831.05	
Pest Eradication Total:						560000.00
Pest Eradication					560000.00	

GRAND TOTAL: 143254073.86

Total Estimated Unduplicated Participants: 4000

Factor D (Divide total by number of participants): 35813.52

Average Length of Stay on the Waiver: 332

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	event	700	1.00	800.00		
Specialized Medical Equipment Total:						458290.95
Specialized Medical Equipment	event	195	1.00	2350.21	458290.95	
Training, Education, and Consultative Services Total:						17535.04
Training, Education, and Consultative Services	event	37	1.00	473.92	17535.04	
Vehicle Modifications Total:						1917435.52
Vehicle Modifications	event	182	1.00	10535.36	1917435.52	
<p>GRAND TOTAL: 143254073.86 Total Estimated Unduplicated Participants: 4000 Factor D (Divide total by number of participants): 35813.52 Average Length of Stay on the Waiver: 332</p>						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care-case management and care advisement Total:						11308869.00
Care Advisor	per month	932	6.60	380.77	2342192.42	
Case Management	per month	3568	6.60	380.77	8966676.58	
In-Home Care Aide Service Total:						42877080.25
In-Home Care Aide Service	15 min	1911	4541.90	4.94	42877080.25	
Respite-Institutional and In-Home Total:						37600331.51
Institutional Respite	per diem	3	1.20	220.69	794.48	
<p>GRAND TOTAL: 167468918.38 Total Estimated Unduplicated Participants: 4500 Factor D (Divide total by number of participants): 37215.32 Average Length of Stay on the Waiver: 332</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Institutional Respite	15 min	3408	1545.20	7.14	37599537.02	
Financial Management Total:						1068866.06
Financial Management	per month	932	11.10	103.32	1068866.06	
Individual-Directed goods and services Total:						11571.66
Individual-Directed goods and services	event	18	1.00	642.87	11571.66	
Assistive Technology Total:						1071208.98
Assistive Technology	event	171	1.00	6264.38	1071208.98	
Attendant Nurse Care Total:						15764178.39
Attendant Nurse Care	15 min	1176	1180.01	11.36	15764178.39	
Community Integration Total:						3000.00
Community Integration	event	6	1.00	500.00	3000.00	
Community Transition Total:						7500.00
Community Transition	event	3	1.00	2500.00	7500.00	
Coordinated Caregiving Total:						4034724.57
Coordinated Caregiving Skilled	per diem	56	359.00	126.02	2533506.08	
Coordinated Caregiving High	per diem	56	299.20	64.19	1075516.29	
Coordinated Caregiving Low	per diem	56	179.50	42.35	425702.20	
Home Accessibility and Adaptation Total:						2580819.36
Home Accessibility and Adaptation	event	336	1.00	7681.01	2580819.36	
Non-Medical Transportation Total:						44800.00
Non-Medical Transportation	event	56	1.00	800.00	44800.00	
Nutritional Services Total:						18400.00
Nutritional Services	event	23	1.00	800.00	18400.00	
Participant Goods and Services Total:						10285.92
<p>GRAND TOTAL: 167468918.38</p> <p>Total Estimated Unduplicated Participants: 4500</p> <p>Factor D (Divide total by number of participants): 37215.32</p> <p>Average Length of Stay on the Waiver: 332</p>						

