

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

2A-3, Out-of-State Service
2B-1, Nursing Facilities
3A, Home Health Services
3D, Hospice Services
3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age
3H-1, Home Infusion Therapy
5A-1, Physical Rehabilitation Equipment and Supplies
5A-2, Respiratory Equipment and Supplies
5A-3, Nursing Equipment and Supplies
5B, Orthotics and Prosthetics
8A, Enhanced Mental Health and Substance Abuse Services
8A-1, Assertive Community Treatment (ACT) Program
8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
8J, Children's Developmental Service Agencies (CDSAs)
8L, Mental Health/Substance Abuse Targeted Case Management
8-O, Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders
9A, Over-The-Counter Products
10C, Local Education Agencies (LEAs)

1.0 Description of the Procedure, Product, or Service

The Community Alternatives Program for Children (CAP/C) is a Medicaid Home and Community-Based Services (HCBS) Waiver authorized under section 1915(c) of the Social Security Act and complies with 42 CFR § 440.180, Home and Community-Based Waiver Services. This waiver program provides a cost-effective alternative to institutionalization for a beneficiary, in a specified target population, who is at risk for institutionalization if specialized waiver services were not available. These services allow the beneficiary to remain in or return to a home and community-based setting.

HCBS waivers are approved by Centers of Medicare and Medicaid Services (CMS) for a specified time. The waiver establishes the requirements for program administration and funding. Federal regulations for HCBS waivers are found in 42 CFR Part 441 Subpart G, Home and Community-Based Services: Waiver Requirements. NC Medicaid can renew or amend the waiver with the approval of CMS. CMS may exercise its authority to terminate the waiver when it believes the waiver is not operated properly.

This waiver serves a limited number of medically fragile and medically complex children. To enroll and participate in this waiver, the individual shall meet the Medicaid eligibility requirements for long-term care.

NC Medicaid is the administrative authority of the waiver and outlines the policies and procedures governing the waiver. NC Medicaid appoints local case management entities to provide the day-to-day operation of the waiver to ensure the primary six waiver assurances are met. These assurances are:

- a. Level of Care (LOC);
- b. Administrative Authority;
- c. Qualified Providers;
- d. Services Plan;
- e. Health and Welfare; and
- f. Financial Accountability.

The requirements of administration of the CAP/C waiver are lists of target populations, waived Medicaid eligibility criteria, services, and the duration of the waiver. The following regulations give the North Carolina Department of Health and Human Services (DHHS) the authority to set the requirements contained in this policy and the CAP/C Waiver:

- a. 42 CFR Part 441 Subpart G, Home and Community-Based Services: Waiver Requirements;
- b. 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 offer HCBS to state-specified target groups of Medicaid beneficiaries who meet a nursing facility level of care that is provided under the Medicaid State Plan.
- c. Section 1902(a) (10) (B) of the Social Security Act provides that Medicaid services are available to all categorically-eligible individuals on a comparable basis. This HCBS waiver:
 1. targets services only to the specified groups of Medicaid beneficiaries that meet the nursing facility level of care established by this policy; and
 2. offers services that are not otherwise available under the State Plan.

This waiver supplements, rather than replaces, the formal and informal services and supports already available to an approved Medicaid beneficiary. Services are intended for situations where no household member, relative, caregiver, landlord, community agency, volunteer agency, or third-party payer is able or willing to meet the assessed and required medical, psychosocial, and functional needs of the approved CAP/C beneficiary.

The HCBS Waiver for CAP/C waives certain NC Medicaid requirements (42 CFR 441.300 through 310) in order to furnish an array of home and community-based services to a Medicaid beneficiary who is at risk of institutionalization. The CAP/C waiver services are:

- a. Assistive technology;
- b. CAP/C in-home aide (IHA);
- c. Care advisor;
- d. Case management;
- e. Community transition service;
- f. Financial management services;
- g. Home accessibility and adaptation;
- h. Goods and services – Participant, Individual-directed, Pest eradication, Nutritional services and Non-medical transportation;
- i. Vehicle modification;

- j. Participant goods and services;
- k. Pediatric nurse aide services;
- l. Respite care (institutional and in-home);
- m. Specialized medical equipment and supplies; and
- n. Training, education, and consultative services.

Refer to **Appendix B** for service definitions and requirements, Appendix F, Glossary of CAP Terms and **Attachment A, HCPCS Codes**, for services which are billable under the CAP/C Waiver.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 - 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 - 2. the NC Health Choice Program (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. The following is only one of the eligibilities and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid

The HCBS waiver authority permits a state to offer home and community-based services for CAP/C services to a child who:

- 1. is determined to require a level of institutional care under the State Medicaid Plan;
- 2. is member of a CAP/C target population that is part the approved waiver;
- 3. meets applicable Medicaid eligibility criteria;
- 4. requires one or more CAP/C service(s) that must be coordinated by a CAP/C case manager in order to function in the community;

5. exercises freedom of choice to enter into or maintain enrollment in the CAP/C waiver when an assessment identifies risk factors that can lead to an out of home placement or increased burden to the support system to meet the needs of an initial applicant or active beneficiary;
6. is age 0 through 20 years of age;
7. meets at least one of the conditions of each of the three individual criterion of the medically fragile criteria when requesting initial participation in the CAP/C waiver:
 - A. A medically fragile child has a primary chronic medical condition or diagnosis (physical rather than psychological, behavioral, cognitive or developmental) that has lasted, or is anticipated to last, more than 12 calendar months; and
 - B. The child's chronic medical condition:
 - i. Requires medically necessary, ongoing, specialized treatment or interventions (treatments or interventions that are supervised or delegated by a physician or registered nurse) without which likely result in a hospitalization; or
 - ii. Resulted in at least four exacerbations of the chronic medical condition requiring urgent or emergent physician-provided care within the previous 12 calendar months; **or**
 - iii. Required at least one inpatient hospitalization of more than 10 calendar-days within the previous 12 calendar months; **or**
 - iv. Required at least three inpatient hospitalizations within the previous 12 calendar months; and
 - C. The child's chronic medical condition requires one of the following:
 - i. the use of life-sustaining device(s); **or**
 - ii. life-sustaining hands-on assistance to compensate for the loss of bodily function; **or**
 - iii. non-age appropriate hands-on assistance to prevent deterioration of the chronic medical condition that may result in the likelihood of an inpatient hospitalization.
8. beneficiary is determined to have meet all the eligibility requirements for enrollment in the CAP/C waiver program and obtained approval to receive long-term care Medicaid in **one** of the categories listed below prior to the receipt of a waiver service:
 - A. Medicaid for the Blind (MAB); and
 - B. Medicaid for the Disabled (MAD);
9. a Medicaid beneficiary in the categories listed below is eligible to participate in the CAP/C waiver:
 - A. Medicaid for Children Receiving Adoption Assistance (I-AS); and
 - B. Medicaid for Children Receiving Foster Care Assistance (H-SF).

Note: MAB and MAD beneficiaries need to be approved for disability by the Social Security Administration.

Note: An application for long-term care Medicaid is only approved when all eligibility requirements for CAP/C participation are met, as referenced in **Subsection 2.1.2.**

b. NCHC

NCHC beneficiaries are not eligible for CAP/C services.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

2.2.4 EPSDT and CAP/C Participation

A Medicaid beneficiary child approved to participate in CAP/C is entitled to receive Durable Medicaid Equipment, Home Health Services, Pharmacy and other State Plan services when the eligibility requirements are met consisting of an evaluation through the EPSDT review process. A child participating in CAP/C who meets the criteria for a specific, requested Medicaid service, is not eligible to receive that specific, requested Medicaid service through CAP/C.

2.2.5 Local Education Agency Special Provision for Services at school for Beneficiary age 5 through 21 years of age

Services requested or approved for a CAP/C beneficiary, between the ages of five through 20, in the school setting or listed in an Individualized Education Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA) is the responsibility of the local education agencies (LEAs).

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Criteria Covered

- a. Medicaid shall cover medically necessary State Plan services and **CAP/C shall cover** entry into CAP/C and necessary CAP/C services for an eligible beneficiary who meets the requirements in **Subsection 2.1.2** and **all** of the following criteria:
 1. meets the required HCBS nursing facility LOC as determined by NC Medicaid and requires long-term care support at a level typically provided in an institution that is directly related to a documented medical diagnosis and functional care need;
 2. the completed CAP assessment identifies there is a reasonable indication the child would need CAP/C services within 30 calendar days of the evaluation;
 3. chooses to participate in CAP/C as evidenced by the written statement of the beneficiary or the primary caregiver on standardized forms approved by NC Medicaid; The beneficiary shall provide the written statement when he or she is age 18 years old and older and is not legally appointed a guardian. The primary caregiver or when appointed as the legal guardian acts in lieu for a beneficiary who is 17 years old and younger and shall sign all document and report all information;
 4. requires CAP/C services on a monthly basis, that are not recreational in nature that mitigate institutionalization through coordinated case management and hands on personal assistance;
 5. requires short-term enrollment in the waiver program to obtain only an installation of a home or vehicle modification or assistive technology 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) calendar months of approval);
 6. able to have his or her health, safety, and well-being maintained at their primary private residence or approved location of service for CAP/C with the use of formal and informal supports, refer to **Appendix F** for definition of informal supports;

7. has medical needs within the average per capita cost of the CAP/C Waiver; refer to **Subsection 5.7.3** and **Appendix F**;
8. has a primary physician that is able to link and coordinate all medical services.
9. able to have an assigned CAP/C slot for program entry, contingent to CAP/C allocations;
10. has an emergency back-up and disaster plan that specifies who shall provide care when key direct care staff cannot provide services or tasks as indicated in the current Plan of Care (POC), and when primary caregiver is experiencing an emergency; and
11. has been determined to be medically fragile and meet the NC Medicaid HCBS LOC criteria; Refer to **Appendix F and Subsection 2.1.2** for definition of Medically Fragile.

Note: An emergency and disaster plan is a mandatory requirement that must be completed during the service plan development or within 30 calendar days of the initial and annual CAP/C enrollment approval. The emergency and disaster plan must be updated quarterly or during an emergency or pandemic.

- b. In addition to the above requirements, when electing to direct care (**consumer direction**) all of the following criteria must be met:
 1. understand the rights and responsibilities of directing his or her own care as evidenced by a completion of a mandatory self-assessment questionnaire and successful completion of an introductory to consumer-direction training and orientation **Refer to Appendix G**;
 2. be willing and emotionally capable to assume the responsibilities of employer of record under the consumer direction by ensuring health and safety and identifying training opportunities to build competencies for him or herself and hired personal assistants as evidenced by a mandatory self-assessment questionnaire, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care (**refer to Appendix F for definition of willing and capable**).

Note: The completed self-assessment questionnaire must explicitly detail the care needs of the beneficiary, how the care interventions specifically meet the needs of the beneficiary, identifies training needs or opportunities for the employer and employees (if applicable), and how assurances of health, safety, and well-being will be managed in the areas of abuse, neglect, and exploitation, fraud, waste and abuse, and emergency and disaster planning, as refer to **Appendix G**.

- c. Meets the specific criteria listed in **Subsection 3.2.2(a)**, and the following requirements:
 1. must have approved service plan that identifies the amount, duration, frequency, and provider taxonomy of CAP/C services and non-CAP/C

services as indicated in the beneficiary's service plan and approved by NC Medicaid or designated entity;

2. must have services provided according to all requirements specified in this policy; all applicable federal and state laws, rules, and regulations; the current standards of practice; and provider agency policies and procedures; and
3. sign and adhere to the Beneficiary Rights and Responsibilities.

3.2.3 Level of Care Determination Criteria

The Home and Community-Based Services (HCBS) for CAP/C targets a beneficiary who meets an HCBS nursing facility level of care (comparable to Medicaid State Plan nursing facility level of care) due to a medical diagnosis or physical disability. The HCBS LOC determination is based on the identification of conditions, diagnoses and treatments that are indicators of a care need that meets or exceeds the Medicaid State Plan nursing facility LOC criteria; and the presence of non-age appropriate activities of daily living (ADLs) deficits that signal the need for the types of supplemental and supportive services CAP/C offers.

A LOC determination must be completed at initial enrollment. An annual LOC is determined using the result of the comprehensive assessment during the annual continued need review. Changes to a beneficiary's condition that may cause the beneficiary to no longer meet HCBS LOC may result in reassessment of LOC using the Service Request Form (SRF).

Qualifying Conditions

HCBS Nursing Facility Level of Care Criteria must require a need for any one of the following:

- a. CAP/C uses the following LOC criteria to evaluate and reevaluate LOC. 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 beneficiary 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 beneficiary'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 beneficiary 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 beneficiary 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.

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 in number 12 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 beneficiary to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the beneficiary's participation in the program and document the beneficiary's progress.

- C. Factors to consider along with the beneficiary'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).

3.2.4 Priority Consideration for CAP/C Participation

The CAP/C arranges for service consideration on a first-come, first-serve basis due to similar acuity needs of individuals applying for participation in CAP/C. When a statewide waitlist is implemented, individuals meeting specific criteria shall be prioritize to the top of an existing waitlist for CAP/C participation, Priority consideration applies to a child meeting any one of the following:

- a. an individual who was receiving personal care-type services through private health insurance plan and is still in need of those services, as evidenced by health record documentation, and the policy underwriter has determined the need to terminate the policy;
- b. transitioning from a nursing facility or a hospitalization stay greater than 90-calendar days with Money Follows the Person (MFP) designation;
- c. an individual transitioning from a 90-day hospital or nursing facility stay utilizing service of community transition;
- d. an actively eligible CAP/C beneficiary transferring to another county or case management entity;
- e. a previously eligible CAP/C beneficiary transitioning from a short-term rehabilitation placement within 90 calendar-days of the placement;
- f. a child under the age 17 years or an adult between the age of 18-20 years old identified as at-risk by their local Department of Social Services (DSS); has an order of protection by the Adult or Child Protective Service (CPS); for abuse, neglect or exploitation; and the CAP/C services are able to mitigate risk; or
- g. a Medicaid beneficiary with active Medicaid temporarily out of the State due to a military assignment of their primary caregiver.

3.2.5 Transfers of Eligible Beneficiaries

When a transfer request is received, the case management entity(CME) shall coordinate the transfer of an eligible CAP/C beneficiary to another county or

entity within 30 calendar-days or the earliest agreed upon timeframe.

- a. The CME shall coordinate the transfer as soon as possible to prevent gaps in service provisions. The following steps must be completed prior to the transfer:
 1. determined anticipated start date of service;
 2. coordinated transition plan between provider agencies;
 3. discuss and plan for the health, safety, and well-being of the beneficiary;
 4. initiate with the Information Technology (IT) contractor the transfer of the electronic health records to the receiving county;
 5. arrange for a home visit by the receiving CME to assess the primary private residence environment identifying any health and welfare concerns and planning for mitigation and safety within five business days of the date the CAP/C beneficiary moves to his or her new primary residence; and
 6. coordinate the provision of services to start on the first date the beneficiary is in his or her new primary private residence.
- b. The case management entity shall assist a CAP/C beneficiary 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.
- c. The (CME) shall assist a CAP/C beneficiary at age 20 to develop an adult transition plan in anticipation of the aging out of CAP/C at 11:59 p.m. of the 21st birthday.
- d. For an actively participating CAP/C beneficiary (current and active service plan) aging out of CAP/C and wishing to transfer to CAP/DA:
 1. The CAP/C 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; and
 - B. consultation with the CAP/C beneficiary 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 CAP/DA effective start date.
 4. On the first day of the birth or identified transfer month, CAP/C services are authorized and provided to this beneficiary.

Note: A Service Request Form (SRF) is not required. A Change of Status assessment is required to identify ongoing adult needs for the generation of an adult service plan.

- e. For a CAP beneficiary transferring to a different county:
 - 1. The CME designee of the transferring agency shall coordinate the transfer with the CME designee of the receiving agency upon the agreed upon transfer date or no less than 30-calendar days of the request to transfer.
 - 2. The CME designee of the transferring and receiving agencies shall discuss and plan for the health, safety and well-being of the beneficiary.
 - 3. The electronic health record is transferred to the receiving county.
 - 4. The CME designee of the receiving agency shall arrange for a home visit within five (5) business days of the date the CAP/C beneficiary is in his or her new primary residence to assess the environment to identify any health and welfare concerns to plan for mitigation and safety.
 - 5. The CME designee shall coordinate and plan the provision of services to start on the first date of the transfer into the receiving county.

Note: An active beneficiary previously approved to participate in CAP/C services can continue to participate in the program when a transfer to another county occurs. A transferring beneficiary continues to be eligible for CAP/C regardless of his or her county or residence, ongoing Medicaid eligibility is determined at the next Medicaid certification period.

3.2.6 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the active beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover CAP/C participation and CAP/C services under any **one** of the following circumstances:

- a. an assessment of medical and functional needs has not been completed by a nurse or social worker to determine reasonable indication of need for services, as defined in **Appendix F**.
- b. the beneficiary does not require and use CAP/C services planned in the service plan that are available to the beneficiary during a 90 calendar-day period despite case management coordination. If services designated in the service plan are not available for more than 30 calendar-days, the case manager shall contact NC Medicaid and provide information related to the lack of services to avoid potential disenrollment;
- c. the CAP/C evidence code has been removed from the eligibility information system (NC FAST) and cannot be re-entered;
- d. the HCBS Service Request Form (SRF) is either incomplete, has been denied, or a request for additional information was not received within the specified timeframe;
- e. the required annual assessment recertification was not approved or completed within 60 calendar-days of the annual assessment date;
- f. the applicant or beneficiary is receiving other Medicaid services or other third-party reimbursed services that are adequately meeting assessed needs and CAP/C services are duplicative;
- g. the applicant or active beneficiary's currently approved services (Medicaid and non-Medicaid) are meeting assessed care needs and the applicant or active beneficiary is determined to not have a reasonable indication of need for one CAP/C service (refer to **Appendix F**);
- h. ongoing waiver participation when the short-term enrolment in the waiver program to receive a home or vehicle modification or assistive technology has been met, and evidence is provided of the installation and a claim has been adjudicated by NCTracks, and no other CAP/C service was assessed to be needed during a quarterly monitoring visit;
- i. the applicant or active beneficiary's health and well-being cannot be met through an individualized person-centered service plan or the creation of a risk agreement when the applicant or active beneficiary resides in an unsafe home environment placing the eligible beneficiary at risk, listed in **Subsection 7.10**;
- j. the CAP/C beneficiary enters an institution for a short-term rehabilitation or hospital stay or long-term institutional stay (refer to **Subsection 7.14**);
- k. when a legal guardian or primary caregiver of the CAP/C beneficiary is employed to be the paid caregiver of CAP/C services, when not authorized through an emergency planning document;
 - l. the applicant or active beneficiary does not exercise his or her freedom of choice to participate in the CAP/C waiver;
- m. the applicant or active beneficiary or responsible party refuses to sign or cooperate with the established service plan and any other required

- documents, placing the applicant or eligible beneficiary's health, safety and well-being at risk (refer to **Subsection 7.10**);
- n. the CME has been unable to establish contact with the beneficiary or his or her responsible party for more than 90 calendar-days, to discuss the provision of CAP/C services listed in the plan of care, despite more than two verbal and two written attempts;
 - o. the beneficiary's Medicaid eligibility is not active or has been terminated;
 - p. the beneficiary is not approved for Medicaid in the specified categories prior to the receipt of CAP/C services in **Subsection 2.1.2**;
 - q. the beneficiary is in a Medicaid sanction period;
 - r. the beneficiary does not reside in an approved primary private residence;
 - s. the beneficiary or responsible party cannot demonstrate willingness or capability to assume the responsibilities of employer of record under the consumer direction as evidenced by repeated completion of the self-assessment questionnaire, orientation trainings, coaching and technical assistance;
 - t. the beneficiary or responsible party demonstrates as evidenced by written correspondence a continued inability or unwillingness to adhere to the rights and responsibilities of CAP/C as outlined in the "Beneficiary Rights and Responsibilities," form signed by the CAP/C beneficiary or primary caregiver, refer to **Appendix D**; or
 - u. the beneficiary has reached his or her 21st birthday by an indication of 12 midnight on the day of the 21st birthday.

Note: The CAP/C beneficiary shall be eligible to participate in CAP/C when in deductible status; however, CAP/C services are not reimbursed by Medicaid until covered medical services are incurred.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 - 1. No services for long-term care.
 - 2. No nonemergency medical transportation.
 - 3. No EPSDT.
 - 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval for CAP/C level of care services.

The provider shall obtain prior approval before rendering CAP/C services.

The provider subject to the EVV requirements shall obtain an EVV confirmation to ensure claims for personal care-type services approved in this policy are adjudicated when the EVV requirements are captured.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the CAP Business System the following:

- a. the service request form; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsections 3.2, 5.3 and 5.4** of this policy

5.2.2 Specific

The Case management entity, or designated entity, shall submit to the CAP Business System the following:

- a. HCBS Service Request Form (SRF) along with the Physician Attestation in **Appendix A**, to determine clinical eligibility for participation in the CAP/C Waiver. The SRF establishes medical fragility and the level of care and is the first indicator of whether a beneficiary is appropriate for CAP/C services. The SRF must be completed within the designated timeframe, but no more than 45 calendar-days from the initiation date. An SRF that is incomplete after 45 calendar-days of initiation will be voided. A slot is not reserved for an SRF pending over 45 calendar-days.
 1. All sections and required fields on SRF must be completed in its entirety to establish eligibility determination for medical fragility and level of care. The eligibility sections and the fields are:
 - A. Service request.
 - B. Beneficiary demographics.
 - C. Beneficiary conditions and related support needs.
 - D. Medications.
 - E. Sensory and Communication Limitation.
 - F. Mood, Behavior and Interpersonal functioning.
 - G. Cardio-Respiratory support needs.
 - H. Nutrition-related support needs.
 - I. Ancillary therapies and other support needs.
 - J. Functional limitation.
 - K. Support network.

- L. Attestation by physician.
- M. Date of LOC request.
- b. The multidisciplinary comprehensive assessment identifying assessed needs and functional level of acuity (refer to **Subsection 5.4**); and
- c. A summary of the risk indicators identified during the comprehensive assessment and recommendations of services, formal and informal, that can mitigate risk factors in establishing community integration or maintaining the community placement.

The case management entity or designated entity shall submit to the DHHS designated contractor a draft of the person-centered service plan that identifies the CAP/C and regular State Plan services in the amount, frequency, duration, and scope based on assessed needs (refer to **Subsection 5.5**) no later than 30 calendar days of an approved comprehensive assessment.

NC Medicaid or its designated entity shall review and approve person-centered service plans developed by the case management entity within the designated timeframe, but no more than 30 (annual) to 60 (initial) calendar days of the submitted service plan by the case management entity. The approval of service plan verifies there is a proper match between the beneficiary need and the service provided. This involves identification of over and under-utilized services through careful analysis of the beneficiary's needs, problems, skills, resources, and progress toward the beneficiary's goals.

Note: DHHS's designated contractor shall submit an electronic prior approval (PA) transfer to NCTracks of approval or denial of CAP/C participation, when the SRF, multidisciplinary comprehensive assessment, and signed person-centered service plan are finalized.

Note: Throughout the assessment process and service plan development, NC Medicaid may revoke administrative oversight and case management appointment if it is determined the Case Management Entity (CME) is not in compliance with CAP/C administrative requirements. In the case of revocation, the person-centered service plan development would temporarily be carried out by NC Medicaid or another designated entity.

5.3 CAP/C Participation

5.3.1 Approval Process

Inquiries and Referrals:

NC Medicaid is responsible for evaluating initial level of care and reasonable indication of need for CAP/C services through the review of comprehensive assessment completed by the case management entity (CME). The NC Medicaid makes initial LOC decisions about CAP/C participation by processing the Service Request Form (SRF) and processing the in-person needs-based eligibility enrollment paperwork (comprehensive assessment).

When a referral is submitted for CAP/C services, the CME or designated entity contacts the interested applicant within 24 business hours of the referral to

request a consent form from the applicant to initiate the gathering of health care information. The applicant shall return the consent form back to the CME or designated entity within seven (7) business days of the dated letter.

Upon receipt by the CME or designated entity of the consent form, the CME shall initiate the processing of the SRF. If the consent form is not received within the required timeline of seven (7) business days, the referral request is voided and an “unable to process” notification letter is mailed to the applicant.

Upon the completion and processing of the SRF, NC Medicaid or designated entity shall notify the applicant by mail using the CAP Business System generated notification letter.

Assessment Approval:

When a CAP/C slot is available, the approved applicant is placed in the assessment assignment queue which notifies the Case Management Entity (CME) or designated entity to arrange a face-to-face visit within the designated timeframe, but no later than 10 business days to initiate the completion of the assessment. The assessment for initial and ongoing applicants, when applicable, must be completed within the designated timeframe, but no later than 30 calendar days of the assignment in assessment assignment.

Coordinate with Medicaid Eligibility Staff:

When the applicant is placed in Assessment Assignment, the CME or designated entity shall assist the applicant, when applicable, to initiate a Medicaid application by entering in basic demographic information by consent of the applicant after the approval of SRF. The county DSS is notified of the on-line application by the CME or designated entity using the DHB- 2193 form.

The CME or designated entity shall follow up with DSS to ensure that the application is being processed during the service plan development phase of enrollment in the CAP/C waiver.

Coordination with Case Management Entity Upon the approval of **initially** approved SRF the CAP/C beneficiary is required to select a case management entity (CME) to assist with completion of the assessment and the development of the person-centered service plan.

Coordination of the Person-Centered Service Plan

The selected CME meets with the CAP/C beneficiary and his or her support system to complete the person-centered service plan. The service plan must contain person-centered goals and a listing of services in the type, amount, frequency, and duration to meet assessed needs. The CAP/C beneficiary and, when applicable, their chosen representative leads the service plan development process.

Coordinate with Medical Professionals

The CME shall coordinate and collaborate with medical professionals and CCNC to obtain medical history data and assistance with care coordination to assure appropriate linkage to medical professionals and services. This information helps

guide the assessment and the Plan of Care Development. The coordination with medical professionals also provides opportunity to confirm enrollment in a health home for the management of preventative and routine health services.

5.3.2 Minimum required documents for CAP/C participation approval:

- a. **Initial:** Contact information for the CAP/C beneficiary and primary caregiver; an approved SRF; Signed consent to release information; Signed Participants' Rights and Responsibilities; Signed Freedom of Choice for CAP/C participation and selected providers; Service plan that outlines service needs and cost summary;

Completed comprehensive multidisciplinary needs assessment that contains the acuity level; emergency and disaster plan; Job or school verification statement; when determined and applicable, the Physician's order and Individual risk agreement, if applicable; and if participating in consumer direction: confirmation of completed consumer direction training education and orientation, completed and approved self-assessment questionnaire, competency validations for each potential employee, confirmation from financial manager of employability of selected personal assistant, referral to financial management, and financial management budget.

- b. **Annual:** Updated contact information for the CAP/C beneficiary and primary caregiver; Signed consent to release information; Signed Participants' Rights and Responsibilities; Signed Freedom of Choice for CAP/C participation and selected providers; Service plan that outlines service needs and cost summary;

Completed comprehensive multidisciplinary needs assessment that contains the annual LOC assessment and functional acuity level; emergency and disaster plan;

When determined and applicable the Job or school verification statement, physician's order, when determined applicable: nurse notes, documentation or summary for Pediatric Nurse Aide (PNA) and In-Home Aide (IHA) services provided over a period of 90 consecutive days and individual risk agreement; and if participating in consumer direction: completed and approved self-assessment questionnaire;

Updated refresher training, employee's competency validation for each potential employee, confirmation from financial manager or employability of selected personal assistant, referral to financial management, and financial management budget; if selecting to participate in consumer direction during the annual assessment confirmation of completed consumer direction training education and orientation, completed and approved self-assessment questionnaire, competency validation for each potential employee, confirmation from financial manager or employability of selected personal assistant, referral to financial management, and financial management budget.

- c. **Change in Status:** Completed comprehensive assessment with summary details and approved signed service plan that outlines service needs and cost of services; and when applicable updated contact information for the CAP/C beneficiary and primary caregiver; signed consent to release information;

signed participant's rights and responsibilities; signed freedom of choice form with selected providers; updated emergency and disaster plan; when determined and applicable, job or school verification statement, Physician's order; and when determined applicable, individual risk agreement, nurse notes, documentation or summary for PNA and IHA services provided over a period of 90 consecutive days.

5.4 CAP/C Comprehensive Multidisciplinary Needs Assessment Requirements

A Nurse who holds a current North Carolina license shall complete an initial and annual multidisciplinary assessment.

Upon completion of the assessment the Nurse shall consult with a multidisciplinary team, which must consist of, at a minimum a social worker, and other disciplines as determined appropriate based on the CAP/C beneficiary's needs. If there are significant concerns related to social determinants of health identified in the comprehensive assessment, such as psychosocial, behavioral, or environmental issues, the Multidisciplinary team (MDT) makes a determination if the other member(s) of the MDT shall conduct a face-to-face visit to assess the home environment to assure planning for the health, safety and well-being of the beneficiary.

The comprehensive needs assessment is completed on each applicant and active beneficiary to determine medical, physical and psychosocial functioning acuity level to plan for all the beneficiary's assessed needs. The assessor assigned to complete an initial comprehensive assessment shall review in detail with the applicant and support system each of the below listed assessment modules:

- a. Contact information;
- b. Diagnosis and history;
- c. Caregiver information;
- 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;
- o. Housing and finances;
- p. Early Intervention and Education; and
- q. Attestations by the assessors.

5.4.1 Initial Multidisciplinary Comprehensive Assessment

The initial multidisciplinary comprehensive assessment is conducted after the determination of the level of care derived from the SRF. The initial assessment is

completed by the case management entity (CME) or designated entity. Each field in the assessment must be completed prior to the initiation of the service plan. The Multidisciplinary comprehensive assessment must be completed within the designated timeframe, but no later than 30 calendar-days of the referral to the assessment assignment workflow.

Note: When a Service Request Form is approved, the CME or designated entity can initiate an on-line Medicaid application referral for the applicant to apply for Medicaid, if applicable.

Upon completion and NC Medicaid approval of the SRF and the comprehensive assessment, the CAP/C beneficiary or designated representative shall agree to select participation in the CAP/C Waiver.

5.5 CAP/C Person-Centered Service Plan Requirements

The medical, functional, and social information collected through the multidisciplinary comprehensive need's assessment is documented in a service plan in the form of identified service needs, beneficiary's risks, and informal caregiver supports' needs. The service plan is initiated after the completion of the multidisciplinary comprehensive assessment and must be in draft form within the designated timeframe, but no later than 30 calendar days of the completed assessment for review and approval by NC Medicaid or designated entity.

The CME shall work closely with the applicant or beneficiary to develop a person-centered service plan based on the needs and risks identified in the completed assessment. A person-centered service plan allows the applicant or beneficiary to identify preferences, likes and dislikes to create a care plan of both formal and informal supports. The completed person-centered plan must contain a plan of care (POC) that lists all approved CAP/C and non-CAP/C services in the type, amount, frequency and duration. The annual average per capita cost for these services must be listed in the POC to evaluate annual cost of care needs.

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 CAP/C beneficiary. The services documented on the service plan effectively meet the needs identified in the assessment. The CME shall use the service plan to achieve the following:

- a. summarize the evaluation and assessment information to highlight the beneficiary's strengths and needs;
- b. outline person-centered goals, objectives, and case management tasks based on the assessment and identified needs;
- c. identify beneficiary's outcomes to be supported;
- d. develop a comprehensive list of CAP/C and non-CAP/C services, medical supplies and durable medical equipment (DME), and document the authorized provider name, amount, frequency and duration of each service;
- e. summarize plan of care cost totals to ensure the Medicaid and CAP/C services are within the average established cost limit;
- f. identify health and welfare monitoring priorities during the service plan period;

- g. ensure the beneficiary's right to choose to participate in CAP/C using direct-led or consumer-directed services, and among service providers to render the approved CAP/C services, as evidenced by a signed provider Freedom of Choice form;
- h. identify health and welfare monitoring priorities during the mandatory quarterly monitoring timelines;
- i. develop a service plan annually and update the POC when warranted due to status changes in the CAP/C beneficiary's care needs.

Note: The annual service plan must be approved by the first day of the month following the Continue Need Review (CNR) assessment month.

5.5.1 Changes and Revision to the Service Plan

The Case Management Entity (CME) along with the CAP/C beneficiary determines whether to revise the person-centered service plan when there is a significant change in the beneficiary's needs. A service plan revision is required when a CAP/C, Medicaid State Plan, or Medicare service is added, reduced, increased, deleted, or when there are changes in type, scope, amount, duration, or frequency of a CAP/C service.

Note: Specified plan of care revisions may require a minor change to the approval without the legal guardian or the primary caregiver's signature. The e-CAP Business System provides guidance in that area.

Service plan revisions, excluding goods and services, training, education, and consultative services, home and vehicle modifications and assistive technology, may be approved retroactively for up to 30 calendar days, when an urgent need is identified that places the CAP/C beneficiary at risk of losing his or her community placement. The service, equipment or supply cannot be procured prior to the first day of the 30-calendar day retroactive date. The beneficiary or the primary caregiver shall agree to and sign and date the service plan acknowledging changes for CAP/C provision.

Documenting a change in services: The CME shall revise the service plan as the beneficiary's needs change. Changes to the service plan are submitted in the web-based case management system within 30 calendar days of the request by the CAP/C beneficiary and must be approved within the designated timeframe, but no more than ten (10) calendar-days of the entered revision.

Documenting a change of provider agency: A service plan update is required for a change in provider agency, the change is a revision, but external review is not needed. The CME shall obtain a signed agreement from the CAP/C beneficiary or the responsible party consenting to the change in provider(s). The freedom of provider choice form must be uploaded to CAP Business System. The change in provider excludes the hiring of a new employee under the consumer direction program.

5.5.2 Assessment and Person-Centered Service Plan Denials

If the multidisciplinary comprehensive assessment or the person-centered service plan is not approved, the designated entity or NC Medicaid notifies the CAP/C beneficiary or legal representative through an electronically generated notice that is mailed to the CAP/C beneficiary. NC Medicaid or the designated entity

notifies the Department of Social Services' (DSS's) eligibility unit of the multidisciplinary comprehensive assessment or service plan denial decision.

If an initial person-centered service plan is not submitted with an authorized signature (beneficiary or legal representative) the CAP/C applicant becomes ineligible for participation in the CAP/C Waiver. Until a signature is obtained that is within 30 calendar days of the initial waiver enrollment approval. If an annual person-centered service plan is not submitted with an authorized signature (beneficiary or legal representative) the CAP/C beneficiary becomes ineligible for continuation of participation in CAP/C until a signature is obtained. If a signature is not obtained within 30 calendar days of the service plan effective date, the CAP/C beneficiary becomes ineligible for continuation of participation.

The DHHS designated contractor or NC Medicaid shall disenroll the beneficiary from CAP/C. The CAP/C beneficiary is notified in writing of the disenrollment. The DSS is notified of the CAP/C disenrollment and the DSS shall notify the CAP/C beneficiary of his or her continued eligibility for Medicaid in the same Medicaid category or a different Medicaid eligibility category.

If the CAP/C beneficiary willfully withdraws from CAP/C and requests to re-enter CAP/C, he or she may re-enter within 90 calendar days of the disenrollment without having to reapply. Reenrollment paperwork consists of the assessment, service plan, rights and responsibility form and freedom of choice form is required to be completed for CAP/C services to begin. CAP/C services are not approved during the period before the reentry process or retroactively approved once services are reinstated.

If the CME or designated entity, does not determine the CAP/C applicant or beneficiary to have a reasonable indication of need for one CAP/C service based on the comprehensive assessment and exception reviews validate this decision, the child or legal representative is notified in writing of the denial of CAP/C participation. The CME or designated entity notifies the DSS using the CAP Business System generated notice of the denial.

5.6 Continued Need Review (CNR) Assessment Requirements

A CNR assessment must be completed at least every 12 consecutive months to determine ongoing need for CAP/C participation and the identification of medical, functional, and psychosocial care needs of the beneficiary for safe community living. The CNR assessment must be completed at the latest within the month of initial CAP/C effective month. A best practice initiative to ensure the assessment and service plan are completed timely, is to begin the completion of the assessment one or two months prior to the CAP/C effective month. The service plan must not be initiated prior to the completion of the comprehensive assessment.

Note: The CAP Business system prompts the CNR work task 60-90 calendar days in advance of the CNR due date.

The CNR assessment follows the same requirements identified in **Subsection 5.4**

During the CNR, the multidisciplinary assessment verifies the LOC continues to be met. When the multidisciplinary assessment cannot clearly validate LOC is met, a new SRF is processed by the CME or designated entity to validate the LOC.

The CNR assessment consists of the following:

- a. completed multidisciplinary comprehensive assessment that identifies LOC and ability to live safely in the community; and
- b. developed and approved person-centered service plan that identifies the beneficiary's preferences, strengths, needs as evidence of completed assessment.

5.6.1 Annual Person-Centered Service Plan Requirements

The annual service plan must be approved by the first day of the month following the identified CNR assessment month and have an effective date for the first day of the month following the CAP/C initial enrollment month. The service plan expires 13 months after the service plan effective date, or an alternative date determined by NC Medicaid.

The CME shall work closely with the CAP/C beneficiary to develop a person-centered service plan based on the needs identified in the completed assessment. A person-centered service plan allows the CAP/C beneficiary to identify preferences, likes and dislikes to create a care plan of both formal and informal supports. The completed person-centered plan must contain a plan of care (POC) that lists all approved CAP/C and non-CAP/C services in the type, amount, frequency and duration. The annual average per capita cost for these services must be listed in the POC to evaluate annual cost of care needs.

The CME shall use the service plan to achieve the items listed in **Subsection 5.5**.

5.6.2 CAP/C Effective Date

The effective date for CAP/C participation is the **latest** of the following:

- a. the date of the Medicaid application;
- b. the date the case was approved for an assessment and placed in assessment-assignment in CAP Business System;
- c. the date of deinstitutionalization; or
- d. in the event of an appeal, the date the Court issues the order, settlement decision, or other document concluding the appeal.

5.6.3 Authorization of Services

If the CAP/C beneficiary or legal representative agrees to participate in CAP/C by signing the freedom of choice form and signs the person-centered service plan at which time, CAP/C participation is approved. The Case Management Entity (CME) shall authorize selected providers according to the approved service plan through service authorizations for approved CAP/C services. The service authorization must detail the approved CAP/C services authorization period, the specific benefit services, and the tasks to be provided in the amount, duration, frequency, and type. The CME shall confirm with the chosen provider the receipt and acceptance of the service authorization within 72 hours of submission of the form. The authorized Medicaid provider shall accept or reject the service

authorization within three (3) business days. Once the authorized Medicaid provider accepts a service authorization in the CAP Business System, a prior approval record for the approved CAP/C service is transmitted to the DHHS fiscal contractor.

The service authorization expires 13 consecutive months from the effective date of the initially approved service plan, or an alternative date determined by NC Medicaid.

Under special circumstances the authorization period may be extended at which time a prior approval segment is transmitted to the DHHS fiscal contractor.

Note: The Case Management Entity (CME) shall use NC Medicaid-approved forms containing the same information for service authorizations and participation agreements.

Regular Medicaid State Plan providers approved to render a Medicaid service to a CAP/C beneficiary receive a service authorization or participation notice acknowledging medical necessity has been met to receive the service as outlined in the provider's plan of care. The Medicaid provider shall follow the policies and procedures governed by that program.

5.7 CAP/C Service Requests and Required Documentation

5.7.1 Assistive Technology, Equipment, Supplies, Home Accessibility and Adaption, and Vehicle Modifications

For requests for assistive technology equipment and supplies, home modification, and vehicle modification, the following additional information is required:

- a. a recommendation by the MDT that identifies the beneficiary's need(s) regarding the assistive technology, equipment and supply or home modification being requested. The recommendation must state the cost of the item;
- b. a plan for how the beneficiary and family is to be trained on the use of the equipment upon installation (the training must be documented by the case manager as completed and signed by the CAP/C beneficiary or responsible party upon the receipt or installation of the approved service);
- c. evidence of medical need submitted by a physician, when applicable;
- d. shipping costs, itemized in the request proposal;
- e. a signed agreement consenting to the disenrollment from CAP/C upon the agreed completion of modification or installation of the technology when entering CAP/C only for supplies, technology and modifications;
- f. other information as required for the specific equipment or supply requested;
- g. when quotes are required for purchase, adaptation or modification, NC Medicaid shall determine, based on the request and the geographical region, how many quotes are required to yield a decision of the approved cost for the adaptation or modification; and
- h. NC Medicaid shall determine the appropriate professional(s) that make written recommendations for services that require those recommendations.

For requests for **assistive technology** equipment and supplies, the following additional information is required:

- a. An assessment or recommendation by an appropriate professional, as determined by the requested need, that identifies the beneficiary's need(s) with regard to the equipment and supplies being requested. The plan of care (POC) must state the cost of an item that a beneficiary requires.
- b. When applicable, a safety back-up plan that includes the following components:
 1. designation of a responsible party that is on-call or on-duty;
 2. back-up plan in the event of system failure; and
 3. timeframe for responding to specific types of emergencies.

Note: Assistive technology, equipment, supply, home modification, and a vehicle modification that continues to be needed at the time of the annual reassessment must be identified during the multidisciplinary assessment and planned in the annual service plan.

For requests for adaptive car seats, the following additional information is required:

- a. CAP/C beneficiary shall have a documented chronic health condition which requires the use of an adaptive car seat for positioning. Car seats are not approved for behavioral restraint.
- b. Case Management entities, along with the designated professional, shall determine medical need for adaptive car seat by the following:
 1. CAP/C beneficiary's weight;
 2. CAP/C beneficiary has a documented seat to crown height that is longer than the back height of the largest child car safety seat if the beneficiary weighs less than the upper weight limit of the current car seat.
 3. reasons why the beneficiary cannot be safely transported in a car using a seatbelt or convertible or booster seat for a CAP/C beneficiary weighing 30 pounds and more; and
 4. certification of necessary care, assessment requirements, and quotes.

For **Home Accessibility and Adaption**, the following additional information is required:

- a. Assessment by a physical therapist, occupational therapist, rehabilitation engineer, adaptive technology professional, or designated and approved individual professional that identifies the beneficiary's need(s) for a home modification request.

For **Vehicle Modification**, the following additional information is required:

- a. A recommendation by a physical therapist or occupational therapist specializing in vehicle modification, a rehabilitation engineer, or designated and approved individual professional.
- b. The recommendation must contain information regarding the rationale for the selected modification, the beneficiary's or primary caregiver's ability to manipulate the modifications, the pre-driving assessment of the beneficiary if

- the beneficiary is driving the vehicle, condition of the vehicle to be modified, the insurance on the vehicle to be modified and an evaluation of the safety and life expectancy of the vehicle in relationship to the modification.
- c. If purchasing a vehicle with an existing ramp or lift on it, the price of the used lift on the used vehicle must be assessed and the current value may be approved under this service definition to cover this part of the purchase price. The beneficiary shall not take possession of the vehicle with the existing ramp or lift prior to the approval by NC Medicaid or its designee.
 - d. The modification must meet applicable standards and safety codes. The Case Management Entity (CME) shall conduct a quality assurance check on the completed adaptation to ensure health and safety of the CAP/C beneficiary.
 - e. Documentation of car insurance to cover the modification.
 - f. If equipment is moved from one vehicle to another, an evaluation of the cost for labor and costs of moving devices or the equipment is required prior to approval.

5.7.2 Supportive Services

For requests for supportive services such as community transition, consumer direction, caregiver training, education, and consultative services, the following additional information is required for:

- a. **Community Transition;**
An itemized Community Transition Checklist.
- b. **Caregiver Training, Education, and Consultative Services;**
Short and long-range outcomes directly related to how the requested service or treatment aids in decreasing the beneficiary's dependence or increase the beneficiary's independence or increase the primary caregiver(s) ability to provide care and to support the CAP/C beneficiary.
- c. **Consumer Direction election:**
 - 1. A completed self-assessment questionnaire (refer to **Subsection 3.2.2.b** and **Appendix G**);
 - 2. Representative Needs Assessment and Representative Designation or Agreement, as applicable;
 - 3. Authorization from the financial manager of employability of the selected personal assistant;
 - 4. Verification of the submission of the personal assistant competency forms confirming ability of hired staff to perform in role of personal assistant;
 - 5. Verification of completed required training; and
 - 6. Consumer Direction Agreement packet approved by NC Medicaid.

The consumer direction beneficiary shall maintain timesheets and workflow sheets of his or her hired assistance that are consistent with the Medicaid record and retention policy.

If the consumer direction beneficiary transfers back to provider-led planning, the CME shall take possession of those files and maintain those files consistent with the record and retention policy.

5.7.3 CAP/C Budget Limits

CAP/C service provisions are planned at an average per capita cost per year of \$129,000.

To assure cost neutrality of the waiver, a cost analysis of the total CAP/C budget and each beneficiary's cost expenditure must be conducted quarterly. When the average per capita cost of the universe of CAP/C services are 75 percent over the average per capita cost of institutional care, NC Medicaid shall do the following:

- a. Develop a cost utilization plan with a timeline of 90 calendar-days to align the universe of CAP/C expenditure within the CAP/C budgetary limits;
- b. Implement a 60 calendar-day cost adjustment plan if the 90 calendar-day cost utilization plan is not able to align with the established budgetary limits; and at the end of the 60 calendar-days, if the cost adjustment plan fails to align the universe CAP/C budget with the established budgetary limit, individual service utilization limits up to \$129,000 must be implemented until the waiver is within the cost neutrality limits. A beneficiary impacted by cost adjustment plan during this time is carefully case managed to identify other formal and informal resources to absorb a portion of the cost of care.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

In-home aide services and pediatric nurse aide services are rendered by a paraprofessional. (Refer to **Appendix B** for service-specific requirements).

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

N.C. Home Care Licensure Rules (10A NCAC 13J)

NC Board of Nursing, <http://www.ncbon.com/>

Federally Recognized Tribes are eligible to provide all CAP/C services when the following items are met.

Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2(10) be licensed or recognized under the State or local law where the provider is located shall be deemed to have been met:

- a. when a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and
- b. if the provider entity meets all applicable standards for such licensure or recognition.

The licensure or recognition must be deemed to have been met regardless of whether the entity obtains a license or other documentation under State or local law.

Providers(s) shall comply with Section 12006 1903(1) (Electronic Visit Verification, EVV) of the 21st Century Cures Act and any subsequent amendments to validate in-home visit(s) rendered for personal care type services approved in this policy.

NC Medicaid shall require the following provider qualifications and training be completed before staff is assigned to provide in-home aide services and pediatric nurse aide to the CAP/C beneficiary:

- a. initial criminal background check and a renewal check when warranted or request;
- b. verification of cardiopulmonary resuscitation (CPR) certification every two years, coinciding with expiration dates;
- c. review of trainings and beneficiary-specific competencies at each job performance review as per agency policy;
- d. completion of NC Medicaid HCBS Orientation; and
- e. have written documentation that recipients of in-home aide and pediatric nurse aide services were informed of the EVV requirement;
- f. complete all required EVV trainings prior to providing in-home aide and pediatric nurse aide services;
- g. train staff on use of EVV system selected; and
- h. ensure administrator, essential personnel and staff within organization participates initial EVV training; and annual and refresher training in EVV, when applicable.

NC Medicaid shall require supervision of the Certified Nursing Assistant (CNA) to be performed at least minimally every 60 calendar days, in the home, by the RN Supervisor.

The following types of staff provide CAP/C services:

- a. Certified Nursing Assistant I, or
- b. Certified Nursing Assistant II

6.2 Case Management Entity (CME) Qualifications

Local case management entities are appointed by NC Medicaid to provide day-to-day oversight of CAP/C in the community (refer to **Subsection 6.2.3**). Competencies of appointed case management entities are evaluated quarterly and documented by a compliance score (refer to **Subsection 7.17**).

The CME shall be an organization with five (5) or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and

community-based services. Each CME shall enroll as a Medicaid provider and be appointed through an agreement with Medicaid to coordinate and manage CAP/C beneficiaries and their services. Every five years, the CME must recertify as a Medicaid provider.

If a CME does not meet the requirement of five (5) years of experience, NC Medicaid shall provide technical assistance for a period of one (1) calendar year, for the agency to build competencies to become approved to coordinate and manage CAP/C beneficiaries and their services independently. NC Medicaid shall approve the CME when it demonstrates the ability to coordinate and manage CAP/C beneficiaries and services.

6.2.1 CAP/C Mandated Requirements to be An Appointed Case Management Entity (CME)

Qualified Case Management Entities shall have:

- a. a resource connection to the service area to provide continuity and appropriateness of care;
- b. experience in pediatrics, medical-complexities, and physical disabilities of all ages;
- c. policies and procedures in place that align with the governance of the state and federal laws and statutes;
- d. three years of progressive and consistent home and community base experience;
- e. ability to provide case management by both social worker and nurse;
- f. physical location;
- g. computer technology and information technology web-based connectivity to support the requirement of current and future automated programs;
- h. meet the regulatory criteria under DHHS or DHSR, if applicable;
- i. staff to participant ratio (appropriate case mix);
- j. confirm the rendering of services within five calendars (5) days of submission of the service authorization;
- k. qualified staff as listed in **Subsection 6.2.1**; and
- l. signed agreement to accept the roles and the responsibility of case management entity, that attest to the adherence of the provision and implementation of the CAP/C HCBS waiver.

The case manager or care advisor shall meet one of the following minimal qualifications:

- a. Bachelor's degree in social work from an accredited school of social work, and one year of directly related experience of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care, and the completion of a NC Medicaid-certified training program within 90 calendar-days of employment;
- b. Bachelor's degree in a human services or equivalent field from an accredited college or university with two or more years of community experience (preferably case management) in the health or medical field directly related

- to homecare, long-term care, or personal care and the completion of a NC Medicaid-certified training program within 90 calendar-days of employment;
- c. Bachelor's degree in a non-human services field from an accredited college or university with two or more years of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a NC Medicaid-certified training program within 90 calendar-days of employment; or
 - d. Registered nurse who holds a current North Carolina license, two-year or four-year degree, one year case management in homecare, long-term care, personal care or related work experience and the completion of a NC Medicaid-certified training program within 90 calendar-days of employment.

Note: An individual with a bachelor's degree or who holds a nursing license as described above, without the number of years of experience, may be designated as an apprentice and shall be hired to act in the role of case manager. The supervisor of the case management shall provide direct supervision and approve all CAP/C workflow documentation and tasks.

Case Manager Continuing Education Requirements

The case manager or care advisor shall complete nine contact hours of continuing education hours per calendar year, of which person-centered training; legislation training related to health care disability and reimbursement strategies; abuse, neglect, exploitation, and program integrity (PI) are mandatory.

Each case manager shall complete a required training curriculum annually as listed below:

- a. Bloodborne Pathogens and Infection Control;
- b. Health Insurance Portability Accountability Act (HIPAA);
- c. End of life planning;
- d. Cultural Diversity, Competency and Awareness; and
- e. Completion of the following NC Medicaid program-specific training modules within one calendar year of implementation of this clinical coverage policy and within one calendar year for a newly hired case manager or care advisor:
 - 1. Introduction to CAP/C;
 - 2. Case Management 101 for HCBS providers;
 - 3. Person-Centered planning;
 - 4. Prior approval Policies and Procedures;
 - 5. Health, Safety and Well-being and Individual Risk Agreement;
 - 6. Consumer direction;
 - 7. Due Process;
 - 8. EPSDT;
 - 9. Money Follows the Person Transition Coordination;
 - 10. Program Integrity (PI);
 - 11. Quality Assurance and Performance Outcomes; and

12. Critical Incident Reporting.

6.2.2 Coordination of Care Performed by the Case Management Entity (CME)

CAP/C beneficiaries are eligible to receive all Medicaid services according to Medicaid policies and procedures, except when those policies or procedures restrict participation or duplicate another Medicaid or other insurance service. The CME is responsible for the following activities: CAP/C administrative oversight, care coordination through assessing, care planning, referring or linking and monitoring, and following up.

Case management and care coordination services are necessary to identify needed medical, social, environmental, financial, and emotional needs and to avert adverse occurrences. These services are provided to maintain the beneficiary's health, safety, and well-being in the community. It is a required component of CAP/C that a case management activity is performed at least monthly and a multidisciplinary case management assessment of health, safety and well-being performed quarterly (refer to **Subsection 7.6**).

6.2.3 Appointed Case Management Entities are Required to Provide Case Management as follows:

The principle activities of case management are:

a. Assessment

An initial and annual and comprehensive assessment (refer to **Subsections 5.4 and 5.6**) to:

1. assess all aspects of the beneficiary, including medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational and other areas;
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 the assessment adequately reflects needs to be met through the service plan;
4. review completed assessment and other summary information to assist with identifying care needs, risk indicators and support system;
5. integrate all other current assessments such the comprehensive clinical assessment, medical assessments, and any other appropriate assessments; and
6. reassess in the required monitoring intervals to determine whether a beneficiary's needs or preferences have changed to make a recommendation for appropriateness of services or a need for change in status assessment.

Case Manager - Assessment Core Knowledge, Skills, and Abilities

The case manager or care advisor shall possess the following knowledge, skills and abilities:

Knowledge of:

1. Formal and informal assessment practices.
2. The population, disability and culture of the beneficiary being served.

Skills and Abilities to:

1. apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and giving options;
2. develop a trusting relationship to engage beneficiary and natural supports;
3. engage a beneficiary and his or her family to elicit, gather, evaluate, analyze and integrate pertinent information, and form assessment conclusions;
4. recognize indicators of risk (health, safety, mental health or 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 beneficiary preferences;
6. consult other professionals and formal and natural supports in the assessment process; and
7. discuss findings and recommendations with the beneficiary and his or her representative, when applicable, in a clear and understandable manner.

b. Care Planning

Care planning is the development and periodic revision of a person-centered service plan based on the information collected through the assessment and reassessment process. The service plan identifies all formal services received in the amount, frequency and duration. The service plan also identifies both formal and informal supports to assure the health, safety and well-being of the beneficiary.

Amount, duration, frequency, and provider type of services are indicated in the beneficiary's CAP/C plan of care (POC). Approval for non-CAP/C services remains with the approval authority for the specific service. The local approval authority (LAA) approves CAP/C services and the overall POC.

Services must be provided according to all requirements specified in this policy: all applicable federal and state laws, rules, and regulations; the current standards of practice; and case management entity policies and procedures.

Case Manager - Care Planning Core Knowledge, Skills, and Abilities

The case manager or care advisor shall possess the following knowledge, skills, and abilities;

Knowledge of:

1. the values that underlie a person-centered approach to providing service to improve beneficiary functioning within the context of the beneficiary's culture and community;
2. models of chronic disease management, wellness 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 group meetings to promote beneficiary and family involvement in case planning and decision-making; and
5. services and interventions appropriate for assessed needs for the development of a service plan;
6. beneficiary focused person-centered practices; and
7. emergency and disaster safety planning.

Skills and Abilities to:

1. identify and evaluate a beneficiary's existing and accessible resources and support systems; and
2. develop an individualized care plan with a beneficiary and his or her supports based on assessment findings that contain measurable goals and outcomes.

c. Referral and Linkage

Referral and related activities link a beneficiary with medical, behavioral, social, and other programs, services, and supports to address identified needs and achieve goals specified in the service plan. The case manager or care advisor shall coordinate with other human services agencies as specified in the service plan.

Referral and Linkage Core Knowledge, Skills, and Abilities

The case manager or care advisor shall possess the following knowledge, skills, and abilities:

Knowledge of:

1. community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, recreation, and housing resources; and
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 the beneficiary;
2. maintain consistent, collaborative contact with other health care providers and community resources throughout the continuum of services;
3. initiate services in the service plan in order to achieve the outcomes derived for the beneficiary's goals; and
4. assist the beneficiary in accessing a variety of community resources.

d. Monitoring and Follow-up

Monitoring and follow-up are key tasks for case managers or care advisors to identify what services and interventions do and do not work and what other potential services and interventions can be arranged to address an ongoing or newly assessed need. When the case manager is performing monitoring and follow-up tasks, announced and unannounced visits with the beneficiary, responsible party, and service providers may be conducted to ensure that the service plan is effectively implemented and adequately addresses the needs of the beneficiary.

Case Manager - Monitoring and Follow-up Knowledge, Skills, and Abilities

The case manager or care advisor shall possess the following knowledge, skills and abilities:

Knowledge of:

1. outcome monitoring and quality management;
2. models of chronic disease management, wellness and preventative intervention; and
3. community beneficiary-advocacy and peer support groups.

Skills and Abilities to:

1. collect, compile and evaluate data from multiple sources;
2. modify care plans as needed with the input of the beneficiary, professionals, and natural supports;
3. discuss quality-of-care and treatment concerns with the beneficiary, professionals, formal and natural supports;
4. assess the motivation and engagement of the beneficiary and his or her supports; and
5. encourage and assist a beneficiary to be a self-advocate for quality care.