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Participant Goods and Services	event	16	1.00	642.87	10285.92	
Pediatric Nurse Aide Services Total:						47713212.96
Pediatric Nurse Aide Services	15 min	1568	5255.50	5.79	47713212.96	
Pest Eradication Total:						630400.00
Pest Eradication	event	788	1.00	800.00	630400.00	
Specialized Medical Equipment Total:						522218.40
Specialized Medical Equipment	event	220	1.00	2373.72	522218.40	
Training, Education, and Consultative Services Total:						20103.72
Training, Education, and Consultative Services	event	42	1.00	478.66	20103.72	
Vehicle Modifications Total:						2181347.60
Vehicle Modifications	event	205	1.00	10640.72	2181347.60	
<p>GRAND TOTAL: 167468918.38</p> <p>Total Estimated Unduplicated Participants: 4500</p> <p>Factor D (Divide total by number of participants): 37215.32</p> <p>Average Length of Stay on the Waiver: 332</p>						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care-case management and care advisement Total:						13075720.00
Care Advisor	per month	1036	6.80	384.58	2709289.18	
Case Management					10366430.82	
<p>GRAND TOTAL: 193414784.33</p> <p>Total Estimated Unduplicated Participants: 5000</p> <p>Factor D (Divide total by number of participants): 38682.96</p> <p>Average Length of Stay on the Waiver: 332</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	per month	3964	6.80	384.58		
In-Home Care Aide Service Total:						49559774.81
In-Home Care Aide Service	15 min	2123	4678.20	4.99	49559774.81	
Respite-Institutional and In-Home Total:						43455815.58
Institutional Respite	per diem	4	1.20	222.89	1069.87	
Non-Institutional Respite	15 min	3787	1591.50	7.21	43454745.70	
Financial Management Total:						1243345.04
Financial Management	per month	1036	11.50	104.36	1243345.04	
Individual-Directed goods and services Total:						12985.80
Individual-Directed goods and services	event	20	1.00	649.29	12985.80	
Assistive Technology Total:						1202135.70
Assistive Technology	event	190	1.00	6327.03	1202135.70	
Attendant Nurse Care Total:						18237799.58
Attendant Nurse Care	15 min	1307	1215.50	11.48	18237799.58	
Community Integration Total:						3000.00
Community Integration	event	6	1.00	500.00	3000.00	
Community Transition Total:						10000.00
Community Transition	event	4	1.00	2500.00	10000.00	
Coordinated Caregiving Total:						4683796.68
Coordinated Caregiving Skilled	per diem	63	365.00	127.28	2926803.60	
Coordinated Caregiving High	per diem	63	308.20	64.83	1258778.18	
Coordinated Caregiving Low	per diem	63	184.90	42.77	498214.90	
Home Accessibility and Adaptation Total:						2893666.86
Home Accessibility and Adaptation	event	373	1.00	7757.82	2893666.86	
<p>GRAND TOTAL: 193414784.33</p> <p>Total Estimated Unduplicated Participants: 5000</p> <p>Factor D (Divide total by number of participants): 38682.96</p> <p>Average Length of Stay on the Waiver: 332</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Non-Medical Transportation Total:						50400.00
Non-Medical Transportation	event	63	1.00	800.00	50400.00	
Nutritional Services Total:						20000.00
Nutritional Services	event	25	1.00	800.00	20000.00	
Participant Goods and Services Total:						12336.51
Participant Goods and Services	event	19	1.00	649.29	12336.51	
Pediatric Nurse Aide Services Total:						55195964.46
Pediatric Nurse Aide Services	15 min	1743	5413.20	5.85	55195964.46	
Pest Eradication Total:						700000.00
Pest Eradication	event	875	1.00	800.00	700000.00	
Specialized Medical Equipment Total:						584977.80
Specialized Medical Equipment	event	244	1.00	2397.45	584977.80	
Training, Education, and Consultative Services Total:						22722.15
Training, Education, and Consultative Services	event	47	1.00	483.45	22722.15	
Vehicle Modifications Total:						2450343.36
Vehicle Modifications	event	228	1.00	10747.12	2450343.36	
<p>GRAND TOTAL: 193414784.33</p> <p>Total Estimated Unduplicated Participants: 5000</p> <p>Factor D (Divide total by number of participants): 38682.96</p> <p>Average Length of Stay on the Waiver: 332</p>						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care-case management and care advisement Total:						14954170.00
Care Advisor	per month	1139	7.00	388.42	3096872.66	
Case Management	per month	4361	7.00	388.42	11857297.34	
In-Home Care Aide Service Total:						56706035.40
In-Home Care Aide Service	15 min	2335	4818.50	5.04	56706035.40	
Respite-Institutional and In-Home Total:						49706623.74
Institutional Respite	per diem	4	1.20	225.12	1080.58	
Non-Institutional Respite	15 min	4165	1639.30	7.28	49705543.16	
Financial Management Total:						1416597.08
Financial Management	per month	1139	11.80	105.40	1416597.08	
Individual-Directed goods and services Total:						13771.59
Individual-Directed goods and services	event	21	1.00	655.79	13771.59	
Assistive Technology Total:						1335572.70
Assistive Technology	event	209	1.00	6390.30	1335572.70	
Attendant Nurse Care Total:						20851847.16
Attendant Nurse Care	15 min	1437	1252.00	11.59	20851847.16	
Community Integration Total:						3500.00
Community Integration	event	7	1.00	500.00	3500.00	
Community Transition Total:						10000.00
Community Transition	event	4	1.00	2500.00	10000.00	
Coordinated Caregiving Total:						5239127.36
Coordinated Caregiving Skilled	per diem	69	365.00	128.55	3237531.75	
Coordinated Caregiving High	per diem	69	317.40	65.48	1434051.29	
Coordinated					567544.32	
<p>GRAND TOTAL: 220780073.98</p> <p>Total Estimated Unduplicated Participants: 5500</p> <p>Factor D (Divide total by number of participants): 40141.83</p> <p>Average Length of Stay on the Waiver: 332</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Caregiving Low	perdiem	69	190.40	43.20		
Home Accessibility and Adaptation Total:						3220345.29
Home Accessibility and Adaptation	event	411	1.00	7835.39	3220345.29	
Non-Medical Transportation Total:						55200.00
Non-Medical Transportation	event	69	1.00	800.00	55200.00	
Nutritional Services Total:						22400.00
Nutritional Services	event	28	1.00	800.00	22400.00	
Participant Goods and Services Total:						14427.38
Participant Goods and Services	event	22	1.00	655.79	14427.38	
Pediatric Nurse Aide Services Total:						63061708.68
Pediatric Nurse Aide Services	15 min	1917	5575.60	5.90	63061708.68	
Pest Eradication Total:						770400.00
Pest Eradication	event	963	1.00	800.00	770400.00	
Specialized Medical Equipment Total:						648943.24
Specialized Medical Equipment	event	268	1.00	2421.43	648943.24	
Training, Education, and Consultative Services Total:						24902.28
Training, Education, and Consultative Services	event	51	1.00	488.28	24902.28	
Vehicle Modifications Total:						2724502.09
Vehicle Modifications	event	251	1.00	10854.59	2724502.09	
<p>GRAND TOTAL: 220780073.98 Total Estimated Unduplicated Participants: 5500 Factor D (Divide total by number of participants): 40141.83 Average Length of Stay on the Waiver: 332</p>						