6.3 General Case Management Responsibilities

NC Medicaid is the administrative authority of the CAP/C waiver. The case management entity shall comply with the following NC Medicaid requirements:

- a. CAP/C application, rules, policy and procedures;
- b. provider enrollment;
- c. authorization of qualified providers for the provision of program services in the community;

- d. program rates and limits;
- e. CAP/C enrollment;
- f. level of care evaluation;
- g. beneficiary service plans;
- h. prior authorization of services;
- i. utilization management;
- j. quality assurance and quality improvement strategy (QIS Framework);
- k. continuous quality improvement;
 - l. performance measures and benchmarks for the CME; and
- m. audits and reports.

6.4 Specific Case Management Entity Responsibilities

The Case Management Entity (CME) is the local entry point for CAP/C enrollment and management. The CME shall:

- a. develop referral procedures according to NC Medicaid standards and community standards of care and share these procedures with the appropriate providers and organizations;
- b. educate the caregiver of children, about CAP/C services;
- c. process referrals for CAP/C enrollment consideration;
- d. provide assistance in obtaining documentation from medical staff to confirm need for specific CAP/C services;
- e. assess beneficiary's appropriateness for CAP/C services, initially and annually;
- f. provide case management or care advisement to the CAP/C beneficiary;
- g. ensure service limits, beneficiary monitoring details, quality assurance reporting and beneficiary risk mitigation are part of the service plan;
- h. complete critical incident reports within 72-hours of the incident; and
- i. address beneficiary complaints and grievances within five business days of the voiced concern.

6.5 Medicaid Provider Requirement to Provide CAP Services

Medicaid providers seeking to provide CAP/C services shall be approved by NC Medicaid through a managed change request. Each selected Medicaid provider of CAP/C services shall undergo a CAP/C overview and orientation training prior to rendering authorized services, and annually thereafter.

The CAP/C provider shall attest to having policies and procedures that identifies the assurance of nonuse of restraints and seclusions.

6.5.1 Providers for Community Transition Funding

Medicaid providers who have the capacity as verified by the CME (refer to **Appendix B**) to provide items and services of sufficient quality to meet the need for which they are intended shall provide transition services. Items and services must be of sufficient quality and appropriate to the needs of the beneficiary. The vendor of service shall provide a receipt or invoice for each purchase for each

reimbursement. Some items may be purchased directly through a retailer, if the item meets the specifications of this service definition.

6.5.2 Providers for Home Accessibility and Adaptation Modifications

Home accessibility equipment and supplies procured through Medicaid must be provided by an enrolled Medicaid Durable Medical Equipment and Supplies (DME) provider. The CME, through a service authorization, authorizes providers who have demonstrated the ability to perform home modifications and installation of equipment. When indicated by the service authorization, the CME shall be the listed provider to submit a claim to Medicaid Management Information System (MMIS) for the home modification taxonomy, and subsequently reimburse the approved home modification contractor through an invoice which identifies the completion of the modification.

6.5.3 Providers for Institutional Respite Services

Institutional respite services must be provided in a Medicaid certified nursing facility or a hospital with swing beds under 10A NCAC 13D rules for the licensing of nursing homes.

6.5.4 Providers for In-Home Respite Services

In-Home respite services must be provided by a homecare agency licensed by the State of North Carolina according to 10A NCAC 13J.1107, In-Home Aide Services, pediatric nurse aide or nurse aide respite service. If the beneficiary's service plan requires the personal care aide, who provides extensive assistance and substantial hands-on care to a CAP/C beneficiary who is only able to perform part of the activity, the personal care aide shall be listed on the Nurse Aide Registry according to G.S. 131E-256. This applies to provider-led in-home respite.

The providers subject to the EVV requirements that provide In-Home respite shall comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments, when applicable.

Note: It is the responsibility of the CME and provider agency to monitor the respite hours so as not to exceed the maximum limits.

6.5.5 Providers for Specialized Medical Equipment and Supplies

When applicable, the CME through a service authorization, authorizes providers who have demonstrated the ability to supply requested equipment and supplies.

6.5.6 Providers for In-Home Care Aide

Personal care aides are provided by home care agencies licensed by the state of North Carolina who comply with 10A NCAC 13J .1107. A spouse, parent, child or sibling of the CAP/C beneficiary may be employed to provide this service **only** if the person meets **all** the following:

- a. CAP/C beneficiary and provider are 18 years of age or older;
- b. meets the aide qualifications; or deemed competent by the appropriate licensed supervisory professional of the in-home care agency to provide the personal care task at that level as defined by the Board of Nursing; and

- c. any employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the CAP/C beneficiary. This restriction applies to other relatives and hired personnel.
- d. provider(s) subject to the EVV requirements must comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments.

6.5.7 Provider for Pediatric Nurse Aide

Home Health providers shall comply with 10A NCAC Chapter 13 Subchapter J; and be in compliance with North Carolina Health Services Regulation in the management of this service.

A spouse, parent, child or sibling of the CAP/C beneficiary may be employed to provide this service **only** if the person meets **all** the following:

- a. CAP/C beneficiary and provider are 18 years of age or older;
- b. meets the aide qualifications; or deemed competent by the appropriate licensed supervisory professional of the in-home care agency to provide the personal care task at that level as defined in 10A NCAC 13J.1110; and
- c. any employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the CAP/C beneficiary. This restriction also applies to other relatives and hired personnel.
- d. provider(s) subject to the EVV requirements must comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments.

6.5.8 Provider for Financial Management

The provider for financial management shall:

- a. be approved by Medicaid as a fiscal intermediary and have the capacity to provide financial management services through both the Budget Authority or Employer Authority model, refer to **Appendix F**;
- b. be authorized to transact business in the State of North Carolina; and
- c. have three years of financial management experience.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements;
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for

Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s);

- c. All CME shall enter all CAP/C workflow requirements in the CAP Business system within the specified timeline. The workflow requirements include referrals, assessments, service plan development, critical incident reports, grievances and complaints, case notes, monitoring visits notes and other supportive documentations; and
- d. All CAP/C approved service providers shall use the CAP Business system to accept or reject service authorizations and participation notices, submit referrals to the CME and enter critical incident reports, grievances and complaints.

7.2 Service Record

A service record must be maintained on each CAP/C beneficiary in the CAP Business System by the CME and approved CAP/C provider(s). A service record is a collection of electronic and printed material that provides a documentary history of the CAP/C beneficiary's HCBS participation and service interventions. The documentation in the service record must comply with all applicable federal and state laws, rules, and regulations.

The CME shall retain the referral information, the current annual completed assessments, service plan and service authorizations, the current waiver year participation case management notes, and any other related correspondence through the required retention timeline. In the event of an audit or the entity is no longer acting in the role of CME, the CME or entity shall request a release of records from the CAP Business System for the timeframe listed in the audit.

7.3 General Documentation Requirements for Reimbursement of CAP/C Service

The minimum service documentation requirements of CAP/C are listed below. All Medicaid providers shall document services prior to seeking Medicaid reimbursement. The Case Management Entity (CME) shall perform follow-up documentation to verify the provision of the service, or to reflect attempts to ascertain why a CAP/C beneficiary is not participating in an approved service according to the established service plan or schedule.

The in-home aide, home health agency and financial management entity must document in their records the confirmation the paid live-in caregiver shares the same address as the CAP participant.

- a. The documentation includes two supporting pieces of evidence, one of which must be a driver's license or another valid photo ID and the other a utility-type or credit card statement/bill, a residential lease agreement, school enrollment forms if enrolled in school or graduated from school within the past three months, or an acceptable piece of evidence approved by NC Medicaid at the request of the provider.
- b. These two supporting pieces of evidence must list the address of the paid live-in caregiver to be the same address as the waiver participant which must be confirmed beginning on June 1 and every six months after that.

- c. The Paid Live-In Caregiver Attestation form is an agency-wide form and filed in your business files.

NOTE: The documentation confirming the hired worker meets the paid live-in caregiver status must be filed in your agency's personnel file or waiver participant's case file.

For Specialized medical equipment, bill cost for the item, consisting of delivery charges and taxes. The cost is what is invoiced by the supplier. The charge to Medicaid must not exceed the maximum reimbursement rates for the equipment or supply. Documentation must comply with the requirements in **Subsection 5.7.**

For Home accessibility and adaptation, bill cost for the item, consisting of the applicable installation and delivery charges, taxes, and permit fees. The cost is what is invoiced by the supplier and installer. Billing must comply with the requirements in **Attachment A and Appendix B.**

For Institutional Respite Care, bill the Medicaid Nursing Facility rate for the CAP/C beneficiary's catchment area for the calendar-day(s) of respite provided to the CAP/C beneficiary. Billing must comply with the requirements in **Attachment A and Appendix B.**

For In-Home aide, pediatric nurse aide and nurse respite, bill the customary charge for the units provided to the CAP/C beneficiary for each date of service. Billing must comply with the requirements in **Attachment A and Appendix B.**

For Financial Management, bill customary charge for hours provided to the CAP/C beneficiary for each month fiscal management services are provided. Billing must comply with the requirements in **Attachment A and Appendix B.**

For Community Transition, goods and services, and training, education, and consultative services, bill the cost for the item, consisting of the applicable delivery charges, and taxes. The cost is what is invoiced by the supplier. Billing must comply with the requirements in **Attachment A and Appendix B.**

7.4 Service Note

The documentation for CAP/C services must fully detail the purpose of the intervention along with the date and duration of time taken to complete the approved service or task. The documentation must be completed within 72 hours of the intervention and signed and dated by the personnel performing the service or task. The CME's case management activities must comply with **Subsections 6.2.2 and 6.2.3.**

The service note must contain, at a minimum, **all** the following:

- a. the purpose of the visit;
- b. the beneficiary's name;
- c. date and duration of the contact;
- d. the goals reflected in the current service plan;
- e. progress towards person-centered goals;

- f. recommendation for continuation, revision or termination of CAP/C service(s); and
- g. the signature and date the service note was written.

If the 72-hour mandatory documentation time is not adhered to, it is considered a “late entry.” Documentation must be noted in the service record as a “late entry” and record:

- a. date the documentation was made;
- b. reason for missing timely entry; and
- c. date of the actual due date that was missed.

Note: A late entry must be documented within 365 consecutive calendar days of the actual service date when other supporting documentation is available to confirm the service intervention.

7.5 Signatures

All entries in the CAP Business System must be signed with a full signature. A full signature consists of the credentials, degree or license for professional staff or the position of the individual who provided the service for paraprofessional staff. For the electronic records in the CAP Business System, signatures, and facsimile signatures may be used if the provider’s process is consistent with all applicable laws, rules and regulations such as the N.C. Boards of Medicine and Nursing and the N.C. rules governing licensure of home care agencies, and CME’s internal policy.

7.6 Frequency of Monitoring of beneficiary and services

The Case Management Entity (CME) and CAP/C providers shall conduct:

- a. a monthly contact by telephone or in person with the CAP/C beneficiary to monitor and assess CAP/C services;
- b. a monthly or quarterly (*based on identified risk indicators in the completed comprehensive assessment*) multidisciplinary treatment team meeting with all providers identified in the service plan to:
 - 1. monitor health and well-being, and
 - 2. review the provision of and continued appropriateness of these services;
- c. a monthly or quarterly (*based on risk indicators*) contact visit, with the CAP/C beneficiary or responsible party, to monitor health and well-being and assess CAP/C services; and
- d. monthly review ensuring that respite service is rendered as authorized; and
- e. quarterly review monitoring total use of respite services over the previous 90-calendar day period.

Note: The Case Manager shall complete a monthly monitoring contact with the beneficiary by telephone or other secured means of contact. On a quarterly basis or a specified designated time frame, the case manager shall conduct a face-to-face monitoring visit with the beneficiary by engaging in one of the following options:

- a. Face-to-face home visit;
- b. Facetime;
- c. Skype;

- d. Video chat; or
- e. Remote Patient Monitoring system.

The above types of electronic or technology engagements must be performed in a secured format to protect the personal health information of the beneficiary. Each of the electronic or technology visits listed above must be pre-authorized by the beneficiary. When electronic or technology visits are performed, the beneficiary shall display on the monitoring screen the in-home aide or personal assistant to confirm his or her presence. The case manager may request a virtual walk through of the home environment to assess the health, safety and well-being of the beneficiary.

Electronic or technology monitoring can only occur twice during the quarterly monitoring scheduling period which begins after the completion of the initial or annual assessment. Take for example, the first quarterly visit after the development of the service plan must be a face-to-face home visit. The second and third quarterly monitoring visits may be conducted through an electronic or technology visit 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 home visit which should occur during the time the annual reassessment is due.

The case manager shall perform a monthly monitoring activity with all approved home and community-based service providers. During the monthly visit, the case manager shall assess the effectiveness of the service plan to identify indicators that may jeopardize the beneficiary's well-being. By routine monitoring, when the case manager determines the service plan is not meeting the current and newly identified needs of the beneficiary, an ad-hoc multidisciplinary team 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.

7.7 Corrections in the service record

Changes or modification in the original documentation to make a correction can be made at any time, when in compliance to **Subsection 7.3**, licensure or certification rules governing CAP/C service. Whenever corrections are necessary in the beneficiary's record, the CME shall seek technical assistance from the CAP Business System Contractor to make the changes to the electronic record and CAP/C providers shall follow their internal policies and procedures.

7.8 CAP/C Service Specific Documentation

The CME shall obtain the below required documentation prior to the approval and implementation of the following CAP/C services:

- a. Assistive Technology;
- b. Home Accessibility and Adaptation Services;
- c. Specialized Medical Equipment and Supplies;
- d. Training, Education, and consultative Services;
- e. Vehicle Modification; and
- f. Goods and Services.

The required documents for the above services are:

- a. comprehensive Multidisciplinary Needs Assessment completed by the case manager identifying equipment, supply, adaptation, or modification needs;
- b. copy of the physician's attestation, order, or signature certifying necessary care along with the request for equipment, supply, adaptation, or modification needs. The recommendation must be less than one-calendar year from the date the request is received;
- c. recommendation by an appropriate professional that identifies the beneficiary's need(s) regarding the equipment, supply, adaptation, or modification being requested;
- d. the estimated life of the equipment as well as the length of time the beneficiary is expected to benefit from the equipment, must be indicated in the request;
- e. an invoice from the supplier that shows the date the equipment, supply, adaptation, or modification were provided to the beneficiary and the cost, with related charges and maintained in the CAP Business System;
- f. long-range outcomes related to training needs associated with the beneficiary's utilization and procurement of the requested equipment, supply, adaptation or modification are reported in the Service Plan, as appropriate; and
- g. documentation for specific equipment, supplies, adaptation, and modification as outlined in the definition. Refer to **Appendix B** for these requirements.

The consumer direction beneficiary, primary caregiver or responsible party shall maintain timesheets and workflow sheets of their hired assistance that are consistent with the record and retention policy, refer to **Section 7.9**.

If the consumer direction beneficiary transfers back to the traditional planning of CAP/C, the case management entity shall take possession of those files and maintain those files consistent with the record and retention policy.

Respite Service

The case management entity and the Medicaid provider shall document respite service as requested based on the category of respite, institutional or non-institutional and the required documentation must contain the following components:

- a. Name of the CAP/C beneficiary;
- b. Medicaid identification;
- c. Type of respite service provided;
- d. Date of the service;
- e. Location the service was provided;
- f. Duration of the service;
- g. Task performed; and
- h. Completed and signed service note, refer to **Subsection 7.4**.

Note: It is the primary responsibility of the CME to monitor the respite hours so not to exceed the maximum limits.

7.9 General Records Administration and Availability of Records

CAP/C providers shall make service documentation available to NC Medicaid and case management entities to review the documentation to support a claim for CAP/C services rendered, when requested. The service record must have:

1. Service authorization submitted by the CME; and
2. Service documentation refer to **Subsection 7.3** required for service billed.

The CME shall retain the following documentation in the service record:

- a. the referral;
- b. all assessments;
- c. service plans;
- d. case management notes;
- e. service authorizations;
- f. monthly contacts;
- g. quarterly beneficiary visits;
- h. quarterly multidisciplinary team meeting documents;
- i. reported critical incidents;
- j. reported complaints;
- k. copies of claims generated by the CME;
- l. required documents generated by other providers and approved by the CME; and
- m. related correspondence complying with all applicable federal and state laws, rules and regulations, and agency policy for the date of services.

7.10 Health, Safety, and Well-being

The primary consideration underlying the provision of CAP/C services and assistance for a CAP/C beneficiary is his or her desire to reside in a community setting. Enrollment and continuous participation in CAP/C services may be denied if a determination is made that the CAP/C beneficiary is unable to participate in the HCBS program despite the service plan and the implementation of an individual risk agreement. An evaluation of the service plan, completed risk agreement(s) and the assessment of beneficiary's medical, mental, psychosocial and physical condition and functional capabilities, may indicate inability to participate in CAP/C when any of the following conditions cannot be mitigated for the CAP/C beneficiary:

- a. The beneficiary is considered to be at risk of health, safety and well-being when his or her responsible party cannot cognitively and physically devise and execute a plan to safety;
- b. The beneficiary lacks the emotional, physical and protective support of a willing and capable caregiver who can provide adequate care to oversee 24-hour hands-on support or supervision to ensure the health, safety, and well-being of the beneficiary with debilitating medical and functional needs;
- c. The beneficiary's needs cannot be met and maintained by the system of providers and or services that is currently available to ensure health, safety, and well-being;
- d. The beneficiary's primary residence is not reasonably considered safe due to:

1. a heating and cooling system that exacerbates medical condition which results in multiple hospital admissions or emergency room visits;
 2. lack of refrigeration for the storage of food and required medication or supplements;
 3. a plumbing, water supply and garbage disposal (garbage and infection material) that exacerbates medical condition which results in multiple hospital admissions and emergency room visit;
 4. electrical wiring is a fire hazard; or
 5. lack of any type of heating and cooking appliance, to maintain the recommended nutritional balance based on medical diagnosis.
- e. The beneficiary's primary residence would reasonably be expected to endanger the health and safety of the beneficiary, paid providers, care advisor, or the case manager due to any **one** of the following:
1. the presence of a physical or health threat due to the credible evidence of unlawful activity conducted in, or on the property of primary private residence;
 2. threatening or physically or verbally abusive behavior by the beneficiary, family member or other persons who live in the home exhibited on more than two occasions. If the abusive behavior meets the definition of a level II critical incident, one occurrence may be sufficient for a recommendation for disenrollment; or
 3. presence of a health hazard due to pest infestation, hoarding of animals or animal excretion.
- f. The CAP/C beneficiary's safety of self and others is impeded by the beneficiary's, legally responsible person's, or caregivers:
1. intrusive and oppositional defiant behavior;
 2. attempts of suicide;
 3. behavior that is injurious to self or others;
 4. verbally abusive or aggressive behavior;
 5. inappropriate sexual advances or verbalizations;
 6. destruction of physical environment; or
 7. repeated failure to follow agreed upon service plan and written or verbal directives.
- g. The beneficiary's primary caregiver or responsible party continuously impedes the health, safety and well-being of the beneficiary by:
1. refusal to follow terms of the service plan or an individual risk agreement;
 2. refusal to sign a plan or other required documents;
 3. refusal to keep the case management entity informed of changes in the status of the beneficiary; or
 4. refusal to remove or lessen the risk or hazard that create an unsafe environment;
- h. The beneficiary 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 or Adult Protective Services (CPS) assessment or care plan, or the parent or responsible party refuse to comply with Child or Adult Protective Services when there is a high-risk factor of existing conditions of abuse, neglect, or exploitation.

- i. CAP/C provider or beneficiary's caregiver shall not use unauthorized or unnecessary interventions that:
 1. restrict CAP/C beneficiary's movement;
 2. restrict CAP/C beneficiary access to other individuals, locations, or activities;
 3. restrict CAP/C beneficiary rights; or
 4. employ aversive methods to modify behavior, (unless provided for a CAP/C beneficiary for whom it is not used as a restraint, but for safety-such as bed rails, safety straps on wheelchairs, standers, adaptive car seats, and specialize crib beds).
- j. CAP/C provider or beneficiary's caregiver shall not use the following unauthorized or unnecessary restraints:
 1. personal; or
 2. mechanical.
- k. CAP/C provider or beneficiary's caregiver(s) shall not use the following:
 1. Drugs used as restraints; or
 2. Seclusion.

Note: If a CAP beneficiary experiences any one of the above listed health, safety and well-being items listed above, an Individual Risk Agreement on a temporary basis may be able to mitigate the assessed health, safety and well-being concerns, refer to

Subsection 7.11.

7.11 Individual Risk Agreement

An Individual Risk Agreement (IRA) outlines the risks and benefits to the beneficiary of a course of action that might involve risk to the beneficiary, the conditions under which the beneficiary is responsible for the agreed upon course of action, and the accountability trail for the decisions that are made. An individual risk agreement permits a beneficiary to accept responsibility for his or her choices personally, through surrogate decision makers, or through planning team consensus. The IRA tool is found in **Appendix E**.

If a CAP/C applicant's assessment identified concerns with the services offered in CAP/C to maintain the health, safety and well-being due to home environmental concerns or the health, safety and well-being, requirements listed in **Section 7.10**, a recommendation can be made to enter the applicant in an individual risk agreement for a specified timeframe to attempt to mitigate the concerns. The timeframe consists of a 90-day conditional CAP/C participation period.

When a CAP/C beneficiary makes a decision that could lead to an adverse consequence, or the likelihood of harm to self or others, the CME designated personnel shall engage the CAP/C beneficiary to discuss the concerns and bring awareness of the possible outcomes of the concerning issue. An agreement must be reached with the CME designated personnel and the CAP/C beneficiary on strategies to mitigate the concerning issues. An individual risk agreement may be used to address concerns.

7.12 Emergency and Disaster Planning

Mandatory Requirement for Emergency and Disaster Planning

The CME designee shall ensure that a comprehensive emergency and disaster plan is created initially and updated at least quarterly. A copy of the emergency and disaster plan must be provided to the beneficiary to place in a prominent location in the primary private residence. The emergency and disaster plan must be shared with in-home service providers and other pertinent service providers. The plan must document family, friends, neighbors, community volunteers and licensed home care agencies, when possible, in the event of an emergency or an unplanned occurrence. An emergency and disaster plan are necessary to inform service providers and first responders on how to manage a medical emergency, disaster preparedness and the identification of a safe residential location in the event the residence is not safe to remain due to a disaster or a pandemic. The emergency plan is used also used for times when the formally (In-home aide or personal assistant) arranged support system is unavailable during regularly scheduled work hours and when the unpaid informal support system is unavailable.

For new individuals with any of the listed conditions addressed above, an acknowledgement agreement for a 90-calendar day short-term CAP/C participation period may be implemented. During this 90-calendar day period, an evaluation is made to determine if risks can be reasonably mitigated to ensure health and welfare. If health and welfare cannot be maintained, disenrollment may be initiated.

For an active CAP/C beneficiary, failure to remediate risk for any one of the listed reasons may result in a disenrollment when a beneficiary willingly chooses to not follow the care plan or the individual risk agreement. If a violation is serious enough, multiple failed agreements may not be required for disenrollment from the program.

7.13 Critical Incident Management

To safeguard the health and welfare of each approved CAP/C beneficiary, NC Medicaid on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation (ANE) and other critical incidents. The critical incident management requirements consist of the following:

- a. Level of reporting is managed by two critical incident levels, Level I and Level II, Level of the incident is determined by severity.
- b. The following critical incidents types must be reported to the state:
 1. **Level I:** accident or injury resulting in the need for medical care beyond first aid, unscheduled hospitalizations, emergency room (ER) visits not resulting in hospitalization, inpatient psychiatric hospitalization, falls, death by natural causes, failure to take medication as ordered by the physician.
 2. **Level II:** CPS referrals (abuse, neglect, exploitation), injuries of unknown source, death other than expected or by unnatural causes, restraints and seclusions, misappropriation of consumer direction funds or other forms of exploitation, falls requiring hospitalization or resulting in death, traumatic injury, treatment or medication administration errors that result in injury or hospitalization, missing person, homicide/suicide, pandemics and media-related events.
- c. CMEs are responsible for reporting all critical incidents within 72 hours of becoming aware of the incident in the CAP Business system.

- d. Level II incidents are identified by, or reported to a CME, require a root cause analysis be conducted in order to identify potential remediation efforts, to mitigate risks to the CAP/C beneficiary's health and welfare, and prevent future incidents. The CME follows the listed steps:
 1. Contact the reporter, if applicable, to discuss the incident.
 2. Contact involved service providers listed on the POC to discuss the beneficiary's care needs and any concerns related to the critical incident report.
 3. Home visit with the beneficiary to conduct a risk assessment of needs.
 4. Review of all past critical incident reports, hospital or ER visits and other data elements to identify trends.
 5. Contact with pertinent individuals or agencies to identify concerns.
 6. Follow-up to assure the beneficiary is receiving necessary services as identified through the recommendations of the incident report.

7.14 Absence from CAP/C Participation

Hospital Stays of 30 Calendar-days or Less

When a CAP/C beneficiary is temporarily absent from CAP/C participation, the CME shall take the following course of action:

- a. determines the reason for the admission, the prognosis, and anticipated length of the absence from the primary private residence;
- b. suspends all CAP/C services except for case management;
- c. notifies the discharge planner that the beneficiary is a CAP/C beneficiary;
- d. notifies the county DSS that the beneficiary has been hospitalized;
- e. monitors the beneficiary's progress through contact with the discharge planner and other appropriate parties;
- f. monitors any changes that can extend the hospitalization beyond 30 calendar-days or result in a transfer to a nursing facility or rehabilitation center;
- g. determines, as necessary, the medical and related home care needs with the physician, discharge planner, and other appropriate parties when the beneficiary is released;
- h. alerts CAP/C providers when to resume care;
- i. informs DSS Medicaid staff that the beneficiary continues on the CAP/C services; and
- j. revises the service plan, if applicable, and sends notices of change to service providers and sends revised service plan to NC Medicaid or its designee nurse consultant for approval, if needed.

Hospital Stays Longer than 30 Calendar-days

Hospital stays of more than 30 calendar-days affect Medicaid eligibility and CAP/C participation. If the beneficiary is hospitalized for more than 30 calendar-days, the CAP/C CME shall contact the local DSS staff by using a DHB-2193 form to learn when the beneficiary's Medicaid status changes to long-term-care budgeting. The CME shall coordinate, when applicable, with the DSS worker the effective date of disenrollment from CAP/C based on the date of the change in Medicaid eligibility for the beneficiary.

The case management entity initiates the disenrollment only when a notice of change letter is received from the local DSS.

Nursing Facility Admissions

Because the beneficiary has already been disenrolled from CAP/C participation due to the nursing facility admission, the case manager or care advisor shall suspend all CAP/C services for 30 calendar-days from the admission date. Service providers shall be-notified of the nursing facility placement. For short-term rehabilitation stays that do not exceed 30 calendar-days, the beneficiary can resume the CAP/C services upon discharge. For nursing facility stays greater than 31 days but less than or equal to 90 calendar-days, the beneficiary can be expedited back on CAP/C with a change in status assessment and service plan.

Temporary Out of Primary Private Residence

If a beneficiary temporarily (for 30 calendar-days or less) leaves his or her primary private residence without knowledge of or prearrangement by the case manager, the CME shall suspend the delivery of CAP/C services by contacting the provider agencies until contact has been made with the beneficiary. No CAP/C services can be provided during this absence. The local DSS Medicaid eligibility staff is notified when an extended absence has been approved to occur. The CAP/C slot remains available to the beneficiary. The CME shall track the absence, since an extended absence can affect Medicaid eligibility and continued CAP/C participation. Unless prior approved by the CME, CAP/C participation is terminated after 90 calendar-days of absence from the primary private residence when CAP/C services are not being provided.

7.15 Voluntary Withdrawals

A CAP/C beneficiary can decide to voluntarily withdraw from CAP/C participation at any time. The CAP/C beneficiary shall submit a written notice containing the date of withdrawal from CAP/C and the beneficiary's, or his or her responsible party's signature to the CME. The CME coordinates the CAP/C disenrollment activity. The planning process for disenrolling the CAP/C beneficiary must coincide with the date the beneficiary makes in the request to withdraw.

The beneficiary can rescind the voluntary withdrawal request prior to the effective date of the change in services, or within 90 calendar days of the effective date.

7.16 Disenrollment

The CME shall disenroll the beneficiary when CAP/C is no longer appropriate, according to CAP/C policies and procedures implemented by NC Medicaid as listed in **Subsections 4.2**. When a CAP/C beneficiary's participation is terminated, the beneficiary's responsible party is notified in writing. Refer to <https://medicaid.ncdhhs.gov/>, for information on due process.

The proposed effective date depends on the reason for the disenrollment. Any of the following are reasons for disenrollment:

- a. the beneficiary's Medicaid eligibility is terminated from CAP/C coverage eligibility;
- b. the beneficiary's physician does not recommend the beneficiary's needs are at a nursing facility level;

- c. the annual assessment reflects care needs that are not approved for nursing facility LOC;
- d. DSS removes the CAP/C evidence code and cannot reenter the evidence code;
- e. the CAP/C CME has been unable to establish contact with the beneficiary or the primary caregiver(s) for more than 90 calendar-days despite two written and verbal attempts;
- f. the beneficiary fails to use CAP/C services as listed in the service plan during a 90-consecutive-day time period of CAP/C participation;
- g. beneficiary's health, safety, and well-being cannot be mitigated through a risk agreement;
- h. beneficiary or primary caregiver does not participate in development of or sign the service plan;
- i. beneficiary or primary caregiver(s) fails to comply with all program requirements consistently, such as failure to arrive home at the end of the approved hours of service, or manipulation of the coverage schedule without contacting the case manager for approval; or
- j. beneficiary or primary caregiver demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of CAP/C as outlined in the "Beneficiary Rights and Responsibilities," form signed by the CAP/C beneficiary. (Refer to **Appendix D**)

Note: Disenrollment from CAP/C, under items "e." through "j" above, may ensue if:

- a. there are three such occurrences, and the beneficiary or primary caregivers have been counseled regarding this issue; or
- b. after one occurrence, if the beneficiary's health and welfare is at risk and cannot be mitigated.

7.17 Quality Assurance

NC Medicaid is expected to have, at the minimum, systems in place to measure and improve its performance in meeting the CAP/C assurances that are cited in 42 CFR 441.302. These assurances address important dimensions of quality, confirming that service plans are designed to meet the needs of a CAP/C beneficiary and that there are effective systems in place to monitor CAP/C beneficiary health and welfare as described below:

- a. The quality, appropriateness, and outcomes of services provided to a CAP/C beneficiary; and
- b. The cost efficiency of the CAP/C beneficiary's care.

An appointed CME is designated to assure the quality and performance of the waiver. Each CME shall maintain a performance score of 90 percent (an aggregated total of established benchmarks, refer to **Mandated Waiver Assurances**) on a quarterly basis for continuation as an appointed CME. A performance score under 90 percent each month results in a corrective action plan and prohibition of enrollment of new CAP/C beneficiaries. A performance score of less than 90 percent for three (3) consecutive months can result in disenrollment as an appointed CME.

Objectives

Quality improvement activities are a joint responsibility of NC Medicaid and its appointed agencies. The case management entities and providers cooperate with all quality management activities by submitting all requested documents, consisting of self-audits, within defined timeframes and by providing evidence of follow-up and corrective action when review activities reveal their necessity.

State Assurances:

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

The following are quality assessment and quality improvement activities of CAP/C:

- a. review of initial applications and continued need reviews for appropriateness, accuracy and outcomes;
- b. review of effectiveness of and compliance to authorized CAP/C services on a quarterly basis;
- c. annual Participant experience survey sent by NC Medicaid or its designee to a representative sample of CAP/C beneficiaries;
- d. critical incident reporting; complaints and grievances; and
- e. on-site or desk-top audits of case management entities and CAP/C provider agencies.

The purpose of case management, which must be tracked, is to:

- a. improve or maintain beneficiary capacities for self-performance of activities of daily living and instrumental activities of daily living;
- b. improve beneficiary compliance with accepted health and wellness prevention, screening and monitoring standards;
- c. reduce beneficiary health and safety risks;
- d. implement strategies to avoid unplanned hospitalizations;
- e. avoid emergency room visits as a means for receiving primary care;
- f. enhance beneficiary socialization and reduce social isolation;
- g. Reduce risks of caregiver burnout;
- h. increase caregiver capacities;

- i. enhance beneficiary awareness self-management of chronic conditions;
- j. foster a more engaged beneficiary;
- k. promote a positive beneficiary personal outlook; and
- l. improve informal caregiver(s) outlook and confidence in their caregiving role.

Mandated Waiver Assurances

Quality assurance activities are conducted to monitor the following six (6) mandated waiver assurances:

a. Level of Care

1. CAP/C applicants for whom there is reasonable indication that services may be needed in the future are provided an individual LOC evaluation.
2. The LOC of an enrolled CAP/C beneficiary is reevaluated at least annually or as specified in the approved waiver.
3. The processes and instruments described in the approved waiver are applied to LOC determination.

b. Service Plan

1. Service plans address all a CAP/C beneficiary's assessed needs and person-centered goals, either by the provision of CAP/C services or through other means.
2. The state monitors services plan development according to its policies and procedures.
3. Service plans are updated or revised in the same month as the CAP/C effective date or when warranted by changes in a CAP/C beneficiary.
4. Services are delivered according to the service plan, which lists the type, scope, amount, duration and frequency of the services.
5. A CAP/C beneficiary is afforded choice between CAP/C services and institutional care and between and among CAP/C services and providers.

c. Qualified Providers

1. The state verifies that providers initially and continually meet required licensure and certification standards and adhere to other standards prior to their rendering CAP/C services.
2. The state monitors non-licensed and noncertified providers to assure adherence to CAP/C requirements.
3. The state implements its policies and procedures for verifying that training is provided in accord to state requirements and the approved waiver.

d. Administrative Authority

NC Medicaid retains administrative authority and responsibility for the operation of the CAP/C Waiver by exercising oversight of the performance of CAP/C Home and Community-Based Services waiver function by other state and local and regional non-state agencies and contracted entities.

e. **Financial Accountability**

State financial oversight exists to assure that claims are coded and paid for according to the reimbursement methodology specified in the approved waiver.

f. **Health and Welfare**

On an ongoing basis, the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

Case management entities shall comply with the waiver mandate of **conflict of interest protections**. Regulations at 42 CFR 441.301(c)(1)(vi) require that providers of Home and Community-Based Services (HCBS) for the beneficiary, or those who have an interest in or are employed by a provider of HCBS for the beneficiary must not provide case management or develop the person-centered service plan. Except when the state demonstrates that the only willing and qualified entity to provide case management and develop person-centered service plan in a geographic area also provides HCBS.

Conflict of interest protections are listed by the following assurances:

- a. The case management entity (CME) shall review with the beneficiary information about disclosure of potential conflict of interest.
- b. The HCBS provider shall review with the CAP/C beneficiary information about disclosure of potential or perceived conflict of interest.
- c. The beneficiary shall voice an agreement or provide written information that the person-centered service plan meets current health and social needs.
- d. The Long-Term Services and Supports Section within NC Medicaid conducts an unbiased review of the service plan to ensure freedom of choice to participate in the waiver and selection of providers were exercised freely by the beneficiary.
- e. The monitoring requirements of the service plan is conducted monthly and quarterly.

A case management entity shall not develop the person-centered service plan and render one of the approved home and community-based services listed in the service plan. When it is determined by Long-Term Services and Supports Section within NC Medicaid that a CME meets the dual-role criteria (entity is in a rural community with limited access to home and community-based services provider network) the CME shall be granted approval to render a home and community-based service in addition to case management.

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. These safeguards are listed below:

- a. The monitoring staff and the service rendering staff are separate and distinct personnel or units within the CME.
- b. The CME performs an independent quality review check on each beneficiary file, on a quarterly basis, to assess concerns of conflict and the needs of the beneficiary is being adequately met.
- c. The CME assesses HCBS in the service region routinely for available providers and discuss free choice of provider and conflict of interest protections with the beneficiary on a quarterly basis.

The Long-Term Services and Supports Section within NC Medicaid shall identify in advance which CME meets the dual role requirement. Assigning a CME as a dual role entity will be based on an analysis of the HCBS provider network. When a CME is approved to function in a dual role, the Long-Term Services and Supports Section within NC Medicaid monitors the CME closely through paid claims, revisions to service plans, monthly and quarterly visit summary reports, incident reports and annual surveys.

Note: A home and community-based services provider agency, vendor or contractor shall not provide a direct service to a CAP/C beneficiary when he or she is biologically related.

Home and Community General Characteristics

CAP/C service provider(s) shall adhere to the general home and community characteristics in all service settings by assuring:

- a. the setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community;
- b. individuals receiving HCBS are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources;
- c. individuals receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
- d. individuals select the setting from among available options, consisting of -non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources);
- e. each individual's rights of privacy, dignity, respect and freedom from coercion and restraint are protected;
- f. settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices; and
- g. the direct provider facilitates individual choice regarding services and supports, and who provides these.

The following additional HCBS Characteristics must be met in Provider Owned or Controlled:

Residential Settings:

- a. provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the state, county, city or other designated entity;
- b. provide privacy in a sleeping or living unit;
- c. provide freedom and support to control individual schedules and activities, and to have access to food at any time;
- d. allow visitors of choosing at any time; and
- e. are physically accessible.

Any modification of these conditions under 42 CFR 441.301(c)(4)(VI)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan. Refer to North Carolina DHHS's HCBS Transition Plan for additional information.

7.18 Program Integrity (PI)

CAP/C Medicaid providers that arrange for services that are not documented on the service plan and authorized by NC Medicaid and are not medically necessary are referred to Medicaid's Program Integrity unit for evaluation and potential recoupment of reimbursement.

Home care agencies that provide nursing or services that are not medically necessary or not performed according to the Service Authorization are referred to Medicaid's Program Integrity unit for evaluation and possible recoupment of reimbursement.

Licensed nurses and nurse aides who falsify health records to qualify a beneficiary for CAP/C are referred to the N.C. Board of Nursing or the appropriate North Carolina Health Care Personnel Registry (DHSR, the N.C. Board of Nursing, or both).

NC Medicaid shall randomly select a representative sample of CAP/C providers to ensure compliance with this policy and CAP/C federal requirements and assurances.

NC Medicaid shall randomly select a representative sample of case management entities and CAP/C providers to ensure compliance with the six (6) federal waiver assurances governed by the 1915(c) HCBS Waiver, and state assurances found in 42 CFR 441.302.

7.19 Use of Telephony and Other Automated Systems

Providers can utilize telephony and other automated systems to document the provision of CAP/C services as subject to NC Medicaid guidelines on telephony, telehealth, and the CAP/DA policy guidance on electronic engagement.

7.20 Electronic Visit Verification Requirements (EVV) Minimum Requirements

Providers Subject to EVV must comply with the requirements listed below:

- a. Comply with Section 12006 1903 (l) of the 21st Century Cures Act and any subsequent amendments.
- b. Register with the State's EVV solution or procure an alternate EVV solution. If provider selects alternate solution, the solution must be compliant with the 21st Century Cures Act and all state requirements.
- c. Provider agencies must have written documentation that they have informed beneficiaries of the EVV requirement in each beneficiary's file.
- d. Provider agencies must ensure staff are trained on use of the EVV system selected and maintain written documentation of initial and at least annual staff training in each employee's file

7.21 Electronic Visit Verification (EVV) Technology Options and Requirements

Effective January 1, 2021, Providers are required to use an Electronic Visit Verification EVV solution to capture in-home aide visits through mobile application, telephony, or fixed visit verification devices.

EVV visit verification validation components required by the 21st Century Cures act are listed below:

- a. Type of service performed;
- b. Individual receiving the service;
- c. Date of the Service;
- d. Location of Service delivery;
- e. Individual providing the service; and
- f. Time the service begins and ends.

7.22 Beneficiaries with Deductibles

A CAP/C beneficiary who has a deductible can participate in the CAP/C traditional or the consumer direction; however, the CAP/C beneficiary as well as the provider agency or the personal assistant shall understand and agree to the conditions of incurring and paying a deductible monthly. When a CAP/C beneficiary is participating in consumer direction program, the beneficiary shall understand that they are responsible to pay their deductible for the hired employee(s) to be paid. The hired employee(s) shall understand and accept that if the beneficiary does not pay his or her deductible, the employee shall not be paid for services rendered during the deductible period until the deductible is met or paid.

7.23 Marketing Prohibition

Agencies providing CAP/C services are prohibited from offering gifts or service-related inducements of any kind to entice an applicant or Medicaid beneficiary to choose it as their CAP/C provider, or to entice a beneficiary to change from their current provider.

8.0 Policy Implementation/Revision Update Information

Original Effective Date: November 1, 1992

Revision Information:

Date	Section Revised	Change
7/1/2010	Sections detailed below	CMS approval of July 2010 waiver renewal
7/1/2010	2.3	Ages eligible for participation changed from birth through 18 years to birth through 20 years
7/1/2010	3.2	Criteria for participation changed to: During each quarter of CAP/C participation, recipient must require case management and at least one other waiver service (excluding respite).
7/1/2010	3.3	Cost Neutrality mechanism changed from individual recipient monthly budget limits to aggregate model with limits on individual services
7/1/2010	3.4	Levels of care changed from Intermediate, Skilled, and Hospital to Nursing Facility and Hospital
10/1/2010	Sections detailed below	Initial promulgation of existing coverage with revisions based on the CMS approval of July 2010 waiver renewal
10/1/2010	5.1.2	Wait list policy changed to prioritize beneficiaries becoming de-institutionalized or transferring from another county or another Medicaid program
10/1/2010	5.2	Addition of congregate nursing care
10/1/2010	5.3	Addition of new service: Pediatric Nurse Aide
10/1/2010	5.4	Change in CAP/C Personal Care services staff level and qualifications
10/1/2010	5.5	Waiver supplies changed to delete items now offered by state plan and add adaptive tricycles
10/1/2010	5.6	Expanded allowable home modifications and budget limit for home modifications
10/1/2010	5.8.11	Addition of mid-year review for high-cost recipients
10/1/2010	5.9	Addition of new service: Motor Vehicle Modifications
10/1/2010	5.10	Addition of new service: Community Transition Funding
10/1/2010	5.11	Addition of new service: Attendant Care

Date	Section Revised	Change
10/1/2010	5.12	Addition of new service: Caregiver Training and Education
10/1/2010	5.13	Addition of new service: Palliative care
10/1/2010	6.1.1	Provider qualifications for case managers changed
10/1/2010	6.2.1	Provider qualifications for direct care nursing staff changed
10/1/2010	6.2.2	Provider qualifications for direct care nurse aides changed
11/1/2010	Attachment A: Claims-Related Information	Addition of TD and TE modifiers for T1000, T1005 and addition of Congregate Nursing Code, G1054 TD and G0154 TE
1/1/2012	Section 1.1, 5.2, 5.3, 5.4, 5.7, 5.11	Attendant care service deleted
1/1/2012	Section 3.2.c	Clarification that level of care is determined by both HP and the DMA Nurse Consultant
1/1/2012	Section 3.2.e, 4.2 c	Wording added to clarify that “quarter” is defined as a rolling 90 calendar-days
1/1/2012	Section 4.2 j	Clarification of use of restraints.
1/1/2012	Section 5.1.2 g	Changed “social worker” to “non-RN” to more accurately reflect case manager qualifications
1/1/2012	Section 5.2, 5.3, 5.4. 5.5, 5.13	Clarification that the service will be discontinued if not required and used for one quarter.
1/1/2012	Section 5.2. f	Clarification of criteria for approval of CAP/C nursing services when private insurance is paying for nursing services
1/1/2012	Section 5.2. k	Wording changed to include adult (18-20-year-old) recipients
1/1/2012	Section 5.3	Annual limit on service raised due to higher rate
1/1/2012	Section 5.5	Clarification that service authorization for waiver supplies is given only for waiver incontinence products
1/1/2012	Section 5.6	Criteria for approval of generator changed
1/1/2012	Section 5.6. h.2	Clarification of criteria for approval of home modifications to rental property
1/1/2012	Section 5.6.m	Deleted requirement for contractor to be licensed
1/1/2012	Section 5.6. n	Clarification of what must be submitted with a request for home modifications

Date	Section Revised	Change
1/1/2012	Section 5.7	Clarification that respite hours are based on total formal support hours
1/1/2012	Section 5.8.5	Information added regarding data sharing with CCNC.
1/1/2012	Section 5.8.11	Criteria for submission of mid-year reviews changed
1/1/2012	Section 6.1.1	Added qualifications for Case Manager supervisors
1/1/2012	Section 7.7. e	Period of time for record retention increased
1/1/2012	Appendix A	Clarified that “calendar” days are used.
1/1/2012	Appendix B	Clarified method for obtaining employment verification
1/1/2012	Attachment A(C)	Added code T1004 for Pediatric Nurse Aide Respite; deleted codes and references to T2027 Attendant Care Services and G0154 TD and TE Congregate Care.
1/1/2012	Attachment B	Updated Letter of Understanding
1/1/2012	3.2 e, 4.2. e	States that waiver incontinence supplies may not be the only waiver service besides case management.
1/1/2012	5.1.2 e	Criteria for monitoring of wait list recipients added
1/1/2012	5.1.2. r	Responsibilities of Case Manager Supervisor added
1/1/2012	5.2, Attachment A	Congregate nursing services added back in.
1/1/2012	5.2. g	Criteria added that nursing services will be denied if private insurance covering nursing services was voluntarily dropped within preceding year.
1/1/2012	5.3, Attachment A	Congregate services added.
1/1/2012	5.6	Clarification of assessor requirements for home modifications
1/1/2012	5.8.9, 5.8.10	Modified to include new procedure of CCME doing claims reviews.
1/1/2012	5.10	Clarification of limits on Community Transition Funding
1/1/2012	6.1.2	Criteria added for case manager supervisor to co-sign work before billing case management activities provided before training completed.

Date	Section Revised	Change
1/1/2012	6.8	Provider qualifications for palliative care services changed
3/1/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/01/2017	Sections detailed below	CMS approval of waiver renewal
03/01/2017	Section 1.0	This section was revised to identify non-waiver services that are available to a CAP/C beneficiary. The comprehensive definition and description of 1915(c) HCBS waiver and the assurances of the waiver were added to this section.
03/01/2017	Section 2.0	Clarity was provided to this section to describe the eligibility requirements for participation in the CAP/C waiver.
03/01/2017	Section 3.0	This section was updated to provide clarity to the eligibility criteria of when CAP/C is covered to include level of care and the qualifying conditions and the identification of priority individuals.
03/01/2017	Section 4.0	This section was updated to clarify when CAP/C services are not approvable.
03/01/2017	Section 5.0	This section was updated to describe CAP/C approval processes and the minimum requirements of completing a referral, assessment and service plan and all limitation imposed. This section was updated to describe the required documentation for waiver service requests.
03/01/2017	Section 6.0	This section was updated to provide clarity of each waiver service and the provider's eligibility and required credential/licensure to render these CAP/C services. This section was updated to include the care coordination responsibilities and competency level of the CAP/C case management entities and staff.
03/01/2017	Section 7.0	This section was updated to provide clarity in the areas of waiver compliance. A description of the general documentation requirements, frequency of monitoring. A description of when corrections are needed to the service record was added to this section.

Date	Section Revised	Change
03/01/2017	Attachment A	This section was updated to identify new processes for claim-related information.
03/01/2017	Appendix A	Form was added to reflect the new referral process for CAP/C participation
03/01/2017	Appendix B	Appendix added to describe waiver services and elaboration on requirements.
03/01/2017	Appendix C	Appendix updated to reflect new processes for determining service hours for a waiver beneficiary.
03/01/2017	Appendix D	Appendix D updated to identify the updated Beneficiary Rights and Responsibilities requirements to participate in CAP/C program.
03/01/2017	Appendix E	Appendix added to comply with HCBS Final Rule in Person-Centered Planning and risk.
03/01/2017	Appendix F	Appendix added to define CAP/C terms.
03/01/2017	Appendix G	Self-Assessment Questionnaire for Consumer-Direction was added to comply with the service package.
03/01/2018	All Sections and Attachments	Technical changes to correct typographical errors, misspellings, punctuation and omissions. Changes to clarify waiver terms, guidelines, and services and update appendices.
03/06/2018	All Sections and Attachments	Policy posted with an Amended Date of March 1, 2018
03/08/2018	Appendix F	Under definition for Medically Fragile, the following statement was removed to allow additional stakeholder engagement to define the conditions for Medically Fragile criteria, letter c: “Note: Assistance with ADLs does not constitute care to compensate for the loss of bodily function.” Policy posted on this date with no change to amended date.
05/09/2018	Sections Indicated Below	Corrected errors in the March 1, 2018 version of the policy, as noted below. No change to Amended Date.
05/09/2018	Section 4.2.2	A time frame was added to letter (d) that was not previously included in the policy. Time frame was removed from policy.

Date	Section Revised	Change
05/09/2018	Appendix B	Under the description of unplanned occurrences, an example of time was provided. Example was removed as it was not in the previous policy.
05/09/2018	Appendix B	Adaptive car seat was inadvertently added to assistive technology, and a utilization limit was added in error. Adaptive car seat is a specialized medical equipment and supply and is correctly added to the right waiver service. The reference error, for the adaptive car seat made in the assistive technology section, was removed from policy.
05/09/2018	Appendix D	Letter (a) corrected to state individuals under the age of 21 must meet the medical fragility criteria if applying for CAP/C waiver services. Letter (q) corrected with the right calendar days as listed in the Subsection 4.2.2 of the policy
09/21/2018	Page 78	Under the heading “HOME ACCESSIBILITY AND ADAPTATION” in item (l.) the word “portal” was changed to “portable”, so the statement is, “Portable back-up generator for a ventilator ...”
03/15/2019	Table of Contents	Added, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.”
03/15/2019	All Sections and Attachments	Updated policy template language.
1/01/2020	Appendix B-Case Management Services	Update to the case management reimbursement rate
1/01/2020	Appendix B-Financial Management Services	Update to the case management reimbursement rate
05/01/2020	All Sections and Attachments	Provides consistency with Medicaid name change in Aug 2018.
05/01/2020	All Sections and Attachments	Used a singular tense for beneficiary instead of plural; beneficiaries were changed to beneficiary.
05/01/2020	All Sections and Attachments	The word including was replaced with consisting of when providing examples.
05/01/2020	Section 1.0	Added new waiver services

Date	Section Revised	Change
05/01/2020	Section 2.1.1(a)	Number 5 was added to alignment the clinical policy with the waiver federal guidelines.
05/01/2020	Section 2.1.2 Section 2.1.2(8) and Section 2.1.2(9)	Updated criteria for medical fragility; the wording in a, b and c was changed. Restated the eligibility categories.
05/01/2020	Section 2.2.4	Addition of new section to provide clarity of EPSDT and CAP/C service requests and coordination.
05/01/2020	Section 2.2.5	Addition of new section to provide clarity of LEA services. This information was moved from 4.2.2(j).
05/01/2020	Section 3.2.2(a)	Numbers 1 and 2 were updated to alignment with federal guidelines for waiver administration. Number 3 was added to this section for provide additional clarity on the business processes. Number 5 was updated to provide clarity of short-term enrollment. Guidance added to this section to inform of the review frequency of the emergency plan.
05/01/2020	Section 3.2.2(b)	Numbers 1 and 2 were updated to describe the requirements used to determine ability to consumer direct. The word recovery was replaced with planning.
05/01/2020	Section 3.2.2(b)	The note section was deleted.
05/01/2020	Section 3.2.3	Updated LOC criteria to align with medical fragility criteria.
05/01/2020	Section 3.2.4	Change header to Priority Consideration for CAP/C Participation. Changed policy holder to policy underwriter Updated f to include individuals under the age of 18 and over the age of 18.
05/01/2020	Section 3.2.5	Updated number 5 and 6 to describe the transfer process and the timelines. Added a new letters c and d to describe the business rules for transfers between CAP/C and CAP/DA.

Date	Section Revised	Change
05/01/2020	Section 4.1	Applicant and active were added to 4.1 (a), (b)
05/01/2020	Section 4.2.2	Applicant was added to 4.2.2 (f) (g), (i), (m)
05/01/2020	Section 4.2.2	Items (a), (c), (g), (h), (o), (t), (u), (v) were updated to align clinical policy with waiver federal guidelines for coverable services. Letter W was added as new to provide clarity of when CAP/C services end. Updated letter c to removed “has not been entered” Letter h was updated to remove the statement “only assessed CAP/C service need is” Updated letter k to include when not authorized through an emergency planning document Updated letter n to delete the statement of “care of in-home aide services, the installation of a home modification or assistive technology” Letter s, updated to state consumer direction instead of consumer-directed model of care
05/01/2020	Section 4.2.2. (j)	This information was deleted from this section and added to section 2.2.4.
05/01/2020	Section 5.2.1	CAP Business System replaced DHHS Utilization Review Contractor
05/01/2020	Section 5.2(a)	Prior approval was replaced with service request form to clearly identify the correct workflow process. Updated to section to include “within the designated timeframe, but no more than 45 calendar-day from the initiation date. Added medical fragility to this section
05/01/2020	Section 5.2(c)	Added designated entity to this section

Date	Section Revised	Change
05/01/2020	Section 5.3.1	<p>This section was updated to include the responsibilities of the CME.</p> <p>This section was updated to rename the heading to Approval Process</p> <p>Added designated entity to this section</p> <p>Deleted Community Care of North Carolina (CCNC) and replaced with Medical Professionals</p> <p>Added guidance to this section about a notification letter for an unable to process SRF.</p>
05/01/2020	Section 5.3.2 a, b & c	<p>The section was updated to clearly identify the required minimal documents to enroll in CAP/C.</p> <p>This section updated to list the required documents.</p>
05/01/2020	Section 5.4	<p>This section was updated to identify the responsibilities of the CME in completing assessments.</p>
05/01/2020	Section 5.4.1	<p>Added designated entity to this section</p> <p>Added statement of “within the designated timeframe”</p>
05/01/2020	Section 5.5 & g, h & note	<p>The section was updated to clarify the timeframe and the responsibilities of the case manager in developing the service plan.</p> <p>Added designated entity to this section</p> <p>Added statement of “within the designated timeframe”</p> <p>Letter h and the note was added as new information to provide clarity of the monitoring requirements.</p> <p>Added assessment month in the Note section.</p>
05/01/2020	Section 5.5.1	<p>The section was updated to identify the responsibilities of the CME in developing the service plan.</p> <p>Added statement of “within the designated timeframe</p> <p>Add new sentence- The change in provider excludes the hiring of a new employee under the consumer direction program.</p>

Date	Section Revised	Change
05/01/2020	Section 5.5.2	<p>The section updated to identify the responsibilities of the new CME.</p> <p>This section updated to add the timeframe for signature.</p> <p>This section was updated to provide policy guidance for transfers and Medicaid eligibility category.</p>
05/01/2020	Section 5.6	<p>This section updated to identify the timeline to complete the assessment.</p> <p>This section was updated to provide clarity to what the CRN consist of.</p>
05/01/2020	Section 5.6.1	<p>The section was updated to change header to Annual Person-Centered Service Plan</p> <p>This section was updated to provide clarity to the annual assessment process.</p>
05/01/2020	Section 5.6.1	<p>This section updated to provide clarity of timeline and due dates for the service plan.</p>
05/01/2020	Section 5.6.3	<p>This section was updated to provide clarity of timeline and due dates for the authorization of services.</p> <p>This section was updated to provide information about the freedom of choice form.</p>
05/01/2020	Section 5.7.1(a), (b)	<p>This section was added to provide clarity of how training is to be documented and when a physician's order is needed</p> <p>New information was added to this section to provide policy guidance for assistive technology and monitoring devices.</p>
05/01/2020	Section 5.7.2:	<p>This section was updated and numbers 3 and 4 were added as new to provide addition clarity of business requirements for participation in consumer-direction.</p>
05/01/2020	Section 6.1	<p>The licensure and DHSR requirements for aide types services were added to this section and moved from 6.6.</p>
05/01/2020	Section 6.1(d)	<p>The training requirements for pediatric nurse aide was deleted from this section and HCBS orientation training was added as a replacement.</p>
05/01/2020	Section 6.2	<p>This section was updated to provide clarity on the ability render case management services.</p>

Date	Section Revised	Change
05/01/2020	Section 6.2.2	Header was updated to include perform by CME in the header. This section was expanded upon to add clarity to the roles and responsibilities of the case manager.
05/01/2020	Section 6.2.3 (a), (b), (c), (d)	This section was expanded upon to add clarity the roles and responsibilities of the case management entity in conducting the assessment. Initial and annual was included in this section.
05/01/2020	Section 6.4	This section was updated to identify the responsibilities of the CME. Process referrals was added to this section. Initially was added to letter e
05/01/2020	Section 6.5	New information added to regarding nonuse of restraints and seclusions.
05/01/2020	Section 6.5.2	The section was updated to clearly identify the requirements for submitting claims for reimbursement for home accessibility and adaptation services.
05/01/2020	Section 6.5.4	Non-Institutional was replaced with In-Home Added nurse aide respite service to this section
05/01/2020	Section 6.5.7	This section was updated to add provider requirements for Pediatric nurse aide services.
05/01/2020	Section 7.1	Letters c, d, and e were added to identify the roles and responsibilities of the CME for documenting workflow steps.
05/01/2020	Section 7.2	New information was added to clarify requirements for record retention.
05/01/2020	Section 7.11	New information was added to provide clarity on the Individual Risk Agreement business requirements. Added designated entity to this section

Date	Section Revised	Change
05/01/2020	Section 7.12	<p>New information was added to provide clarity on the Emergency back-up and Disaster Planning business requirements.</p> <p>Added other pertinent service providers to this section.</p> <p>Added pandemic to this section.</p> <p>Clarity that a 90-day plan means short-term CAP/C participation</p>
05/01/2020	Section 7.13	<p>New information was added to provide business requirements for critical incident management.</p> <p>Added pandemic to this section.</p>
05/01/2020	Section 7.14	<p>Added the use of new form DHS-2193.</p> <p>Added policy guidance on the disenrollment process initiated by the CME.</p>
05/01/2020	Section 7.17	<p>Added the federal requirement for conflict of interest protection to this section</p>
05/01/2020	Section 7.17	<p>Added “an applicant or Medicaid” to this section.</p>
05/01/2020	Attachment A	<p>Added newly approved waiver services procedure codes to this section</p>
05/01/2020	Appendix B - Respite	<p>Update to existing information and addition of new information for this waiver service.</p>
05/01/2020	Appendix B – Pediatric Nurse Aide	<p>A new definition was created for this service.</p> <p>Added the maximum number of hours a paid legally responsible person may qualify to receive weekly.</p>
05/01/2020	Appendix B – In-Home Nurse Aide	<p>This section was updated to add limited to the service definition</p> <p>Added the maximum number of hours a paid legally responsible person may qualify to receive weekly.</p>
05/01/2020	Appendix B – Home Accessibility and Adaptation	<p>This service was updated to provide clarity to coverable items and exclusion.</p>

Date	Section Revised	Change
05/01/2020	Appendix B – Goods & Services	This service was updated to clarify coverable items and exclusion and newly approved goods and services.
05/01/2020	Appendix B – Training, Education and Consultative Services	A new exclusion was added to this section.
05/01/2020	Appendix B – Assistive Technology Services	Added new information to this section to provide guidance on the approval of a monitoring system
05/01/2020	Appendix B – Vehicle Modification	This service was updated to clarify coverable items and exclusion.
05/01/2020	Appendix C	The definition for multiple siblings was updated in this section. A new definition for Caregiving to other non-disabled siblings or other siblings in the home was added.
05/01/2020	Appendix D	Updated form
05/01/2020	Appendix F	New definitions were added to the Appendix: <ul style="list-style-type: none"> • Activities of Daily Living • General Utility • Independent Assessment • Independent Assessment Entity • Medical Fragility • Portable Generator • Reasonable Indication of Need • Recreational in Nature • Respite • Short-Term Intensive • Unplanned Occurrences • Other clarifications were made to existing definitions
05/01/2020	Appendix G	The Consumer Direction Self -Assessment was updated.