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care- management and care advisement Total:						16947792.00
Care Advisor	per month	1243	7.20	392.31	3511017.58	
Case Management	per month	4757	7.20	392.31	13436774.42	
In-Home Care Aide Service Total:						64368032.09
In-Home Care Aide Service	15 min	2548	4963.10	5.09	64368032.09	
Respite-Institutional and In-Home Total:						56391040.88
Institutional Respite	per diem	4	1.30	227.37	1182.32	
Non-Institutional Respite	15 min	4544	1688.40	7.35	56389858.56	
Financial Management Total:						1614271.67
Financial Management	per month	1243	12.20	106.45	1614271.67	
Individual-Directed goods and services Total:						15896.16
Individual-Directed goods and services	event	24	1.00	662.34	15896.16	
Assistive Technology Total:						1471557.60
Assistive Technology	event	228	1.00	6454.20	1471557.60	
Attendant Nurse Care Total:						23633403.04
Attendant Nurse Care	15 min	1565	1289.60	11.71	23633403.04	
Community Integration Total:						4000.00
Community Integration	event	8	1.00	500.00	4000.00	
Community Transition Total:						10000.00
Community Transition	event	4	1.00	2500.00	10000.00	
Coordinated Caregiving Total:						5817727.72
Coordinated Caregiving Skilled	per diem	75	365.00	129.84	3554370.00	
Coordinated Caregiving High	per diem				1621342.28	
<p>GRAND TOTAL: 250076492.63 Total Estimated Unduplicated Participants: 6000 Factor D (Divide total by number of participants): 41679.42 Average Length of Stay on the Waiver: 332</p>						

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		75	326.90	66.13		
Coordinated Caregiving Low	perdiem	75	196.20	43.63	642015.45	
Home Accessibility and Adaptation Total:						3545360.00
Home Accessibility and Adaptation	event	448	1.00	7913.75	3545360.00	
Non-Medical Transportation Total:						60000.00
Non-Medical Transportation	event	75	1.00	800.00	60000.00	
Nutritional Services Total:						24000.00
Nutritional Services	event	30	1.00	800.00	24000.00	
Participant Goods and Services Total:						15233.82
Participant Goods and Services	event	23	1.00	662.34	15233.82	
Pediatric Nurse Aide Services Total:						71570087.24
Pediatric Nurse Aide Services	15 min	2091	5742.90	5.96	71570087.24	
Pest Eradication Total:						840000.00
Pest Eradication	event	1050	1.00	800.00	840000.00	
Specialized Medical Equipment Total:						716572.52
Specialized Medical Equipment	event	293	1.00	2445.64	716572.52	
Training, Education, and Consultative Services Total:						27617.52
Training, Education, and Consultative Services	event	56	1.00	493.17	27617.52	
Vehicle Modifications Total:						3003900.36
Vehicle Modifications	event	274	1.00	10963.14	3003900.36	
<p>GRAND TOTAL: 250076492.63</p> <p>Total Estimated Unduplicated Participants: 6000</p> <p>Factor D (Divide total by number of participants): 41679.42</p> <p>Average Length of Stay on the Waiver: 332</p>						