Date	Section Revised	Change
05/01/2020	Appendix H	The Emergency Back-up and Disaster Plan was updated.
05/01/2020	Table of Contents	Updated language, “To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.”
05/01/2020	Attachment A	Added, “Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
08/15/2020	Title page	Update the Division’s name
08/15/2020	Appendix B – Pediatric Nurse Aide	Updated the definition to clarify ADLs for a child under the age of three. Updated this section to clarify the timeframe of bi-monthly (two times per week). Updated this section to clarify that a legal guardian is the legal guardian of a CAP/C beneficiary 18 years old and older.
08/15/2020	Appendix B – CAP In-Home Aide Service	Updated the definition to clarify ADLs for a child under the age of three. Updated this section to clarify the timeframe of bi-monthly (two times per week).
08/15/2020	Appendix C	Updated the title to read “Determination of Support Need”.
08/15/2020	Appendix F	Updated this section to add Bed Mobility. Updated the medical fragility definition to align with the new criteria.
08/15/2020		Policy was amended to align with the approved CAP/C 1915(c) HCBS waiver. The policy will be enforced with an effective date of 8/1/2020 as a result of training and orientation to new policy changes.
07/01/2021	5.1	New section to provide guidance for providers subject to the EVV mandate

Date	Section Revised	Change
07/01/2021	6.1	Added requirements for providers of In-home respite that are subject to the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act.
07/01/2021	6.5.4	Added requirements for providers of In-home respite that are subject to the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act.
07/01/2021	6.5.6 (d)	Added requirements for providers of In-home aide agencies that are subject to the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act.
07/01/2021	6.5.7(d)	Added requirements for providers of pediatric nurse aide agencies that are subject to the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act.
07/01/2021	7.3	Added requirements on the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act.
07/01/2021	7.19	Updated this section to include the state's requirements on telephony.
07/01/2021	7.20	New section to add telephony requirements on the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act.
07/01/2021	Attachment A	Added requirements on the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act. Updated HCPC Code table
07/01/2021	Appendix B	Added requirements on the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act.
07/01/2021	Appendix B	Added clarifying information qualifying conditions for a paid caregiver for an individual under the age of 18.
07/01/2021	Appendix F	Added requirements on the federal mandate for the Electronic Visit Verification under the 21 st Century Cures Act.
07/01/2021	Appendix F	Technical update the medical fragility definition

Date	Section Revised	Change
07/01/2021	All sections	Policy posted July 1, 2021, but the EVV requirements have a retro approval date effective January 1, 2021.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NC Tracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction) billed through NCTracks.

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)			
S5125	T1004	T2029	T2040
S5125UN	T1005	T1016	T2027
S5165	T1019	T2041	T2027TF
H0045	T2038	T2025	T2039
S5150	S5111	A0090	E0700
	S9122TF	H2010	
	S9122TG	T5999	

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Refer to the CAP/C fee schedules for current rate and billing units: <https://medicaid.ncdhhs.gov/>

F. Place of Service

Case management services are provided in the case manager's office, a beneficiary's primary private residence, the community, acute inpatient hospital, or nursing facility. Acceptable places for all other CAP/C services to be provided are dependent on service type.

The place of service code for a paid live-in caregiver that meets the EVV requirements is code 99.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

H.1CAP/C Claim Reimbursement

Date of Service: Date of service billed must be the date the service is provided or rendered.

The Case Management Entity (CME) shall bill for case management services, home accessibility and adaptation, vehicle modifications, adaptive tricycles, adaptive car seats, training and education services, community transition services, participant goods and services, according to this policy, their own agency policy, and *NCTracks Provider Claims and Billing Assistance Guide*:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

Approved CAP/C providers shall bill for, financial management, in-home aide, pediatric nurse aide, home accessibility and adaptation, assistive technology, and medical equipment and supplies according to **Subsections 6.4, 6.5, and 7.3**, their own agency policy and *NCTracks Provider Claims and Billing Assistance Guide*:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

Provider(s) subject to the EVV requirements shall capture and verify seven (7) core in-home visit components, which are required under the 21st Century Cures Act to complete real-time electronic verification, tracking, and documentation. These core components are:

- a. Date of Service;
- b. Location of service delivery;

- c. Individual providing service;
- d. Type of services performed;
- e. Individual receiving service;
- f. Time service begins; and
- g. Time service ends.

The qualifying services to be validated are listed below:

- a. S5125 – CAP/C In-home aide services
- b. S5150 – CAP/C In-home respite care
- d. T1004 –CAP/C Pediatric nurse respite services
- e. T1019- CAP/C Pediatric nurse aide
- f. S9122 TF- CAP/C In-Home Aide congregate care
- g. S9122 TG – CAP/C Pediatric nurse aide congregate care

The provider(s) submitting a claim for a paid live-in caregiver must attest using a Paid Live-in Caregiver Attestation Form the caregiver meets the live-in status definition to allow the claim to bypass the EVV edits using place of service (POS) 99, refer to Appendix F.

CAP/C services are provided in an amount, duration, and scope, consistent with the beneficiary's medical needs and must be provided according to the service authorization. The amount of service provided cannot exceed what is contained in the approved CAP/C service plan. A provider shall not bill for a service if the procedure is not valid for the CAP/C benefit program, or if the policies and procedures relevant to that service were not adhered to. CAP/C providers shall not file a claim for a beneficiary who is ineligible for CAP/C services.

The following case management activities or tasks, performed for a specific beneficiary, are billable:

- a. Assessing the individual for CAP/C participation. This documents the time for both members of the assessment team (if applicable) to arrange, coordinate, and complete assessment activities;
- b. Planning CAP/C services, along with completing the service plan and revising the plan as needed;
- c. Locating service providers for approved CAP/C services and ordering the services from those providers. Locating and arranging informal support to meet the beneficiary's needs;
- d. Coordinating the provision of other Medicaid home care services, such as Private Duty Nursing, Home Health and DME;
- e. Monitoring CAP/C services, along with the delivery of services and reviewing claims and related documentation;
- f. Monitoring the beneficiary's situation, documenting the continuing need for CAP/C participation, the level of care and the appropriate services, as well as taking appropriate action on findings;
- g. Working with the CAP/C beneficiary, family, and others involved in the beneficiary's care to assure their health, safety, and well-being. This provides emergency planning and backup planning activities;
- h. Coordinating Medicaid eligibility issues with DSS, along with those related to helping the beneficiary get information to DSS;

- i. Arranging and coordinating activities related to the disenrollment of CAP/C that occurs prior to the disenrollment date;
- j. Time spent talking with those involved in the beneficiary's care;
- k. Time coordinating the service authorizations; and
- l. Time spent completing other correspondence directly related to the beneficiary's care.

A request for payment for linking an individual to Medicaid services through the completion of an SRF for an individual who does or does not become a participant of the CAP/C program can be made when a final decision of approval or denial is rendered on the SRF.

Note: The maximum hours of reimbursement for this activity is two (2).

A request for payment for an assessment of an individual who does not become a CAP/C beneficiary can be made if **all** of the following conditions are met; this type of claim is called an "assessment only" claim:

- a. The individual has a properly approved SRF;
- b. The assessment was completed according to CAP/C policies and procedures;
- c. The assessment is documented and certified by both assessors on the CAP/C assessment form; and
- d. The individual is authorized for Medicaid in a Medicaid category eligible for CAP/C coverage on the date of service.

Note: The maximum hours of reimbursement for this activity is six (6).

Both claim types described above are paid directly by NC Medicaid instead of through NCTracks. To submit a request for reimbursement for these claim types:

- a. Prepare a paper claim for the identified service
- b. Prepare a cover letter that reports:
 1. The Individual's name and Medicaid ID number; and
 2. The number of hours used to perform tasks.

For assessment only requests, list the reason the individual will not be participating in CAP/C.

The following case management activities are considered administrative costs and are not allowed to be billed separately:

- a. outreach;
- b. travel time;
- c. activities after the beneficiary's discharge, termination, or death;
- d. attending training;
- e. completing time sheets;
- f. recruiting, training, scheduling, and supervising staff;
- g. billing Medicaid;
- h. documenting case management activities; and
- i. gathering information to respond to quality assurance requests that are not covered activities for case managers and care advisors.

Appendix A: CAP/C Service Request Form

*** = Required**

Request Date *	
Service Requested	<input type="checkbox"/> CAP Children <input type="checkbox"/> CAP Adults <input type="checkbox"/> Private Duty Nurse <input type="checkbox"/> PACE

Applicant Demographics	
Applicant's First Name	
Last Name	
Applicant has Medicaid? *	<input type="checkbox"/> Yes <input type="checkbox"/> Pending <input type="checkbox"/> Not Applied <input type="checkbox"/> No
Medicaid MID	
Social Security Number *	
Medicare ID	
Date of Birth *	
Age	
Gender *	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status *	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Partner or Significant Other <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
County *	
Primary Language Spoken In Household *	<input type="checkbox"/> English <input type="checkbox"/> Spanish or Spanish Creole <input type="checkbox"/> Other
If Other, Specify	
Is interpreter (spoken) or translator (written) needed or wanted? *	<input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant Address	
Address 1	
Address 2	
City	
State	

Zip	
Phone	
Legal guardian in place? *	<input type="checkbox"/> Yes <input type="checkbox"/> No

Legal Guardian Details	
Legal guardian in place? *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Guardian Last Name	
First Name	
Phone	
Address 1	
Address 2	
City	
State	
Zip	

Prioritization Factors If Applicant Is Determined To Be Eligible	
An individual 18 years or older who is currently participating in a 1915 c HCBS waiver in NC and wants to transition to this HCBS waiver.	<input type="checkbox"/>
An individual with an active AIDS diagnosis with a T-count of 200 or lower.	<input type="checkbox"/>
An individual approved through Money Follows the Person, Division of Vocational Rehabilitation Services or CAP Community Transition services for transitional purposes for an active transition to community.	<input type="checkbox"/>
An individual identified at risk by his or her Department of Social Services who has an order of protection by Children or Adult Protective Services for abuse, neglect or exploitation.	<input type="checkbox"/>
An individual with Alzheimer's Disease or a related disorder.	<input type="checkbox"/>
An individual who has a terminal illness and enrolled in Hospice and who is in jeopardy of entering a non-hospice institution because care needs cannot be met with current supportive services.	<input type="checkbox"/>
Has the applicant previously been a CAP beneficiary?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, is the applicant returning to CAP due to military service redeployment of the applicant's primary caregiver?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Beneficiary Conditions and Related Support Needs

Diagnosis Information	
Diagnosis Entry Screen	
Diagnosis	

ICD10 Code *	
Is this diagnosis the primary dx? *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Onset	
Has this diagnosis lasted more than 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this diagnosis anticipated to last more than 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Hospitalizations/Emergency Care (Include current stay if applicable)	
Total number of physician ordered hospital stays in the last year for primary medical intervention. *	
If the applicant had less than three hospital stays in the last year, were any of the stays a readmission for the same admitting diagnosis? *	<input type="checkbox"/> Yes <input type="checkbox"/> No
If the applicant had less than three hospital stays in the last year, were any of the stays greater than 10 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the applicant have a chronic medical condition that resulted in at least four (4) exacerbations of the chronic medical condition requiring urgent/emergent physician-provided care within the last year?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Medications	
Meds Entry Screen	
Medication Name	
Other	<input type="checkbox"/> Medication Name
PRN *	<input type="checkbox"/> Yes <input type="checkbox"/> No
If PRN, freq > every 4 hrs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

# of physician ordered meds to be administered by a nurse requiring injections.	
# of physician ordered meds to be administered by a nurse requiring IVs.	
# of physician ordered meds to be administered by a nurse requiring nasogastric tube.	
# of physician ordered meds to be administered by a nurse requiring hypodermoclysis.	
# of physician ordered meds to be administered by a nurse for PRN meds where there is a need for frequent and ongoing RN judgment due to varying dosages.	
# of Psychiatric/Psychotropic Meds being used to manage a primary medical condition. Include any such medications in the medications listing.	

Sensory/Communication Limitations	
Speech ability/making self-understood (Rarely/never)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Hearing (Severe difficulty or none)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vision (Severe difficulty or blind)	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mood			
Unrealistic fears	<input type="checkbox"/>	Crying/tearfulness	<input type="checkbox"/>
Sad, pained, worried facial expressions	<input type="checkbox"/>	Negative statements	<input type="checkbox"/>
Persistent anger	<input type="checkbox"/>	Anxious non-health concerns	<input type="checkbox"/>
Elevated mood, euphoric	<input type="checkbox"/>	Expansive	<input type="checkbox"/>
Unpleasant mood in morning	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>
Excessive irritability	<input type="checkbox"/>		

Behavior			
Wandering	<input type="checkbox"/>	Verbal expressions of distress	<input type="checkbox"/>
Repetitive verbalizations	<input type="checkbox"/>	Angry outbursts	<input type="checkbox"/>
Repetitive physical movements	<input type="checkbox"/>	Dangerous to self	<input type="checkbox"/>
Self-deprecation	<input type="checkbox"/>	Withdrawal from activities of interest	<input type="checkbox"/>
Insomnia/disturbed sleep patterns	<input type="checkbox"/>	Paranoid ideation	<input type="checkbox"/>
Suicide attempt/ideation	<input type="checkbox"/>		

Interpersonal Functioning			
Homicidal	<input type="checkbox"/>	Combative/Hx of Altercations	<input type="checkbox"/>
Dangerous to others	<input type="checkbox"/>	Physically abusive	<input type="checkbox"/>
Verbally abusive	<input type="checkbox"/>	Socially inappropriate behavior	<input type="checkbox"/>
Resists care	<input type="checkbox"/>	Fear of strangers	<input type="checkbox"/>
Illogical comments	<input type="checkbox"/>	Reduced social interaction/isolation	<input type="checkbox"/>

Cardio-Respiratory Support Needs					
Suctioning - Oral	<input type="checkbox"/>	Frequency	<input type="checkbox"/> Continuous <input type="checkbox"/> Continuous during sleep <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Every four hours	<input type="checkbox"/> Every six hours <input type="checkbox"/> Every eight hours <input type="checkbox"/> Every 12 hours <input type="checkbox"/> Every 24 hours <input type="checkbox"/> Less than once a day	<input type="checkbox"/> 3-6 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Less than weekly <input type="checkbox"/> PRN <input type="checkbox"/> Other

Suctioning - Oropharyngeal	<input type="checkbox"/>	Frequency	<input type="checkbox"/> Continuous <input type="checkbox"/> Continuous during sleep <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Every four hours	<input type="checkbox"/> Every six hours <input type="checkbox"/> Every eight hours <input type="checkbox"/> Every 12 hours <input type="checkbox"/> Every 24 hours <input type="checkbox"/> Less than once a day	<input type="checkbox"/> 3-6 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Less than weekly <input type="checkbox"/> PRN <input type="checkbox"/> Other
Suctioning - Nasotracheal	<input type="checkbox"/>	Frequency	<input type="checkbox"/> Continuous <input type="checkbox"/> Continuous during sleep <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Every four hours	<input type="checkbox"/> Every six hours <input type="checkbox"/> Every eight hours <input type="checkbox"/> Every 12 hours <input type="checkbox"/> Every 24 hours <input type="checkbox"/> Less than once a day	<input type="checkbox"/> 3-6 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Less than weekly <input type="checkbox"/> PRN <input type="checkbox"/> Other
Suctioning - Nasal	<input type="checkbox"/>	Frequency	<input type="checkbox"/> Continuous <input type="checkbox"/> Continuous during sleep <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Every four hours	<input type="checkbox"/> Every six hours <input type="checkbox"/> Every eight hours <input type="checkbox"/> Every 12 hours <input type="checkbox"/> Every 24 hours <input type="checkbox"/> Less than once a day	<input type="checkbox"/> 3-6 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Less than weekly <input type="checkbox"/> PRN <input type="checkbox"/> Other
Ventilator dependent	<input type="checkbox"/>	Frequency	<input type="checkbox"/> Continuous <input type="checkbox"/> Continuous during sleep <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Every four hours	<input type="checkbox"/> Every six hours <input type="checkbox"/> Every eight hours <input type="checkbox"/> Every 12 hours <input type="checkbox"/> Every 24 hours <input type="checkbox"/> Less than once a day	<input type="checkbox"/> During Sleep <input type="checkbox"/> Being weaned <input type="checkbox"/> PRN <input type="checkbox"/> Other
		Stable?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Vent Type	<input type="checkbox"/> Negative pressure <input type="checkbox"/> Pressure-cycled <input type="checkbox"/> Volume-cycled	<input type="checkbox"/> Combination pressure and volume cycled <input type="checkbox"/> Flow-cycled <input type="checkbox"/> Time-cycled	
Pulse oximetry	<input type="checkbox"/>	Frequency	<input type="checkbox"/> Continuous <input type="checkbox"/> Continuous during sleep <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Every four hours	<input type="checkbox"/> Every six hours <input type="checkbox"/> Every eight hours <input type="checkbox"/> Every 12 hours <input type="checkbox"/> Every 24 hours <input type="checkbox"/> Less than once a day	<input type="checkbox"/> 3-6 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Once per week <input type="checkbox"/> Less than weekly <input type="checkbox"/> PRN <input type="checkbox"/> Other
Non-vent tracheostomy	<input type="checkbox"/>	Problems with weaning?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nebulizer usage	<input type="checkbox"/>	At least 2 schedule/day & 1 PRN/day?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiac monitoring			<input type="checkbox"/>		
Chest physiotherapy/use of chest PT vest			<input type="checkbox"/>		
Use of cough assist device			<input type="checkbox"/>		
Apnea monitoring			<input type="checkbox"/>		

CPAP/BiPAP	<input type="checkbox"/>	Help getting device on?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oxygen therapy	<input type="checkbox"/>	Requires rate adjustments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory assessment	<input type="checkbox"/>	Multiple times/day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is respiratory pacer required?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does applicant need on-going physician ordered care by a nurse to prevent advancement of cardio-respiratory care needs?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Nutrition-Related Support Needs					
Enteral Feeding/Tube Feeding	<input type="checkbox"/>	Frequency	<input type="checkbox"/> Continuous <input type="checkbox"/> Continuous during sleep <input type="checkbox"/> Every hour <input type="checkbox"/> Every two hours <input type="checkbox"/> Every four hours	<input type="checkbox"/> Every six hours <input type="checkbox"/> Every eight hours <input type="checkbox"/> Every 12 hours <input type="checkbox"/> Every 24 hours <input type="checkbox"/> Less than once a day <input type="checkbox"/> 3-6 times per week	<input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Less than weekly <input type="checkbox"/> PRN <input type="checkbox"/> Other
% of daily nutrition/fluids	%	Feeding Tube Type	<input type="checkbox"/> DT (duodenal) <input type="checkbox"/> GJ tube (gastrostomy-jejunostomy) <input type="checkbox"/> GT (gastrostomy) <input type="checkbox"/> JT (jejunostomy)	<input type="checkbox"/> Low profile GT <input type="checkbox"/> NG (nasogastric) <input type="checkbox"/> OG (orogastric) <input type="checkbox"/> Other	
Parenteral Nutrition (TPN)	<input type="checkbox"/>				
Soft/Mechanical Soft	<input type="checkbox"/>				
Thickened Diet	<input type="checkbox"/>				
Pureed Diet	<input type="checkbox"/>				
Supplemental formula diet physician prescribed	<input type="checkbox"/>				
Diabetes management (daily)	<input type="checkbox"/>	Insulin use	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sliding Scale	<input type="checkbox"/> Yes <input type="checkbox"/> No
Weight management	<input type="checkbox"/>				
Fluid mgmt/force fluids	<input type="checkbox"/>				
Input/output monitoring	<input type="checkbox"/>				
Other nutrition treatment/Diet?	<input type="checkbox"/>				
Other, Desc					

Ancillary Therapies Being Received				
Physical Therapy	<input type="checkbox"/>	Frequency	<input type="checkbox"/> More than once a week <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks	<input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly
Physical Therapy Details				
Occupational Therapy	<input type="checkbox"/>	Frequency	<input type="checkbox"/> More than once a week <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks	<input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly

Occupational Therapy Details				
Speech Therapy	<input type="checkbox"/>	Frequency	<input type="checkbox"/> More than once a week <input type="checkbox"/> Weekly <input type="checkbox"/> Every two weeks	<input type="checkbox"/> Monthly <input type="checkbox"/> Less than monthly
Speech Therapy Details				
Other	<input type="checkbox"/>	Other, Desc		
Other Therapy Details				

Other Support Needs					
Bowel and/or Bladder Program	<input type="checkbox"/>	If yes, select program	<input type="checkbox"/> MACE <input type="checkbox"/> I/O catheters <input type="checkbox"/> Mitrofanoff <input type="checkbox"/> Enema <input type="checkbox"/> Digital stimulation and Suppositories for bowel Training <input type="checkbox"/> Other		
Ostomy	<input type="checkbox"/>	Yes			
	<input type="checkbox"/>	No			
Dialysis	<input type="checkbox"/>	Dialysis Type	<input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemofiltration <input type="checkbox"/> Hemodiafiltration <input type="checkbox"/> Intestinal dialysis	Dialysis Frequency	<input type="checkbox"/> Once a week <input type="checkbox"/> Twice per week <input type="checkbox"/> Three times per week <input type="checkbox"/> Four times per week <input type="checkbox"/> Five times per week <input type="checkbox"/> More than five times per week
Wound Care	<input type="checkbox"/>	Open Wound?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sterile Dressing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ulcer Care	<input type="checkbox"/>	Ulcer Staging	<input type="checkbox"/> Normal <input type="checkbox"/> Category/Stage One <input type="checkbox"/> Category/Stage Two <input type="checkbox"/> Category/Stage Three <input type="checkbox"/> Category/Stage Four <input type="checkbox"/> Unstageable <input type="checkbox"/> Suspected Deep Tissue Injury		
Isolation - infection/disease	<input type="checkbox"/>				
Other Physician-Ordered Care - by nurse to prevent advancement of a progressive disability					<input type="checkbox"/>
Care Desc					
Need for Teaching/Counseling - related to disease process, disability, diet or medication					<input type="checkbox"/>
Need for Adaptive Programs					<input type="checkbox"/>

Functional Limitations	
ADL Limitations	
Are there non-age appropriate hands-on care needs, not previously mentioned, to prevent deterioration of health conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, describe the hands-on care needs	

Other Functional Limitations	
Can the applicant ambulate without person assistance? *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the applicant confined to a wheelchair or bedbound?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contractures	<input type="checkbox"/>
Paralyzed	<input type="checkbox"/>
Fall Frequency last 6 months	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 or more
Prognosis Comments	

Additional Comments about Treatment Needs	
Additional Comments	

Support Network	
Primary Caregiver Lives in Applicant's Home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, how far away does the primary caregiver live (in approximate miles)?	
Primary Caregiver's Health is Stable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, what is the primary caregiver's health condition?	

Applicant Consent	
The applicant has consented to sharing the information documented in this Service Request Form with his or her local Department of Social Services and any agency or organization responsible for enrolling or assisting the applicant in enrolling in CAP. *	<input type="checkbox"/> Yes <input type="checkbox"/> No

Submitting Agency Identification and Applicant Primary Care Physician	
Submitter Name	

Requesting Agency	
Address	
City	
State	
Zip	
Phone	
Fax	

Referring Physician Details	
Applicant's Primary Care Physician *	
Physician NPI *	
Primary Physician Practice Name	
Primary Physician Address *	
Primary Physician City *	
Primary Physician State *	
Primary Physician Zip	
Primary Care Physician Telephone	

Comments	
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Appendix B: Service Definitions and Requirements

CAP/C service definitions and the specific provider requirements for each of the following definitions:

CASE MANAGEMENT (CME)

A service that directs and manages the special health care, social, environmental, financial and emotional needs of a CAP/C beneficiary in order to maintain the beneficiary's health, safety and well-being and for continual community integration.

The CME shall retain the following documents:

- a. service request form;
- b. all assessments;
- c. service plan;
- d. case management notes;
- e. service authorizations;
- f. copies of claims generated by the CME;
- g. any required documents generated by other providers and approved by the CME; and
- h. related correspondence in compliance with all applicable federal and state laws, rules and regulations.

Case management is a CAP/C service offered to a CAP/C beneficiary to assist in navigating community systems and gaining access to Medicaid services to meet his or her identified needs. The comprehensive Multidisciplinary assessment identifies the lack of an informal support system and the need for a case manager to assess, plan, refer, link, monitor, and provide follow-up to needed services and interventions. When the assessment identifies a CAP/C beneficiary to be at risk of institutionalization, case management must be listed in the service plan on a monthly basis to ensure the coordination of necessary services to maintain community placement. The CAP/C beneficiary has the option to select an approved case management provider, which is the sole case management provider for that CAP/C beneficiary. If a request is made to transfer to another CME, a root cause analysis must be performed within five (5) days by NC Medicaid to assure the health and well-being of the CAP/C beneficiary, as well as to identify utilization limits and access the performance of the newly selected CME. NC Medicaid shall approve the transfer of CME.

There are two types of case managers under case management and four principles of case management (listed below):

The two types of case managers are:

- a. **Case Manager** provides services for a CAP/C beneficiary participating in provider-led services.
- b. **Care Advisor** provides specialized case management to a CAP/C beneficiary participating in consumer direction care. The care advisor focuses on empowering a CAP/C beneficiary to define and direct their own personal assistance needs and services. The care advisor guides and supports the CAP/C beneficiary, rather than directs and manages the CAP/C beneficiary, throughout the service planning and delivery process. These functions are done under the guidance and direction of the CAP/C beneficiary or responsible party.

There are Four Principle Activities of Case Management:

- a. assessing;
- b. care planning;
- c. referral and linkage; and
- d. monitoring and follow-up.

Limits, Amount And Frequency

Service utilization limitation:\$4,524.80 per calendar year, effective January 1, 2020:

CAP/C beneficiary shall not receive another Medicaid-reimbursed case management service in addition to CAP/C case management.

A request can be made for additional case management reimbursable time per calendar year when the original allocation is exhausted. The following conditions must apply:

- a. the CAP/C beneficiary experiences a natural disaster and requires additional case management support to link to housing and other needed supports; or
- b. the CAP/C beneficiary 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.

Non-covered case management activities are:

- a. employee training for the case manager;
- b. completing time sheets;
- c. traveling time;
- d. recruiting staff;
- e. scheduling and supervising staff;
- f. billing Medicaid; and
- g. documenting case management activities.

CMEs shall not be a direct provider of a CAP/C service in conjunction with case management.

Qualified Provider(s)

The CME is an agency approved by NC Medicaid to act as the CAP/C coordinating agency in a county. The CME shall authorize the rendering of approved HCBS listed in the service plan to selected qualified service providers. The CME is responsible for the day-to-day case management activities for an eligible CAP/C beneficiary. These agencies can be county departments of social services, county health departments, hospitals, or qualified case management agencies. The CME shall provide monthly and quarterly case management services and provide lead entity services.

- a. The CME shall be an organization with three (3) or more years of direct service experience in providing case management to individuals at risk of institutionalization and receiving home- and community-based services.
- b. Each CME shall enroll as a NC Medicaid provider and be approved through an agreement by the State Medicaid Agency to provide lead entity CAP/C services. At the designated time that is communicated in a correspondence, the case management entity shall recertify as a Medicaid provider.

Qualified Case Management Entities shall have:

- a. Resource connection to the service area to provide continuity and appropriateness of care;
- b. Experience in pediatrics and physical disabilities;
- c. Policies and procedures in place that align with the governance of the state and federal laws and statutes;
- d. Three (3) years of progressive and consistent home and community-based experience;
- e. Ability to provide case management by both a social worker and a nurse;
- f. A physical location;

- g. Computer technology and web-based connectivity to support the requirement of current and future automated programs;
- h. Met the regulatory criteria under DHHS or DHSR;
- i. Appropriate staff to participant ratio; and
- j. Ability to authorize services within 72 hours of the approved service plan.

The case manager or care advisor shall meet **one** of the following qualifications:

- a. Bachelor's degree in social work from an accredited school of social work, and one (1) year of directly related community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a NC Medicaid-certified training program within three (3) consecutive months of employment;
- b. Bachelor's degree in a human services or equivalent field from an accredited college or university with two (2) or more years of community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a NC Medicaid-certified training program within three (3) consecutive months;
- c. Bachelor's degree in a non-human services field from an accredited college or university with two (2) or more years of community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a NC Medicaid-certified training program within three (3) consecutive months; or
- d. Registered nurse who holds a current North Carolina license, two (2) year or four (4) year degree, one (1) year case management experience in homecare, long-term care, personal care or related work and the completion of a NC Medicaid-certified training program within three (3) consecutive months.

All case managers must meet the hiring requirements of their organization and successfully pass a background check that includes an abuse registry check.

The case manager or care advisor shall complete mandatory continuing education hours per year to include claim reimbursement; CAP Business System trainings and refreshers; recognition and reporting of abuse, neglect and exploitation; and program integrity (PI).

RESPIRE

Respite care provides short-term 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 tasks. This service is arranged during the day, evening, or night for any increment of time in the beneficiary's primary private residence, current approved residential accommodations, or in a facility licensed to provide the level of care (LOC) required by the beneficiary (such as a nursing facility or hospital).

Institutional Respite is a service for CAP/C 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.

In-Home Respite 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.

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.

In-Home Respite 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.

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

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 CME, provider agency, and family to track the respite hours used to ensure the beneficiary remains within the approved limits.

The three categories of respite services listed below correspond with the type of personal care approved in service plan:

- a. In-home Aide respite;
- b. In-home Pediatric Aide respite;
- c. Nursing respite, when the beneficiary is approved to receive nursing care.

The allotted respite hours may be used in combination with institutional respite.

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 Case Management Entity (CME) and the Medicaid provider shall document respite service as requested based on the category of respite, institutional or In-home and the required documentation must contain the following components:

- a. Name of the CAP/C beneficiary;
- b. Medicaid identification;
- c. Type of respite service provided;
- d. Date of the service;
- e. Location the service was provided;
- f. Duration of the service;

- g. Task performed; and
- h. Completed and signed service note.

Respite services are subject to the EVV requirements and the provider agency shall comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments, when applicable.

Limits, Amount and Frequency

The maximum allotted days or hours for respite include both institutional respite care and in-home respite; in situation of more than one CAP/C beneficiary in a household, respite hours are assigned per household. When acute care needs of one beneficiary in the household of two or more CAP/C beneficiaries are identified, an assessment by the case management entity is performed to determine if individualized respite hours are needed to meet the needs of that individual CAP/C beneficiary.

Respite hours are not approved to be provided for staff oversight sleep time; to provide oversight to other minor children in the home or to relieve other paid providers.

Respite hours arranged during a scheduled family vacation with the CAP/C beneficiary cannot total, in combination with in-home aide, pediatric nurse aide or nurse respite care, 24 hours in one day.

Respite hours must not be used for situations in which short-term-intensive hours or an unplanned service occurrence request could be approved.

Once the yearly allotment of respite hours is used, there are no more available hours until the beginning of the next fiscal year. Additional respite hours are not approved.

Foster care services are not billed during the period that respite is furnished for the relief of the foster care provider.

These additional limitations apply to in-home respite:

- a. This service may not be used as a regularly scheduled daily service.
- b. The unpaid caregiver may not be the paid provider of respite services.
- c. Respite may not be used for a beneficiary who is living alone or with a roommate.
- d. Staff sleep time is not reimbursable.

The combined use of both institutional respite care and non-institutional respite care must not exceed 30 calendar days or 720 hours in one fiscal year. A day of institutional respite counts as 24 hours towards the annual limit.

Qualified Providers

10A NCAC 13J .1107 IN-HOME AIDE SERVICES

Licensure: TITLE 10: CH22, 0.0100; 10 NCAC 06B .0101- Institution: settings of a hospital or a nursing facility or similar setting.

Federally Recognized Tribes - Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2(10) be licensed or recognized under the State or local law where the provider is located shall be deemed to have been met:

- a. When a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and
- b. if the provider entity meets all applicable standards for such licensure or recognition.

The licensure or recognition must be deemed to have been met regardless of whether the entity obtains a license or other documentation under State or local law.

PEDIATRIC NURSE AIDE

A service for a CAP/C beneficiary 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 transferring) 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 CAP/C beneficiary'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). The personal care needs must fall within the NA II scope of nursing practice.

The staff providing the care must be an NAI or the Home Health agency shall have competencies for NA I + 4 tasks.

Typical NA 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 CAP/C beneficiary; essential shopping, cleaning and caring for clothing; performing basic housekeeping tasks such as sweeping, vacuuming, dusting, mopping and washing dishes; identifying medications for the CAP/C beneficiary; 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.

This service type is substantial. This means that the beneficiary'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 personal care aides or home health aides not registered with DHSR, unless participation in the CAP/C is through consumer direction.

ADL care for a beneficiary under the age of three (3) years is considered age appropriate and the responsibility of the parent or responsible representative. If the needed ADL assistance includes personal care needs, the care is not for normal age-appropriate functioning. 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 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 direction 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 CAP/C service occurrence requests are eligible to be used with this service. Unplanned CAP/C services occurrence requests are used to request an adjustment beyond the approved CAP/C service for a particular day(s) due to an unexpected event (such as a sick or snow day).

A CAP/C beneficiary 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*.

Pediatric Nurse Aide services, when medically necessary, shall be provided in the home, community, and workplace when identified as person-centered goals in the service plan.

Pediatric Nurse Aide services are subject to the EVV requirements and the provider agency shall comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments, when applicable.

A paid live-in caregiver is excluded from the EVV requirements. The provider agency must attest the paid live-in caregiver assigned to the CAP/C beneficiary meets the definition of a paid live-in caregiver to be excluded from capturing EVV data, refer to Appendix F. An attestation must be completed initially and every six (6) after the initial attestation.

An assigned Nurse Aide shall accompany or transport (based on the agency's policy) a CAP/C 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 assistance for the CAP/C beneficiary.

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.

Note: 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 CAP/C beneficiary when a prospective employee is within the 10-year rule and the CAP/C beneficiary shall have the autonomy to approve the exemption.

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

Limits, Amount and Frequency

The type, frequency, tasks and number of hours per day of this CAP/C service are authorized by the CME, based on medical necessity of the CAP/C beneficiary, caregiver availability, budget limits and other available resources.

A spouse, parent, step-parent, or grandparent (who is the primary caregiver and makes the sole decisions on behalf of the waiver beneficiary for health care and emergency issues), is eligible for hire as the employee when a CAP/C beneficiary is 18 years of age or older. A spouse, parent, or grandparent, of the CAP/C beneficiary may provide this service only when:

- a. CAP/C beneficiary and provider are 18 years of age or older; and
- b. Meets the qualifications to perform the level of personal care determined by the CAP/C assessment.

To comply with Fair Labor Standards Act, a relative, paid staff and when approved, a legal guardian of a CAP/C beneficiary 18 years old and older, may be paid overtime for hours worked greater than 40-hour week when Department of Labor Laws are met.

A legal guardian, Power of Attorney, Health Power of Attorney of a CAP/C beneficiary age 18 and over cannot be hired to provide personal care services to CAP/C beneficiaries unless an exemption is granted.

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

CAP/C funding must not be used to pay for services provided in public schools when service needs fall under the provision of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

Nurse Aide services must not be provided at the same day or time as CAP/C 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.

A prospective employee submitting an application for hire under consumer direction program shall not perform services until competencies and trainings are verified or completed.

Payment to a legal guardian or a responsible party (an individual who acts on the behalf of the wavier beneficiary) to provide in-home aide services to a CAP/C beneficiary between the ages of 18-20 years old may be made when any **one** of the following extraordinary circumstances is met:

- a. There are no available CNAs in the CAP/C beneficiary's county or adjunct counties through a Home Health Agency or In-Home Aide Agency due to a lack of qualified providers, and the CAP/C beneficiary needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
- b. The CAP/C beneficiary 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 CAP/C beneficiary chooses to receive care in their home instead of an institution.
- c. The CAP/C beneficiary 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 CAP/C beneficiary 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 CAP/C beneficiary; regular interruption at work to assist with the management of the CAP/C beneficiary's monitoring or supervision needs; or an employment termination.
- d. The CAP/C beneficiary 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 CAP/C beneficiary and avoid institutionalization.
- e. Other documented extraordinary circumstances not previously mentioned that places the CAP/C beneficiary's health, safety and well-being is in jeopardy resulting in an institutional placement.

For each of the extraordinary circumstances described, the maximum number of hours approved for payment for providing personal care services is up to 40 hours per week. The approved hours are based primarily on the assessed needs identified in the assessment.

The payment for instrument activities of daily living such as meal preparation, laundry, money management, home maintenance, shopping, and medication management is inclusive with the payment for the performance or assistance with activities of daily living (ADLs) tasks.

When the legal guardian is authorized to receive payment for providing personal assistance services, the CAP/C beneficiary monitored closely by the case management entity (CME) to ensure quality assurance of the health, safety and well-being of the CAP/C beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.

The assigned CME shall perform a bi-monthly (two times per month) in-person monitoring visit to ensure the services are provided according to the service plan and the CAP/C participation business requirements.

A legal guardian will not be approved to provide personal care services and receive payment because of an unjustified unwillingness to work with Home Health Agencies/In-Home Aide Agencies. A legal guardian will not be approved to provide personal care services and receive payment if there are other providers available to render personal care services when the CAP/C beneficiary has been discharged from a Home Health Agency/In-Home Aide Agency due to non-complaint or violent behavior exhibited by the CAP/C beneficiary or the legal guardian.

A legal guardian who is currently approved to receive payment for performing personal care services to a CAP/C beneficiary has previously met the conditions outlined above; therefore, a grandfathering process is not necessary.

When it is determined to be in the best interest of the CAP/C beneficiary to have a legally responsible individual to provide personal care services, a physician's recommendation must be provided to the case manager outlining the specific care needs of the CAP/C beneficiary 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 weighed. A total of 40 hours per week may be authorized and approved.

42 CFR §440.167 prohibits federal financial participation (FFP) for payments to legally responsible individuals for the provision of State plan personal care services or similar services. This prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide. Legally responsible individuals do not include the parent of an adult beneficiary (including a parent who also may be a legal guardian) or other types of relatives, except as provided in state law).

Qualified Provider

Refer to **Subsection 6.6** for qualifications.

Licensure: TITLE 10: CH22, 0.0100; 10 NCAC 06B .0101- Institution: settings of a hospital or a nursing facility or similar setting.

Federally Recognized Tribes - Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2(10) be licensed or recognized under the State or local law where the provider is located is deemed to have been met:

- a. When a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and

b. if the provider entity meets all applicable standards for such licensure or recognition.

The licensure or recognition is deemed to have been met regardless of whether the entity obtains a license or other documentation under State or local law.

Home Health agency shall follow the DHRS and BON regulations in assigning NAI to a CAP/C beneficiary requiring specialized or skilled nursing care. Home Health agency shall obtain a physician's order to render the authorized pediatric nurse aide service.

Consumer Direction Providers

Consumer direction 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/C beneficiary as documented by the consumer-directed beneficiary or responsible party through the self-assessment questionnaire and uploaded to the case file by the CME.

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

CAP IN-HOME AIDE SERVICE

A service for CAP/C beneficiary that, during the hours of service provision, limited to extensive hands-on (not merely set-up or cueing) assistance is provided for two of the seven key ADLs (bathing, dressing, eating, toileting, hygiene, mobility and transferring), at a minimum. This service is intended for a beneficiary who is unable to perform these tasks independently due to a medical condition identified and documented on a validated assessment. The need for assistance with ADLs relates directly to the CAP/C beneficiary's physical, social environmental and functional condition. Personal Care Aide Services, when medically necessary, are provided in the community, home, workplace, or educational settings. The personal care needs must fall within the NA I scope of nursing practice.

ADL care for a beneficiary under the age of three (3) years is considered age appropriate and the responsibility of the parent or responsible representative. If the needed ADL assistance includes personal care needs, the care is not for normal age-appropriate functioning.

Tasks, amount, frequency, and duration must be clearly outlined in job duties developed by the CAP/C beneficiary or responsible party or representative participating in consumer direction.

CAP In-Home Aide service is subject to the EVV requirements and the provider agency shall comply with Section 12006 1903(1) of the 21st Century Cures Act and any subsequent amendments, when applicable.

A paid live-in caregiver is excluded from the EVV requirements. The provider agency must attest the paid live-in caregiver assigned to the CAP/C beneficiary meets the definition of a paid live-in caregiver to be excluded from capturing EVV data, refer to Appendix F. An attestation must be completed initially and every six (6) after the initial attestation.

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/C 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 service occurrence requests are eligible to be used with these services. Unplanned CAP/C services occurrence requests are used to request an adjustment beyond the approved CAP/C service for a particular day(s) due to an unexpected event (such as a sick or snow day).

Activities of Daily Living (ADLs) care for children under the age of three years is considered age appropriate and the responsibility of the parent or responsible representative. 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.

A CAP/C beneficiary 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 CAP/C 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 assistance for the CAP/C beneficiary

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 a CAP/C beneficiary is 18 years of age or older.

A spouse, parent, or grandparent (who is the primary caregiver and makes the sole decisions on behalf of the waiver beneficiary for health care and emergency issues) of the CAP/C beneficiary shall provide this service only if:

- a. CAP beneficiary and provider are 18 years of age or older; and
- b. The person meets the qualifications to perform the level of personal care determined by the CAP 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 CAP/C beneficiary.

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.

Note: Individuals with criminal offenses (listed above) occurring more than 10 years before 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 CAP/C beneficiary when a prospective employee is within the 10-year rule and the CAP/C beneficiary shall have the autonomy to approve the exemption.

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

Limits, Amount and Frequency

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

Documentation must be provided when specific training and education services are needed, and documentation is provided to support training needs were met. A prospective employee applying for hire under the consumer direction program shall not perform services until competencies and trainings are verified or completed.

CAP/C funding must not be used to pay for services provided in public schools when service needs fall under the provision of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

In-Home Aide services may not be provided at the same day or time as pediatric Nurse Aide services or private duty nursing. In-Home Nurse Aide services must not be provided if they duplicate other Medicaid or non-Medicaid services.

Payment to a legal guardian or responsible party (an individual who acts on the behalf of the waiver beneficiary) to provide in-home aide services to a CAP/C beneficiary between the ages of 18-20 years old may be made when any **one** of the following extraordinary circumstances is met:

- a. There are no available CNAs in the CAP/C beneficiary's county or adjunct counties through a Home Health Agency or In-Home Aide Agency due to a lack of qualified providers, and the CAP/C beneficiary needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
- b. The CAP/C beneficiary 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 CAP/C beneficiary chooses to receive care in their home instead of an institution.

- c. The CAP/C beneficiary 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 CAP/C beneficiary 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 CAP/C beneficiary; regular interruption at work to assist with the management of the CAP/C beneficiary's monitoring or supervision needs; or an employment termination.
- d. The CAP/C beneficiary 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 CAP/C beneficiary and avoid institutionalization.
- e. Other documented extraordinary circumstances not previously mentioned that places the CAP/C beneficiary's health, safety and well-being is in jeopardy resulting in an institutional placement.

For each of the extraordinary circumstances described, the maximum number of hours approved for payment for providing personal care services is up to 40 hours per week. The approved hours are based primarily on the assessed needs identified in the assessment.

The payment for instrument activities of daily living (IADLs) such as meal preparation, laundry, money management, home maintenance, shopping, and medication management is inclusive with the payment for the performance or assistance with activities of daily living (ADLs) tasks.

When the legal guardian is authorized to receive payment for providing In-Home Aide services, the CAP/C beneficiary monitored closely by the case management entity (CME) to ensure quality assurance of the health, safety and well-being of the CAP/C beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.

The assigned CME shall perform a bi-monthly (two times per month) in-person monitoring visit to ensure the services are provided according to the service plan and the CAP/C participation business requirements.

A legal guardian will not be approved to provide personal care services and receive payment because of an unjustified unwillingness to work with Home Health Agencies or In-Home Aide Agencies. A legal guardian will not be approved to provide personal care services and receive payment if there are other providers available to render personal care services when the CAP/C beneficiary has been discharged from a Home Health Agency/In-Home Aide Agency due to non-complaint or violent behavior exhibited by the CAP/C beneficiary or the legal guardian.

A legal guardian who is currently approved to receive payment for performing personal care services to a CAP/C beneficiary has previously met the conditions outlined above; therefore, a grandfathering process is not necessary.

When it is determined to be in the best interest of the CAP/C beneficiary to have a legally responsible individual to provide personal care services, a physician's recommendation must be provided to the case manager outlining the specific care needs of the CAP/C beneficiary 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 weighed. A total of 40 hours per week may be authorized and approved.

42 CFR §440.167 prohibits federal financial participation (FFP) for payments to legally responsible individuals for the provision of State plan personal care services or similar services. This prohibition is based on the presumption that legally responsible individuals may not be paid for supports that they are ordinarily obligated to provide. Legally responsible individuals do not include the parent of an adult beneficiary (including a parent who also may be a legal guardian) or other types of relatives, except as provided in state law).

Qualified Provider(s)

Refer to **Subsection 6.6.**

Licensure: TITLE 10: CH22, 0.0100; 10 NCAC 06B .0101- Institution: settings of a hospital or a nursing facility or similar setting.

Federally Recognized Tribes - Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2 (10) be licensed or recognized under the State or local law where the provider is located shall be deemed to have been met:

- a. when a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and
- b. if the provider entity meets all applicable standards for such licensure or recognition.

The licensure or recognition is deemed to have been met regardless of whether the entity obtains a license or other documentation under State or local law.

Consumer direction 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/C beneficiary as documented by the consumer-directed beneficiary or responsible party through the self-assessment questionnaire and uploaded to the case file by the CME.

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

FINANCIAL MANAGEMENT SERVICES

Financial Management Services (FMS) are provided for a CAP/C beneficiary who is directing his or her own care, to ensure that consumer direction funds outlined in the service plan are managed and distributed as intended. An approved financial manager shall perform financial management services to reimburse the personal assistant(s) and designated providers.

Financial managers shall provide education and training to orient the CAP/C beneficiary to the roles and requirements of the consumer direction. Financial managers facilitate the employment of the personal assistant employee and the requirements of the consumer direction by completing the following tasks:

- a. Serving as the beneficiary's Power of Attorney for Internal Revenue Service's processes;
- b. Submitting payment of payroll to employees hired to provide services and supports; and
- c. Ordering employment related supplies and paying invoices for approved waiver-related expenses.

The Financial Manager shall:

- a. deduct all required federal, state taxes, including insurance, prior to issuing payment;
- b. maintain separate accounts on each beneficiary's services, and producing expenditure reports as required by the state Medicaid agency;
- c. provide payroll statements on at least a monthly basis to the personal assistant(s)
- d. completes necessary background checks (criminal and registry) and age verification on personal assistants;
- e. administer benefits to the personal assistant(s) as directed by the CAP/C beneficiary; and
- f. file claims for self-directed services and supports.

Limits, Amount and Frequency

FMS are billed in one (1) unit per as per the established and approved Medicaid Fee Schedule, effective January 1, 2020.

A consumer direction initiation (Start-up) fee must be assessed the first month of enrollment and must not exceed (1 unit). Monthly management fees are assessed each month and must not exceed (1 unit) per month.

A consumer direction transition fee must be assessed for a CAP/C beneficiary transferring from one fiscal intermediary to another and must not exceed 1 unit. A consumer direction transition fee must be assessed for a CAP/C beneficiary transferring back to a previous fiscal intermediary and must not exceed .5 units during the transition month.

Qualified Provider(s)

A qualified provider of this services is Accountants, financial advisors, financial managers, attorneys, other individuals meeting qualifications of financial management. The Financial Manager 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. The FMS shall maintain current and archived CAP/C beneficiary, attendant, service vendors and FMS files as required by Federal and State rules and regulations, including HIPAA requirements. Internal controls for monitoring this process must be contained in the system and described in the policies and procedures.

The agency providing FMS shall also:

- a. have the capacity to provide Financial Management Services through both the Agency with Choice (AwC) and Fiscal and Employer Agent (F/EA) models
- b. be authorized to transact business in the State of North Carolina, pursuant to all State laws and regulations; and
- c. be approved as a Medicaid Provider for Financial Management Services (or in the process of applying for such approval).

The agency providing FMS shall have experience and knowledge of **all** the following:

- a. Automated standard application of payment;
- b. Check Claims;
- c. Electronic Fund Transfer;
- d. Electronic Fund Account;
- e. International Treasury Service;
- f. Invoice processing platform;
- g. Judgment Fund;

- h. Payment Application Modernization;
- i. Prompt Payment;
- j. Automated Clearing House;
- k. Cash Management Improvement Act;
- l. GFRS and FACTS I;
- m. Government wide Accounting;
- n. Intergovernmental Reconciliation;
- o. Standard General Ledger; and
- p. Tax Payer Identification Number.

ASSISTIVE TECHNOLOGY

Assistive technology for a CAP/C beneficiary consists of items, product systems, supplies, and equipment, that are not covered by State Plan Home Health or Durable Medical Equipment and Supplies, acquired commercially, modified, or customized, and used for

- a. improving or maximizing the functional capabilities of the beneficiary;
- b. improving the accessibility and use of the beneficiary's environment; or
- c. addressing twenty-four hours beneficiary coverage issues.

This service must 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;
- c. specialized accessibility and safety adaptations or additions;
- d. ceiling track system for the purpose of transfers;
- e. an Environmental Control Unit (ECU) or Electronic Aid to Daily Living (EADL) that allows a beneficiary with a disability to control aspects of their environment that are operated by electricity (such as lights, door strikes and openers Heating and Ventilating Contractors Association (HVAC), television, telephone, hospital bed, computer, small appliances). An ECU or EADL can range from a single function device to a whole house computed-based system; and
- f. Adaptive Tricycles: An item 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 documented by an assessment of need.

This service consists of 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/C service consists of a plan for training the CAP/C beneficiary, family, primary caregiver, personal aides, or assistants who 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/C 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 can 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/C beneficiary.

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 a 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. 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.

Limits, Amount and Frequency

The cost of assistive technology is contained in a combined home and vehicle modification 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 assistive technology will be denied.

Adaptive tricycles for a CAP/C beneficiary: \$ 3,000 over cycle of the five (5) year waiver.

Assistive technology for a CAP/C beneficiary excludes items that are covered under the Home Health Final Rule and duplicates a Medicaid State Plan service.

Note: Medicaid assumes no liability related to the use or maintenance of the equipment and assumes no responsibility for returning the private primary residences to its pre-modified condition. Assistive technology may not be furnished to adapt living arrangements.

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 CME.

Items that are covered through DME, orthotics and prosthetics and home health supplies are obtained through the respective programs prior to requesting from CAP/C. CAP/C does not cover items that are covered by these programs that were denied for the beneficiary for lack of medical necessity.

Assistive Technology Service excludes the following:

- a. equipment that adds to the total square footage of the home;
- b. home improvements, renovations, and repairs;
- c. a dwelling where the owner refuses the technology;
- d. equipment that is not portable when the home is rented;
- e. service agreements, maintenance contracts, and extended warranties;

- f. equipment or technology related to swimming pools, hot tubs, spas, or saunas;
- g. items that are recreational in nature;
- h. items that have general utility to a non-disabled beneficiary;
- i. replacement of equipment that has not been properly used, has been lost or purposely damaged; and
- j. computers, laptops, tablets, or smart phones.

Qualified Provider(s)

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 along with certification of clinical competency is required for augmentative communication evaluations) shall provide assistive technology. Additional provider qualifications to 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.

COMMUNITY TRANSITION SERVICES

A service for a prospective CAP/C beneficiary for transitioning from a 90-calendar day or more institutional setting to a community setting. The funds are used to pay the necessary and documented expenses for a CAP/C beneficiary to establish a basic living arrangement.

Community transition services are available to cover expenditures for initial set-up expenses for a CAP/C beneficiary who make the transition from an institution to their own primary private residence in the community.

Community Transition Services shall cover:

- a. Equipment, essential furnishings, and household products including furniture for the bedroom or living room, window coverings, food preparation items, and bed or bath linens;
- b. Security deposits or other such payments required to obtain a lease on an primary private residence;
- c. Set-up fees or deposits for utility or service access such as, telephone, electricity, heating); and
- d. Any other service, equipment, or item that is not listed above that is necessary to integrate in the community and does not duplicate a Medicaid State Plan service.

Items and services must be of sufficient quality and appropriate to the needs of the beneficiary according to the CAP/C assessment. The service note must document the necessary reason for the items and services. A copy of the invoice of these items and services must be filed in service record by the CME and the CAP/C Medicaid provider. The vendor of the service must provide a receipt or invoice for each purchase for each requested reimbursement. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service definition.

Limits, Amount and Frequency

Community transition services are available to cover, initial set-up expenses, not to exceed \$2,500 over the cycle of CAP/C approval period. This service does not provide ongoing payments for rent.

A request for this service can be made on, during the assessment assignment, or after the completion of the comprehensive assessment. All service requests must be made and utilized within one year from the date of beneficiary's discharge from an institution.

This service does not include rent or back rent payments.

Qualified Provider(s)

The CME shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

HOME ACCESSIBILITY AND ADAPTATION

Home accessibility and adaptation provides equipment and physical adaptations or minor modifications, as identified during an assessment, to enhance the CAP/C beneficiary's mobility, safety, and independence in the primary private residence. This service often plays a key role in preventing institutionalization.

An assessment must be reviewed by the multidisciplinary team including 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 request to certify that the requested adaptation is necessary. The physician's order and the assessment of need completed by the multidisciplinary team must be on file with the case manager's records. 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.

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.

The vendor or CME shall file a claim to Medicaid upon the receipt of an invoice to receive reimbursement for this service. The original invoice must be retained in the beneficiary's health record.

Home modifications can be provided only in the following settings:

- a. A primary private residence where the CAP/C beneficiary resides that is owned by the beneficiary 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 only 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
- d. Modification of an existing bathroom to improve accessibility for a disabled beneficiary, such as : installation of roll in shower, 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. 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);
- g. Lift systems and elevators that are used inside a beneficiary's private primary residence and are not otherwise covered under DME;
- h. Porch stair lifts;
- i. 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;
- j. 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;
- k. 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.
- l. 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 home accessibility and adaptation service consists of the following:

- 1. Technical assistance in device selection;
- 2. Training in device use by a qualified assistive technology professional;
- 3. Purchase, necessary permits and inspections, taxes, and delivery charges;
- 4. Installation;
- 5. Assessment of modification by the case manager and by any applicable inspectors to verify safety and ability to meet beneficiary's needs;
- 6. 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 CAP/C beneficiary or his or her family shall own any equipment that is repaired; and
- 7. 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 beneficiary's needs.

Note: Medicaid shall assume no liability related to use or maintenance of the equipment and assumes no responsibility for returning the private primary residence to its pre-modified condition. Home modifications may not be furnished to renovate living arrangements.

Limits, Amount and Frequency

Home accessibility and adaptation provides a combined vehicle modification and assistive technology budget of \$28,000 per beneficiary per the cycle of the CAP/C waiver, which is renewed every five years from the date of its latest approval. When the maximum utilization limit is reached, requests for home modification are denied. **The CME shall track all costs of home accessibility and adaptation aids billed and paid, in order to avoid exceeding the \$28,000 limit over the cycle of CAP/C (five years).**

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded and not authorized by the CME

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 CAP/C objectives of avoiding institutionalization.

Items that are covered through DME, orthotics and prosthetics and home health supplies are obtained through the respective programs prior to requesting from CAP/C. CAP/C does not cover items that are covered by one of these programs but were denied for that particular CAP/C beneficiary for lack of medical necessity.

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 beneficiary;
- 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 CAP/C beneficiary; and
- o. Air filtration that is less than or equal to 50 parts per billion ozone by-products.

Medicaid is the payer of last resort; if the beneficiary has private insurance that covers the item, the CME shall verify and document the insurance coverage. The item must be billed through the private insurance payer.

Funding for CAP/C services available through CAP/C must be shared to meet the needs of the household. Equipment, technology and modification are shared when the disabilities of two or more CAP/C beneficiaries living in the same household are similar.

The total budget for home accessibility and adaption services is planned per CAP/C beneficiary and the total budget must be shared between the two parents when a shared custody order is in effect.

A CAP/C beneficiary who resides in foster care is eligible to receive a home modification when the modification is portable.

A CAP/C beneficiary 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.

Qualified Provider(s)

The Case Management Entity (CME) shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

GOODS AND SERVICES

A service for a CAP/C beneficiary that provides services, equipment, or supplies not otherwise provided through CAP/C or through the Medicaid State Plan. The service helps assure the health, safety and well-being when the CAP/C beneficiary or responsible party does not have resources to obtain a necessary item or service. The service must aid in the prevention or diversion of institutional placement.

This service is not otherwise provided through this waiver or through the Medicaid State Plan; and the CAP/C beneficiary does not have the funds to purchase the goods and services and he or she is not available through another source.

Participant goods and services are items that are intended to:

- a. increase the CAP/C beneficiary’s ability to perform activities of daily living (ADL’s) or instrumental activities of daily living (IADL’s); and
- b. decrease dependence on personal assistance services or other Medicaid-funded services.

The following are the specific coverable items for this service definition:

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	Items to assist with mobility
Long handle sponges Long handle	Button aids Zipper pulls Socks aids	Reacher and grasping aids Doorknob grippers Key turners	utensils and adaptive utensils No spill cups	Bottom wipers Bedside commode cushion	Bed raisers Orthopedic pillows Wheelchair

brushes		Wheelchair or walker	straw holder	Incontinence	canopy
Long handle		baskets/bags/caddy	two-handle	disposal	
shoehorns		Safety aid	mug	system	
Elastic		Magnifying glass or	Scooper	Protectants for	
shoelaces		magnifier	bowls and	a mattress,	
Bath tap		Writing aids	plates	chair or car	
turners		Large number clock	one pull can	seat to protect	
		Bedside table	opener	against	
		Emergency hand	Plate guards	incontinence	
		cranked radio	Jar openers	accidents	
		Flashlight	Bibs		

Non-medical transportation services are intended to allow a CAP/C beneficiary the ability to access the community to obtain medication, food, attend appointments and to meet goals of community integration included in person-centered service plan. 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 Non-Emergency Medical Transportation (NEMT).

The maximum utilization for transportation services per CAP/C beneficiary cannot exceed \$800.00 per fiscal year in combination with other approved goods and services.

- a. Mile reimbursement - .58 cents per mile with a maximum radius of 35 miles from the CAP/C beneficiary's residence. The maximum allowable per trip is \$21.80. The maximum allowable trips per month is three (3).
- b. 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.
- c. Taxi rides or share rides - The maximum allowable per trip is \$21.80. The maximum allowable trips per month is three (3).
- d. Gas Vouchers - .58 cents per mile with a maximum radius of 35 miles from the CAP/C beneficiary's residence. The maximum allowable for one gas voucher per trip is \$21.80. The maximum allowable gas vouchers per month is three (3).

Individual Directed Goods and Services are services for a CAP/C beneficiary directing care that provides; services, equipment, or supplies not otherwise provided through this program or through the Medicaid State Plan. As a result, the CAP/C beneficiary 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 CAP/C beneficiary 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 CAP/C beneficiary'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 CAP/C beneficiary’s needs established in the service plan.

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 CAP/C beneficiary’s 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:

The following are the specific coverable items for this service definition:

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	Items to assist with mobility
Long handle sponges Long handle brushes Long handle shoehorns Elastic shoelaces Bath tap turners	Button aids Zipper pulls Socks aids	Reacher and grasping aids Doorknob grippers Key turners Wheelchair or walker baskets/bags/caddy Safety aid Magnifying glass or magnifier Writing aids Large number clock Bedside table Emergency hand cranked radio Flashlight	utensils and adaptive utensils No spill cups straw holder two-handle mug Scooper bowls and plates one pull can opener Plate guards Jar openers Bibs	Bottom wipers Bedside commode cushion Incontinence disposal system Protectants for a mattress, chair or car seat to protect against incontinence accidents	Bed raisers Orthopedic pillows Wheelchair canopy

Nutritional Services are services for a CAP/C beneficiary 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 services are necessary to assist the CAP/C beneficiary to maintain community placement and for the management of health and safety as identified in the person-centered service plan.

The services under the waiver's Nutritional Services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with CAP/C objectives of avoiding institutionalization.

A medical necessity review must be conducted, and an approval provided to allow coverage of nutritional services under the CAP/C.

The maximum utilization for nutritional services per CAP/C beneficiary cannot exceed \$800.00 per fiscal year in combination with other approved goods and services.

Pest Eradication

A service for CAP/C beneficiary that provides a one-time pest eradication treatment. This service is coverable when the CAP/C beneficiary 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.

This service is not intended for monthly, routine or ongoing treatments.

The maximum utilization for nutritional services per CAP/C beneficiary cannot exceed \$800.00 per fiscal year in combination with other approved goods and services.

Participants goods and services and individual goods and services are excluded when this service is approved and reimbursed to its maximum limits during each qualifying fiscal year.

Limits, Amount And Frequency

This service must not duplicate the following State Plan services:

- a. medical transportation services provided by the Medicaid State Plan;
- b. informal supports such as family, friends, neighbors or community resources that can provide transportation without charge shall be utilized prior to using CAP/C funding;
- c. transportations services provided by CAP/C must not duplicate or replace transportation services offered by the Medicaid State Plan;
- d. items that are not of direct medical or remedial benefit to the CAP/C beneficiary;
- e. items covered under the Home Health Final Rule;
- f. items covered through Medicaid State Plan DME, orthotics, prosthetics, and home health supplies;
- g. items that meet the definition exclusions for being recreational in nature;
- h. items that meet the definition exclusions for being general utility to a non-disabled beneficiary;
- i. service agreements & maintenance contracts not related to the approved service;
- j. warranties;
- k. equipment related to swimming pools, hot tubs, spas, and saunas that are not approved in the person-centered service plan or named in the exclusion definition and not determined to be a medical necessity;
- l. replacement of equipment that has not been properly used, has been lost, or purposely damaged per documentation or through observation;
- m. technology hardware, when considered recreational in nature;
- n. pharmacy related items that are not approved in the service plan; or

- o. outdoor monitoring systems that are not approved in the service plan.

The cost of goods and services for each CAP/C beneficiary must not exceed \$800.00 annually (July – June). Products and items listed on the State Medicaid Plan are prohibited from being reimbursed by this service unless approved by NC Medicaid’s LTSS unit.

A physician’s order is required for the listed items to establish medical necessity:

- a. nutritional services;
- b. equipment used for swimming pools and spas; and
- c. security systems, alarms on gates or video camera for the telephony management of a chronic medical condition.

Note: The above requested items must undergo an EPSDT review. If medical necessity is determined, the processing of the request is initiated through the State Plan first; and if the requested service is not available through State Plan, CAP/C funding is used.

The required documents for approval and reimbursement of this service are:

- a. comprehensive Multidisciplinary declaration of need assessment completed by the case manager identifying equipment, supply, adaptation, or modification needs;
- b. copy of the physician’s order, when determined to be applicable;
- c. recommendation by an appropriate professional that identifies the beneficiary’s need(s) with regard to the equipment, supply, adaptation, or modification being requested;
- d. the estimated life of the equipment as well as the length of time the beneficiary is expected to benefit from the equipment, must be indicated in the request; and
- e. an invoice from the supplier that shows the date the equipment, supply, adaptation, or modification were provided to the beneficiary and the cost, with related charges and maintained in the CAP Business system.

Qualified Providers(s)

The Case Management Entity (CME) shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

SPECIALIZED MEDICAL EQUIPMENT

Specialized medical equipment and supplies are:

- a. Adaptive car seat: An item used for safe transport, documented by an assessment of need; and
- b. Vehicular transport vest: An item for safe transport, documented by an assessment of need.

Specialized medical equipment and supplies services consist of the following:

- a. The performance of assessments by the CME to identify the type of equipment needed by the beneficiary;
- b. Training by the CAP/C provider to the beneficiary or caregivers in the operation and maintenance of the equipment or use of the supply; and
- c. Repair of the equipment determined by the CME is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment.

Limits, Amount and Frequency

The service under the waiver's Specialized medical equipment is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with CAP/C objectives of avoiding institutionalization.

Vehicular transport vest for a CAP/C beneficiary 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 beneficiary weighs less than the upper weight limit of the current car seat, as documented in the service record. As priced per plan year. Those items that are not of direct medical or remedial benefit to the beneficiary are excluded and not authorized by the CME.

Items that are covered through DME, orthotics and prosthetics and home health supplies are obtained through the respective programs prior to requesting from CAP/C. CAP/C shall not cover items that are covered by one of these programs but were denied for the particular beneficiary for lack of medical necessity.

Specialized medical equipment and supplies excludes the following:

- a. items that are commercial and have general utility to a non-disabled CAP/C beneficiary;
- b. service agreements, maintenance contracts, and excluded warranties;
- c. equipment related to swimming pools, hot tubs, spas, and saunas; or
- d. replacement of equipment that has not been properly used, has been lost or purposely damaged.

Qualified Provider(s)

The CME shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

TRAINING, EDUCATION, AND CONSULTATIVE SERVICES

A service for a CAP/C beneficiary that provides for training, orientation, and treatment regimens, regarding the nature of the illness or disability and its impact on the CAP/C beneficiary and his or her family or the individual(s) who provide unpaid care, support, training, companionship, or supervision which may include family members, neighbors, friends and companions.

The purpose of this service is to

- a. enhance the decision-making ability of the beneficiary,
- b. to improve the mental health and social interaction of the beneficiary,
- c. to enable the beneficiary to independently care for him or herself; or
- d. to enhance or aide in the ability of the family member or personal care assistant under the consumer direction program in caring for the CAP/C beneficiary.

Training, education and consultative services consist of information, techniques, and supportive services to maintain health, safety and well-being of the CAP/C beneficiary. All training, education and consultative services are documented in the service plan as a goal with the expected outcomes. This service covers conference registration, enrollment fees for classes and office fees for therapies that are not covered under Medicaid State Plan.

Service is provided by community colleges, universities, counselors or an organization with a training or class curriculum approved by NC Medicaid designed contractor and documented in the CAP/C beneficiary's service note.

Limits, Amount and Frequency

Training, education, and consultative services are limited to \$500 per fiscal year (July 1- June 30) when the service prevents or diverts an institutional placement.

This service does not include the cost of travel, meals, or overnight lodging to attend a training event or conference.

Personnel hired through a Home Care Agency, Home Health Agency, Hospice Agency and Consumer-directed care are excluded from utilizing this service.

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded and not authorized by the CME.

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded and not authorized by the CME.

Items that are covered through DME, orthotics and prosthetics and home health supplies are obtained through the respective programs prior to requesting from CAP/C. CAP/C shall not cover items that are covered by one of these programs but were denied for a particular beneficiary for lack of medical necessity.

Training, education, and consultative services exclude the following:

- a. services that are recreational in nature;
- b. services that have general utility to a non-disabled CAP/C beneficiary;
- c. reimbursement for registration fees when participation occurred prior to the service request;
- d. reimbursement for licensing, certification, or credentialing; or
- e. Training, education and consultative services for a paid caregiver.

The required documents for approval and reimbursement of this service are:

- a. Comprehensive Multidisciplinary Needs Assessment completed by the case manager identifying equipment, supply, adaptation, or modification needs;
- b. copy of the physician's order, when determined to be applicable;
- c. recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the equipment, supply, adaptation, or modification being requested; and
- d. an invoice from the supplier that shows the date the equipment, supply, adaptation, or modification were provided to the beneficiary and the cost, with related charges and maintained in the CAP Business system.

Qualified Provider(s)

The CME shall verify and approve providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

VEHICLE MODIFICATION

Vehicle modification is a service for a CAP/C beneficiary 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 CAP/C beneficiary's primary means of transportation. The vehicle must be owned by the CAP/C beneficiary 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.

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 beneficiary'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 listed items are covered when the items listed in the assessment are specific to the disability that may be included in the exhaustive list.

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 CAP/C objectives of avoiding institutionalization.

An assessment of need must be reviewed by a multidisciplinary team including a Physical Therapist or Occupational Therapist specializing in vehicle modifications, or a Rehabilitation Engineer or Vehicle

Adaptation Specialist to certify 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 of need must be submitted with the request for Vehicle Modifications. Upon a determination analysis of a request, a physician’s signed order may be request, when applicable, to certify that the requested adaptation is necessary. When a physician’s signed order is required, the order must be on file with the case manager’s records. When feasible, there must be at least one competitive quote 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.

Documentation regarding each of the requirements must be submitted as indicated in **Subsection 5.7.1**.

Limits, Amount and Frequency

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, in order 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 vehicle that is adapted must belong to the CAP/C beneficiary’s parent or the legally responsible representative, refer to **Appendix F**.

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).

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 CAP/C objectives of avoiding institutionalization.

All equipment purchased through the CAP/C services uses a selection process to ensure the most efficient use of Medicaid funds.

Items that are covered through DME, orthotics and prosthetics and home health supplies are obtained through the respective programs prior to requesting from CAP/C. CAP/C shall not cover items that are covered by one of these programs but were denied for a particular beneficiary for lack of medical necessity.

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;

Qualified Provider(s)

The CME shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

Appendix C: Determination of Support Needs

BASIC FORMULA

The approval of hours is person-centered and is based on the CAP/C beneficiary's care needs, the caregiver's availability, medical necessity and other available formal and informal resources. The hours are authorized on a weekly basis based on the care needs of the CAP/C beneficiary.

The number of hours of nurse aide hours authorized for a CAP/C beneficiary is illustrated below. The CME or designated contractor assesses the CAP/C beneficiary's care needs and the caregivers' availability and determines the number of hours available using the following formula:

Work Time

Actual hours worked

+ ½ to 2 hours commute per day (actual commute time)

– # hours other support available

= X hours max per week

The approval of hours is based on the care needs of the CAP/C beneficiary. All the hours authorized are contingent upon interventions being provided for the CAP/C beneficiary's care needs. For example, a CAP/C beneficiary may have interventions done during the day but sleeps through the night with no interventions needed; night covered care would not be covered because beneficiary's care needs can be met at night by primary caregiver(s). Hours are only authorized when there are medically necessary interventions taking place.

Parents or responsible party who work must provide employment verification. The Case Manager verifies the caregiver's employment schedule. Verification consists of a written statement on employer letterhead or company generated verification. The statement verifies the caregiver is employed and details the hours and schedule of employment. Hours for work are not approved unless employment verification is provided. If a caregiver is self-employed, the substitute work verification form prepared by NC Medicaid may be used instead. If this form is used, the case manager or another independent party shall be reasonably sure that the information in it is accurate. If a caregiver does not meet the criteria for use of the form, the form is not permitted to be used as work verification and hours for work are not approved.

Work time is not approved for volunteer work.

WORKING AT HOME

Caregiver availability is assessed on a case-by-case basis according to the caregiver's physical proximity to the child and the caregiver's flexibility in being able to address care needs during work hours or to arrange work hours around care needs.

ATTENDING SCHOOL

Caregivers attending school in pursuit of a diploma or a degree for purposes of employment may count their school time as work time. Time is calculated as follows: actual time spent in class per week, plus commute time if applicable. The school transcript must be provided.

CAREGIVER'S OVERTIME AND ON-CALL

CAP/C hours are not authorized to cover caregiver's overtime hours. CAP/C hours are not authorized to cover caregiver's on-call time.

WORK AND SCHOOL OR MULTIPLE JOBS

The primary caregiver needs to make other arrangements for care coverage when hours worked due to work, school, or multiple jobs is not sufficient to provide care coverage.

MULTIPLE SIBLINGS

When two or more children enrolled in CAP/C, CAP/C services available through the program must be shared to meet the needs of the household. The following services are shared:

- a. in-home aide and pediatric nurse aide services using congregate care;
- b. home accessibility and adaptation services, assistive technology; and
- c. vehicle modification, when the disabilities are similar.

CAREGIVING TO OTHER NON-DISABLED SIBLINGS OR OTHER SIBLINGS IN THE HOME

Additional assistance cannot be provided by CAP/C because of the presence of siblings in the home. The hours approved are based on the medical needs of the CAP/C beneficiary, not the demands of other siblings or family members.

Appendix D: Beneficiary Rights and Responsibilities Beneficiary Rights and Responsibilities Agreement Form

The Beneficiary Rights and Responsibilities Agreement Form is a document used to provide the CAP beneficiary and his or her parent, legally responsible party, or designated caregiver information about the rights and responsibilities to participate in the Community Alternatives Program (CAP) and the requirements to receive designated CAP services to meet assessed needs. The document provides the CAP beneficiary the opportunity to willingly agree to select participation in the Community Alternatives Program (CAP) while outlining the responsibilities of the CAP beneficiary and the Case Management Entity (CME) to assure safe community living.

By signing this form, the CAP beneficiary, parent, legally responsible party, or designated caregiver expresses understanding and agreement to the following:

I understand:

1. The CAP is an alternative home and community-based service option. To qualify for CAP, I must be a member of the target population and meet a nursing facility level of care (LOC) which identifies my needs to be like individuals in an institutional placement. I must meet a LOC initially and annually to be considered for participation in CAP.
2. The CAP waives some Medicaid eligibility requirements to allow the receipt of home and community-based services to be provided and received in my home and community. The waiving of the Medicaid eligibility may result in my out of pocket expenses such as a Medicaid spend down, deductible or premium.
3. The CAP supplements rather than replaces the supports and services already available to me and my family.
4. The CAP allows me to participate in one of the three service options offered through this program when I meet all the qualifying conditions. The three service options are: provider-led, consumer-directed and coordinated caregiving (specified for disabled adults).
5. The CAP provides an array of home and community-based services, known as CAP services, to meet my assessed needs to keep me safe in my home and allows me to integrate in the community.
6. The CAP allows me the right to use CAP services that were identified through a comprehensive assessment to meet my needs. My approved services will be listed on a Plan of Care (POC) in the correct type, amount, frequency, and duration that are consistent with my assessed needs.
7. The CAP develops a service plan that lists my person-centered goals, my cultural preferences, my likes and dislikes and the areas I would like to assume safe responsibility. The service plan must be signed and reviewed every 90 days to assure my needs are being met. A request can be made at any time for a new service or additional usage of an existing service. The service plan can be revised at any time based on my changing needs.
8. The CAP allows me the right to select any provider or person to render my approved CAP services through one of the service options. If I am between the ages of 0-18 a parent; stepparent,

parent's spouse or significant other (live-in or not), foster parent, custodial parent or adoptive parent, sibling under the age of 18, sibling living in the home over 18, anyone acting as "loco parentis" cannot to be selected and receive payment to provide my care, unless qualifying conditions are met. If I am 18 years old and over an appointed guardian appointed Health Power of Attorney or Power of Attorney or executor, the estate cannot be selected and receive payment to provide my care, unless qualifying conditions are met.

9. The CAP can deny a new request for a CAP service or reduce, terminate or suspend an approved CAP service based on my changing needs. If that happens, I will be notified in writing and be given instructions on how to appeal the adverse decision.
10. The CAP requires work verification documentation to support the approval of the hours for hands on care such as nursing and personal care services.
11. The CAP requires a declaration of need assessment for equipment, modification, technology, training and education and goods and services.
12. The CAP is intended to always protect my health, safety, and well-being while I receive home and community-based services. The protection is managed through monthly and quarterly visits, reporting and processing my critical incidents, completing my emergency and disaster plan and pre-planning my transition.
13. The CAP for children services stop at 11:59 p.m. prior to the 21st birthday.
14. The CAP can be terminated if I fail to meet the guiding Clinical Coverage policies as outlined in the program, I am enrolled.

I agree to:

1. Provide the assessor information about my health care condition and my supportive network of family and friends to assist in identifying my clinical and home and community-based needs, initially, annually and when requested due to a change in my status.
2. Correspond with my Department of Social Services (DSS) to keep my files updated and to maintain my qualification for long-term care Medicaid eligibility.
3. Pay out of pocket expenses such as a Medicaid spend down, deductible or premium, I will incur the medical expenses of the established amount before my Medicaid is made available. I will also pay my selected providers the cost of these incurred medical expenses.
4. Participate in one of the three service options offered through this program when I meet all the qualifying conditions. If I agree to participate in consumer direction, I or my designated representative must be able and willing to direct my care as evidence by a self-assessment questionnaire. If I agree to participate in the provider-led or coordinated caregiving option, I or my designated representative must comply with the care plan and agree to monitoring visits.
5. Inform my Case Management Entity of my person-centered goals, my cultural preferences, my likes and dislikes and the areas I would like to assume safe responsibility. If in addition to my service plan, I create an Individual Risk Agreement (IRA) to assume more risk in my decisions making, the IRA must contain realistic goals and timelines. The IRA goals must be reviewed on an agreed upon timeline to ensure progress or course correction.
6. Use the CAP services in the type, amount, frequency, and duration listed in my Plan of Care (POC) and to report to the Case Management Entity within 48 hours when the services were not used as listed in my POC.
7. Meet with the assigned Case Management Entity on an agreed upon schedule to review my service plan.

8. Exercise my freedom of choice by selecting providers or persons of my preference to render my approved CAP services. Specific individuals can not directly provide my approved CAP services and receive payment unless specific qualifying conditions are met. These individuals are legal guardian, an appointed guardian, appointed Health Power of Attorney, Power of Attorney or executor of the estate.
9. Exercise my fair hearing rights, within the established timeframe, when I determine it to be in my best interest to continue future consideration for CAP participation, the receipt of a new CAP service request or for ongoing CAP participation.
10. Submit to my Case Management Entity work verification documentation to support the approval of the hours for hands on care such as nursing and personal care services.
11. Work collaboratively with my multidisciplinary team to identify my needs for equipment, modification, technology, training and education and goods and services.
12. Report incidents of abuse, neglect or exploitation and other critical incidents to my Case Management Entity or my selected providers to assist with protecting my health, safety, and well-being.
13. Participate in monthly contact meetings with my Case Management Entity, and to join the quarterly multidisciplinary treatment team assessment visits to assist with the management of my health, safety and well-being.
14. Allow my Case Management Entity to visit in my home at least quarterly and when agreed upon.
15. Allow my Case Management Entity to make unannounced visits, when deemed appropriate.
16. Create and share an emergency and disaster plan annually and quarterly.
17. Create a transition plan with my Case Management Entity at key times during my participation in CAP.

I agree to select participation in the Community Alternatives Program, and willingly agree to comply with the guiding policies as outlined in the Clinical Coverage Policy, 3K-1 or 3K-2.

If I fail to willingly comply with the guiding Clinical Coverage policies, 3K-1 or 3K-2, my agreement to participate in the Community Alternatives Program may end.

CAP Beneficiary Name: _____

Legally Responsible Person/Primary Caregiver Name: _____

CAP Beneficiary Signature

Date

Legally Responsible Person/Primary Caregiver

Date

Appendix E: Individual Risk Agreement

INDIVIDUAL RISK AGREEMENT

The risk(s) that have been identified below have been determined and the CAP beneficiary has chosen to assume responsibility in addressing the risk. The details of the risk(s) have been explored and the beneficiary understands how the specified risks may impact the beneficiary's health, safety and well-being. The Case Management Entity and the CAP Waiver beneficiary have negotiated an agreement with measurable time frames. Risks that have been identified will be continuously monitored and re-evaluated throughout the length of the agreement. The CAP beneficiary is aware of the possible consequences of not addressing risks as outlined in their agreement.

Name –CAP Waiver Beneficiary

Name – CAP Case Management Entity

Name(s) – Individuals involved in risk identification and reduction discussion

1. Describe the risk(s) identified by case management entity [e.g., exhibited behavior that is deemed to be verbally/physically abusive to others, non-compliance of the service plan; or risk/hazard(s) in the person's environment (pest infestation, lack of sufficient water supply, etc.)].

2. Describe case management entity's identified adverse outcome/harm that may result from the CAP beneficiary's failure to address the risk(s) (e.g., decline in physical/emotional health, injury to self or others, etc).

3. Describe the CAP beneficiary's understanding of identified risk(s) and his/her plan for addressing it.

4. What alternative measures may be used by the case management entity, the CAP beneficiary, or by his or her informal supports to minimize risk, reduce adverse outcome(s) identified in #2 above? (e.g., durable medical equipment, adaptive equipment; increased personal care hours, improve network of informal supports)

5. Briefly describe the agreement reached including consequences of failure to work toward a solution.

The risks identified by the agency have been explained to me. I accept the risk(s) associated with my choice, decision or preferred course of action.

SIGNATURE – CAP Beneficiary / Legal Responsible Representative

Date Signed

SIGNATURE –Case Management Entity

Date Signed

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Appendix F: Glossary of CAP Terms

Activities of Daily Living (ADLs)

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.

Bathing – Ability to take a full-body bath or shower, bed bath or sponge bath, shampooing, and transferring in and out of the tub or shower and drying off.

Dressing – Ability to dress and undress self, sequencing clothing appropriately and putting on any necessary item of clothing or other essential items specific to dressing (tying, fastening, buttoning and zipping) or braces and splints.

Eating – Ability to feed self-feed and drink liquids orally.

Bed Mobility and Mobility – Ability to move to and from a lying positing, turn side to side and position body while in bed, in chair or recliner or other type of furniture the child sleeps in, and walk and climb.

Personal hygiene – Ability to perform grooming activities such as brushing teeth, combing hair, washing face and hands, and skin care.

Toileting – Ability to use the toilet, commode, bedpan, urinal and ability to transfer on and off the toilet, cleanse, and adjust clothes.

Transfer – Ability to move between surfaces, to and from the bed, chair, wheelchair, vehicle and standing position.

Administrative Authority

Medicaid shall maintain its authority over rules, regulation and policy that govern how CAP/C is operated. The operation of CAP/C can be decentralized, and local agencies can be designated to play important roles in facilitating the access of an eligible beneficiary to the waiver, including performing waiver operational functions.

Applicant

An individual seeking to participate in the Community Alternatives Program.

Assessment Assignment

An applicant who has met the basic eligibility requirement of level of care and has been assigned a CAP/C slot. The applicant is approved for an assessment to identify clinical need for CAP/C participation and the development of a service plan.

Assurance

The commitment by a state to operate an HCBS waiver program in accordance with statutory requirements.

Average Waiver Cost Limits

To maintain cost neutral service provision of that of institutional care, a mandatory requirement of a 1915 (c) HCBS waiver, the average cost limit for CAP/C is \$129,000, per CAP/C beneficiary, per year. This average cost of a CAP/C beneficiary's care needs may be less than, equal to or more than the specified average cost.

Beneficiary

An individual receiving Medicaid benefits.

Budget Authority

A concept of consumer-direction that allows a CAP/C beneficiary the opportunity to exercise choice and control over a specified amount of CAP/C funds. The CAP/C beneficiary has decision-making authority regarding who provides a service, when the service is provided and how the service is provided, consistent with CAP/C service specifications and other requirements. The CAP/C beneficiary has the authority to make changes in the distribution of funds among the CAP/C services included in his or her budget.

Case Management Entities

Appointed agencies to act as the lead entities in a county. The appointed entity is the local entry point and approval authority for CAP/C services. The lead entity is appointed by NC Medicaid to be responsible for the day-to-day case management functions for potential and eligible CAP/C beneficiaries. These agencies may include county departments of social services, county health departments, hospitals, or a qualified CME. The appointed CME shall be an entity capable of providing case management and lead entity services.

Case management entity Mandated Requirements

Qualified Case Management Entities must have:

- a. A resource connection to the service area so to provide continuity and appropriateness of care;
- b. Experience in Pediatrics and physical disabilities;
- c. Policies and procedures in place that aligns with the governance of the state and federal laws and statutes;
- d. Three (3) years of progressive and consistent home and community-based experience;
- e. Ability to provide case management by both a social worker and a nurse;
- f. Physical location;
- g. Computer technology web-based connectivity to support the requirement of current and future automated programs;
- h. Meet the regulatory criteria under Department of Health and Human Services, Division of Health Services Regulation (DHHS/DHSR)
- i. Staff to participant ratio (appropriate case mix); and
- j. Implementation of services within five (5) days of POC approval.

Care Coordination

Collaborative engagement with various providers to improve healthcare interventions while utilizing information and information systems to help achieve person-centered goals. The purpose of care coordination is to manage care needs, reduce duplication of efforts, ease expected and unexpected transitions and limit gaps of service provision. Care coordination is important because it provides the ability to identify service preferences to meet emerging strengths, needs, and goals while increasing efficiency and communication to improve clinical outcomes and ensure beneficiary satisfaction.

Community Alternative Programs (CAP)

A Medicaid Home and Community-Based Services waiver authorized under § 1915(c) of the Social Security Act and Medicaid funds; to provide home and community-based services to Medicaid beneficiaries who require institutional care, but for whom care can be provided cost effectively and safely in the community with CAP services. CAP beneficiaries must meet all Medicaid eligibility requirements. CAP Programs consist of the following:

- a. Community Alternatives Program for Children: CAP/C
- b. Community Alternatives Program for Disabled Adults: CAP/C
- c. Community Alternatives Program for Disabled Adults choosing to self-direct: CAP/CD

Community Alternative Program for Children (CAP/C)

A Medicaid HCBS Waiver authorized under § 1915(c) of the Social Security Act serving medically fragile and medically complex children ages 0- 20 years who are at risk of institutionalization.

Community Integration

The setting (living arrangement, place of services and types of services):

- a. Supports full access to the greater community;
- b. Is selected by the individual from among settings options;
- c. Ensures individual rights and privacy, dignity and respect, and freedom from coercion and restraints;
- d. Optimizes autonomy and independence in making life choices; and
- e. Facilitates choice regarding services and who provides them.

Consumer Direction

An alternative care option offered under the CAP/C waiver. Consumer direction is a self-directed care model for a CAP/C beneficiary and his or her caregivers who wish to remain at their primary private residence and have increased control over their own services and supports. It offers a CAP/C beneficiary the choice, flexibility and control over the types of services they receive, when and where the services are provided, and by whom the services are delivered.

Comprehensive Multidisciplinary Needs Assessment

A collaborative process that is used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. The assessment supports the determination that an individual requires CAP/C services as well as the development of the service plan.

Disenrollment

The voluntary or involuntary dismissal from participation in CAP/C.

e-CAP Web-based Tool

A Web-based software application developed by an approved Medicaid contractor to support the operations of CAP/C under the provision of 1915 (c) HCBS.

Electronic Visit Verification (EVV)

A federal mandate through the 21st Century Cures Act that is used to verify visit activity for services delivered as part of home- and community-based service programs. EVV offers a measure of accountability to help ensure that individuals who are authorized to receive services in fact receive them.

The CURES Act is designed to improve the quality of care provided to individuals through further research, enhance quality control, and strengthen mental health parity.

The visit verification validation components are listed below:

Type of service performed:

- Individual receiving the service;
- Date of the service;
- Location of service delivery;
- Individual providing the service; and
- Time the service begins and ends.

A paid live-in caregiver provide aide services to a CAP/C beneficiary is excluded from capturing EVV data.

Emergency plan

Provision for alternative arrangements for the delivery of services that are critical to a beneficiary's well-being in the event that the identified caregiver or provider responsible for furnishing the service fails or is unable to deliver them. The emergency back-up plan must also contain disaster planning.

Employer Authority

A concept of consumer direction that allows a CAP/C beneficiary to exercise the choice and control over the individuals who furnish CAP/C services authorized in the service plan. Under the employer authority model there are two options:

- a. Agency with Choice also known as co-employment- This option makes arrangements for an organization to assume responsibility for employing and paying workers; reimbursing allowable services through Medicaid; withholding; and filing and paying Federal, state and local income and employment taxes.
- b. Common Law Employer- This option designates the CAP/C beneficiary as a common law employer of workers who furnish services and supports, and assumes all responsibilities associated with being the employer of workers. The DHHS fiscal contractor performs employer-related tasks on behalf of the CAP/C beneficiary but does not serve as the common law employer of the hired direct staff. This option is the used in the CAP/C program.

Family

Family is an informal support system and is defined as **one** or more of the following:

- a. The beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent;
- b. Anyone who has legal responsibility for the minor beneficiary;
- c. Grandparents of the beneficiary;
- d. Siblings of the beneficiary;
- e. The spouse of an adult (18 years of age or older) beneficiary; or
- f. Anyone who has legal responsibility for an adult (18 years of age or older) beneficiary.

The Case Manager is responsible for verifying legal guardianship when that person is not the parent of a minor or when an adult beneficiary has a legal guardian. The Case Manager is not expected to keep copies of this documentation or submit the documentation to NC Medicaid.

Family, as defined here, shall not be the paid provider of any CAP/C service or supply.

Financial Management Services

Financial Intermediary (FI) support is provided to a CAP/C beneficiary who directs some or all of their CAP/C services. This support may be furnished as a CAP/C service or conducted as an administrative activity. When used in conjunction with the employer authority, this support includes operating a payroll service for CAP/C beneficiary's employed workers and making required payroll withholdings. When used in conjunction with the budget authority, this support includes paying invoices for CAP/C goods and services and tracking expenditures against the consumer direction budget.

Free Choice of Provider

Requires that a Medicaid eligible beneficiary may seek care from any willing and qualified service provider as defined under the State's Medicaid Plan, according to 42 CFR 431.51(a)(1).

Freedom of Choice

The right afforded to a beneficiary to choose to participate in the CAP and to select any and all CAP/C services assessed to meet their needs.

Freedom of Choice of Provider Form

A form signed by the CAP/C beneficiary or responsible party that clearly outlines the selected provider of their choice.

General Utility

Items or services that are designed for use by a nondisabled beneficiary. Exceptions to this exclusion may be granted if the item or service is needed to prevent decline or improve a diagnosed medical condition or physical limitation, as documented by a medical professional.

Health and Welfare

The safeguard and protection against abuse, neglect and exploitation of a beneficiary who is participating in the CAP/C Waiver, in accordance with 42 CFR 441.302 (a).

Home and Community Based Services

Services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of 42 CFR 441, subpart G.

Home and Community-Based Final Rule

New requirements for providing home and community-based services. The HCBS Final rule ensures the Medicaid's home and community-based services program provide full access to the benefits of community living and offer services in the most integrated settings.

Home Accessibility and Adaptation

Equipment and physical adaptations or modification to the CAP/C beneficiary's private primary residence that are required to promote health, safety and well-being. Medically necessary items are identified in an approved Service Plan.

Independent Assessment

Initial assessments are those completed for applicants not currently receiving services, who have an approved service request form (SRF).

Individual

An applicant is an individual seeking initial participation in the CAP/C regardless of Medicaid eligibility.

Individual Risk Agreement

An agreement that outlines

- a. the risks and benefits to the beneficiary of a particular course of action that might involve risk to the beneficiary;
- b. the conditions under which the beneficiary assumes responsibility for the agreed upon course of action; and
- c. the accountability trail for the decisions that are made.

A risk agreement allows a beneficiary or responsible party to assume responsibility for his or her personal choices, through surrogate decision makers, or through planning team consensus.

Informal Support System

An informal support system, is defined as one or more of the following:

- a. The beneficiary's parent, stepparent, grandparent, foster parent, custodial parent, adoptive parent, sibling or other relative;
- b. The spouse of an adult (18 years of age or older) beneficiary; or
- c. Friends, neighbors, church member or anyone providing emotional, physical, or financial support.

Institutional Care

Refers to specific benefits authorized in the Social Security Act. These are hospital and the long-term care services. Institutions assume total care of the individuals who are admitted. Institutions must be licensed and certified by the state, according to federal standards.

Institutional Respite Care

Institutional respite care is the provision of temporary support to the primary caregiver(s) of the CAP/C beneficiary by taking over care of the CAP/C beneficiary for a limited period of time. The provision of this service takes place in a Medicaid certified nursing facility or a hospital with swing beds. This service may be used to meet a wide variety of needs, including family or caregiver emergencies, relief of the caregiver, and planned vacations or special occasions when the caregiver needs to be away from home for some extended period of time.

Instrumental Activities of Daily Living (IADL's)

Normal day-to-day home maintenance activities performed by a CAP/C beneficiary or responsible party. These activities are necessary for maintaining a beneficiary's immediate environment by providing assistance with primary private residence (home) maintenance, housework, laundry, meal prep, medication management, money management, phone use, shopping, errands and transportation.

Level of Care for the CAP/C Waiver

A disability of medical and physical abnormalities includes primary medical diagnoses that are chronic in nature. The overriding medical condition is primarily physical rather than psychological, behavioral, or developmental (if the primary medical condition is cognitive, the diagnosis primarily results from a medical condition that impairs cognition). The beneficiary needs in-home supports and services similar to that provided in an institution. The beneficiary requires interventions to engage in activities of daily living

to prevent adverse physical and medical consequences that may require institutional placement to maintain health, safety, and well-being.

Medically Fragile

Medical fragility is used to identify medical conditions primarily for a CAP/C beneficiary between the ages of 0 through 20 years who has **all** of the following qualifying conditions:

- a. A medically fragile child has a primary chronic medical condition or diagnosis (physical rather than psychological, behavioral, cognitive or developmental) that has lasted, or is anticipated to last, more than 12 months; and
- b. The child's chronic medical condition requires **one** of the following:
 1. 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. at least four (4) exacerbations of the chronic medical condition requiring urgent or emergent physician-provided care within the previous 12 months; **or**
 3. at least one (1) inpatient hospitalization of more than 10 calendar-days within the previous 12 consecutive calendar months; **or**
 4. at least three (3) inpatient hospitalizations with the previous 12 months; and
- c. The child's chronic medical condition requires **one** of the following:
 1. the use of life-sustaining device(s);
 2. life-sustaining hands-on assistance to compensate for the loss of bodily function; or
 3. non-age-appropriate hands-on assistance to prevent deterioration of the chronic medical condition that may result in the likelihood of an inpatient hospitalization.

To meet this criterion, the child must have either of the following:

Documented life-sustaining assistance to compensate for the loss of bodily function such as endotracheal tube, ventilator, suction machines, dialysis machine, J-Tube and G-Tubes, oxygen therapy, cough assist device, and High-frequency chest wall oscillation vest.

Documented life-sustaining, hands-on assistance to compensate for loss of bodily function, such as to Malone Antegrade Continence Enema (MACE), in and out catheters, an enema prescribed by a physician on a regularly scheduled basis (daily or 3-5 times per week), anal digital stimulation order by a physician on a regularly scheduled basis (daily or 3-5 times per week), Vagus Nerve stimulation (VNS) swipe, severe contractures and rigidity of the arms and hands that require guided movement for eating, oropharyngeal suctioning, or requires repositioning at least every two hours.

Medical Treatment

Medical treatments are medical care services other than routine office visits, follow-up appointments, or management of a health care plan, that directly prevent or ameliorate health deterioration; services aimed at preventing or delaying acute episodes of physical illness; and must be provided by a registered nurse or medical doctor.

NC Medicaid

The N.C. Medicaid is designated as the administrative authority over the CAP/C waiver. N.C. Medicaid manages the CAP/C waiver. N.C. Medicaid shall develop policies and procedures based on federal

guidelines for operating the program and is required to oversee the management and operation by the local lead agencies and other designated entities. N.C. Medicaid shall provide training and technical assistance to lead entities.

NC Tracks

A current web-based service for North Carolina's health care providers and consumers as part of the multi-payer Medicaid Management Information System for NC Department of Health and Human Services, that allows provider enrollment in the Medicaid program and claim submittal to Medicaid program.

Non-Institutional Respite Services

Non-institutional respite care is the provision of temporary support to the primary unpaid caregiver(s) of the CAP/C beneficiary, by taking over the tasks of primary caregiver for a limited period of time.

Nursing

Professional skilled nursing services is defined as assessment, judgment, intervention and evaluation of interventions that require the education, training, and experience of a registered nurse (RN) or a licensed practical nurse (LPN) who holds a current valid license issued by the North Carolina Board of Nursing to practice nursing as under NCGS 90-171, and 21 NCAC 36. Skilled nursing does not include those tasks that can be delegated to unlicensed personnel (21 NCAC 36). Services must be substantial. This means the beneficiary requires interventions that can be performed only by a licensed nurse, according to the North Carolina Nurse Practice Act (NCGS 90 171; NCAC 36). Services must be continuous. Skilled nursing assessment, interventions, or both are performed by a licensed nurse at least every 2-4 hours during the hours that Medicaid-covered nursing are provided.

Paid Live-in Caregiver

A paid live-in caregiver is defined as a person who lives in the same household as the waiver participant and is hired and paid by an in-home aide or home health agency or through the consumer direction program to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL).

Paid Live-in Caregiver Attestation

Paid live-in caregiver attestation is documentation that consists of an attestation form that confirms the paid caregiver shares the same address as the waiver participant. To meet the paid live-in status, the provider agency (in-home aide, home health agency and financial management entity) must maintain documentation of the employment agreement and two supporting pieces of evidence, one of which must be a driver's license or another valid photo ID and the other a utility-type or credit card statement/bill, a residential lease agreement, school enrollment forms if enrolled in school or graduated from school within the past three months, or an acceptable piece of evidence approved by NC Medicaid at the request of the provider. These two supporting pieces of evidence must list the address of the paid live-in caregiver to be the same address as the waiver participant which must be confirmed initially upon hire and annually during the CAP enrollment renewal period. These documents should be filed in your agency's personnel file or waiver participant's case file.

Parent or Legally Responsible Representative

The parent or legally responsible representative is defined as a person acting for and legally authorized to execute a contract for the CAP/C applicant or beneficiary, such as a legal guardian, parent, stepparent, custodial parent, adoptive parent, grandparent or a sibling of a minor child, or holder of medical power of attorney. Except for parents of minor children, legal authorization requires a separate legal document. The

case manager is responsible for verifying legal guardianship when that person is not the parent of a minor or when an adult CAP/C beneficiary has a legal guardian. The case manager is not expected to keep copies of this documentation or submit the documentation to NC Medicaid or designated contractor Parent or legally responsible representative, as defined here, shall not be the paid provider of any CAP/C service or supply.

Note: Throughout this policy, wherever the term “parent(s)” appears, “parent(s), legally responsible representative, or both” is implied.

Participant

A Medicaid beneficiary who has been approved to participate in the CAP/C waiver.

Participant Notice

Written notification to the agency or agencies providing regular State Plan services to inform of CAP/C approval and participation. The notice documents and verifies the non-CAP/C home and community care services the CAP/C beneficiary is receiving (or will be receiving pending Medicaid approval) and reminds the provider to coordinate any changes with the CME.

Personal Care Aide

A personal care aide is a certified professional provided through a licensed home care agency that provides hands-on assistance to a CAP/C beneficiary receiving personal care under this clinical coverage policy.

Personal Care Assistant

A personal care assistant is a paraprofessional provided through consumer direction who provides hands-on assistance to a CAP/C beneficiary receiving personal care under this clinical coverage policy. This personal care assistant is hired by the CAP/C beneficiary or responsible party to provide help with personal care and home maintenance.

Personal Maintenance Tasks are basic activities of daily living that must be performed to assure and support one’s health, safety, and well-being.

Person-Centered Planning

The person-centered service plan must reflect the services and supports that are important for the CAP/C beneficiary to meet the needs identified through an assessment of need, as well as what is important to the CAP/C beneficiary regarding preferences for the delivery of such services and supports.

Portable Generator

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.

Primary Private Residence (Home)

The primary private residence that a CAP/C beneficiary owns or rents in his own right or the primary private residence where a CAP/C beneficiary resides with other family member, parents, grandparents, or friends. A CAP/C beneficiary’s primary residence may be a foster-care type setting. A primary private residence is not licensed or regulated as any kind of group home or other board and care facility. No more

than four (4) unrelated people can live in the primary private residence of an approved CAP/C beneficiary.

Quarterly

Three calendar months.

Reasonable Indication of need

An individual or active CAP/C beneficiary who is a member of the target population and meets a clinical determination of level of care (LOC), and the need-based assessment identifies reasonable indication of need for at least one or more of the services offered in CAP/C to maintain community placement or integration thus avoiding the potential of an institutional placement.

Reasonable indication from the comprehensive assessment that:

- a. at least one CAP/C service, at least monthly; or
- b. temporary CAP/C participation is required for monthly monitoring when services are furnished on less than a monthly basis.

Recreational in nature

Items and services that are purely for entertainment, leisure or, enjoyment, and have no direct remedial benefit to the CAP/C beneficiary.

Respite care

A service that provides short-term 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. This service can be arranged during the day, evening or night for any increment of time in the CAP/C beneficiary's home. This service can also be arranged for overnight care in the home or a facility (such as a nursing facility or hospital).

Responsible Party

A person who may act on behalf of the CAP/C beneficiary; a responsible party may be: a legal representative who is legally authorized to execute a contract for the beneficiary (such as Power of Attorney, Health Power of Attorney, legal guardian, financial planner) or an individual (family member or friend) selected by the CAP/C beneficiary to speak for and act on their behalf.

For ages 0-20 the responsible party is considered to be the beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent. Anyone who has legal responsibility for the minor beneficiary.

Restorative Nursing

Restorative nursing is a nursing intervention that promotes the CAP/C beneficiary's ability to adapt and adjust to living independently as safely as possible.

Restorative nursing focuses on achieving and maintaining optimal physical, mental and psychosocial functioning. Generally, restorative nursing is initiated when a CAP/C beneficiary is discharged from formalized physical, occupational or speech therapy.

Service Request Form (SRF)

An individual being considered for CAP/C services shall be a member of the targeted population and meet the required level of care consistent with a nursing facility. A service request form replaces the FL-2 form and must be completed to determine the basic clinical eligibility criteria for medical fragility and

level of care for potential CAP/C participation. This form has a scoring logic for assessing medical fragility and level of care.

Short-term intensive

A limited service provision beyond the previously approved service provision amounts to address a change in the CAP/C beneficiary's condition due to a new diagnosis, a change in medical prognosis or condition resulting in additional or increased medical needs, functional ability, home or a caregiver crisis. The duration of time for short-term intensive care is anticipated to be less than three (3) consecutive weeks

Respite may be used during vacations when the total personal care hours do not exceed 24 hours per day.

Significant Change in Acuity

For purposes of requiring a different level of care determination, a significant change or decline in condition is defined as **one** of the following:

- a. start or discontinuation of a tracheostomy tube;
- b. start or discontinuation of tube feedings;
- c. increase or decrease in seizure activity such that a revision to the service plan is needed;
- d. increase or decrease in need for ADL assistance such that a revision to the service plan is needed; or
- e. a change in status that requires more skilled care or monitoring.

Staff to Participant Ratio

A sufficient number or responsible persons to safely meet the needs of CAP/C beneficiary, including full or part-time direct service staff member. When identifying the appropriate staff to participant ratio, consideration of beneficiary with greater needs must be emphasized.

Unplanned occurrence

When the approved hours need to increase for that day to accommodate for an unplanned event. Unplanned occurrence only applies to in-home care, pediatric nurse aide or respite.

Willingness and Capability (Consumer Direction)

Readiness to assume the role of employer as evidenced by the completion of the required forms, documentation, and training; current and past collaboration and cooperation with the CME, financial management agency, and NC Medicaid; understanding Medicaid guidelines; being aware of fraud, waste, and abuse; and having access to an informal support system.

Appendix G- Consumer-Direction Self-Assessment Questionnaire

The self-assessment questionnaire is used to determine your readiness to direct your care in the consumer-direction option of the Community Alternatives Program. The tools in the self-assessment questionnaire will identify areas that you are knowledgeable and areas that you may need additional help. These tools will also assist you in identifying your personal care needs and the required skills your hired employee will need to assure your health, safety, and well-being. Once you complete the self-assessment questionnaire; you will make it available to your case management entity. The self-assessment questionnaire includes the following sections:

- Is Consumer-Direction Right for Me?
- What Areas Do I Need Help?
- Task List and Employee Competency Validation

Beneficiary name: _____

Person completing form: _____

Individual acting as employer: _____

Self-Assessment Questionnaire Completion Guide

Purpose

The self-assessment questionnaire is used to determine your readiness to consumer direct. The self-assessment will also be used to identify your training needs and confirm the ability of your employee(s). This tool will provide guidance to you, as the individual acting as the employer, in completing the self-assessment questionnaire.

Who Completes the Self-Assessment?

The self-assessment questionnaire shall be completed by the individual acting as the employer.

Beneficiaries 0-17 years old: to be completed by the parent or responsible party

Beneficiaries 18 years old and older: to be completed by the beneficiary

Beneficiaries 18 years old and older requiring a representative: to be completed by the representative

Sections of the Self-Assessment

Is Consumer-Direction Right for Me?

- Complete section during consumer-direction orientation.
- Answer questions related to health care needs from the perspective of the beneficiary.
- Answer questions related to managing care, finances, and employer responsibilities from the perspective of the individual acting as the employer.

What Areas Do I Need Help?

- Complete section after consumer-direction orientation.
- Place a check by the appropriate response to indicate your current knowledge level of each topic.

Task List and Employee Checkoff

- Complete section for all employees.
- Circle the tasks that are required to address the beneficiary's health care needs.
- Provide a response detailing how the employee(s) should complete the selected task.
- Check the response to indicate the employee's ability to complete the selected task.
 - *Previous caregiver: individual has previously provided services to the beneficiary*
 - *Hlth./pers. care experience: individual has health/personal care work experience*
 - *Training provided: employer will provide training to employee on selected task*

Is Consumer-Direction Right for Me?

Consumer-direction offers freedom and independent thinking. Complete this section below during your orientation session to help decide if consumer-direction is right for you.

Date consumer-direction enrollment process initiated:

Why do you wish to participate in the consumer-direction option of CAP?

1. Do you want to appoint someone as your representative for consumer-direction?

Yes

No

If yes, allow representative to complete the remaining sections of the questionnaire on your behalf.

2. Do you want to be an employer?

Yes

No

Registering with the Internal Revenue Service as an employer of record is a requirement.

3. Are you able to dedicate approximately 2-4 hours per year for consumer-direction education?

Yes

No

NC Medicaid provides annual training to consumer-direction participants.

4. Are you able to dedicate time daily and weekly for managing your employee and completing employer related tasks?

Yes

No

Managing employee schedules, tasks, and approving timesheets is a requirement.

5. Will you allow a financial management agency to manage your waiver services' expenses and employee payroll?

Yes

No

Financial management services through an NC Medicaid CAP provider is a requirement.

6. Do you feel comfortable telling an individual what you like and don't like about the services he or she provides?

Yes

No

An employer is required to give directives independently to an individual on the services provided.

7. Do you plan to hire a family member as your employee?

Yes

No

Is yes, state relationship. _____

A parent, step-parent, or a parent's significant other may not be the employee of a minor child.

8. Do you know how to provide step-by-step instructions to someone to assist in meeting your health care needs?

Yes

No

An employer is required to independently provide clear instructions to an employee.

9. Are you able to identify signs of abuse, neglect, or exploitation?

Yes

No

Any occurrence of abuse, neglect, or exploitation must be reported to the local DSS immediately.

10. Are you able to store confidential employment documents in a secure location?

Yes

No

An employer must have the ability to safely store employment documents to ensure privacy.

What Areas Do I Need Help?

In this section, you will rate your knowledge and experience of each listed item to identify what areas you need help in understanding. Check the response that applies to your current knowledge and experience level.

<u>No knowledge/experience</u>	I have no knowledge or experience in this area; extensive training needed.
<u>Minimal knowledge/experience</u>	I have some knowledge and experience in this area; substantial training needed.
<u>Substantial knowledge/experience</u>	I have advanced knowledge and experience in this area; minimal training needed.
<u>Extensive knowledge/experience</u>	I have expert knowledge and experience in this area, little training needed.

	No knowledge/ experience	Minimal knowledge/ experience	Substantial knowledge/ experience	Extensive knowledge/ experience
Deciding how to set a fair pay rate for an employee(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Setting job standards/responsibilities for an employee(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completing an employee performance review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing an employee(s) work tasks and timesheets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creating a job description	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resolving issues/conflict with an employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No knowledge/ experience	Minimal knowledge/ experience	Substantial knowledge/ experience	Extensive knowledge/ experience
Finding other available services/resources in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for back-up or emergency care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid fraud, waste, and abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracking/monitoring use of Medicaid services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Self-Assessment Questionnaire/Training Completion Signature Page

My signature indicates that I have participated in a consumer-direction orientation session and completed the self-assessment questionnaire. I will follow the recommendations presented to me that may include: additional training, re-completion of the self-assessment questionnaire, and requests of other items that are needed to move forward in consumer-direction enrollment. I understand that compliance with NC Medicaid, case management entity, and financial management agency requirements is necessary for continued participation in the consumer-direction model of care. Failure to comply with consumer-direction requirements will result in my removal from the consumer-direction model of care and I will receive CAP services in the traditional provider managed model of care.

Individual acting as employer name:

Beneficiary name:

Individual acting as employer signature:

Date signed:

The care advisor's signature indicates that he or she has reviewed the self-assessment questionnaire, evaluated the responses to determine the consumer-direction abilities of the beneficiary/individual acting as the employer, and provided necessary training.

Training/education completed: _____

Following the completion of training the beneficiary/individual acting as the employer displays the ability to consumer direct.
 Yes No

If no; further evaluation and consult with NC Medicaid will be completed to determine beneficiary/employer's readiness to consumer direct.

Care advisor name:

Care advisor signature:

Date signed:

Task List and Employee Competency Validation

Beneficiary name: _____

Name of individual acting as employer: _____

Name of direct care employee: _____

Directions to complete: Circle the skill that is needed to address the beneficiary's care needs. Provide instructions on how the employee(s) shall complete the task. Provide the appropriate response to indicate the employee's ability to complete the task. Complete for each employee.

Note: Tasks should align with needs identified in the comprehensive assessment.

Task	Instructions to employee:	Employee's ability to complete task:
bathing		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
toileting		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
incontinence care		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
dressing		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No

		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
personal hygiene		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
transfers/ambulation positioning		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
fall prevention		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
feeding/meal prep		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
vital signs/ monitoring		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
therapy reinforcement		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
G-tube/J-tube care		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
IV fluids/site check		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
administering/ monitoring medication		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
		Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

seizure management	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
apnea monitoring	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
catheter care	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
wound care	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
housekeeping	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
shopping	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
meal preparation	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
transportation	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
other	Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No

other		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No
other		Previous caregiver: <input type="checkbox"/> Yes <input type="checkbox"/> No Hlth./pers. care experience: <input type="checkbox"/> Yes <input type="checkbox"/> No Training provided: <input type="checkbox"/> Yes <input type="checkbox"/> No

Appendix H: Emergency Back-Up and Disaster Plan

My Emergency and Disaster Plan

In the event of an emergency or disaster, and when my primary caregiver or legal guardian is not available, the person to contact to provide information about my care needs is:

This person is familiar with me because he/she is my: _____

This person's Address is: _____

This person's Phone number is: _____

IMPORTANT INFORMATION ABOUT ME

I NEED TOTAL OVERSIGHT OF MY CARE BECAUSE OF MY ABILITY

I AM REGISTERED WITH MY LOCAL EMERGENCY MANAGEMENT AGENCY

My Health Insurance Policy #: _____

My Primary Language is: _____

My Cultural and Religious Considerations are: _____

My Primary Caregiver/Parent/Legal Guardian Name(s) is:

Street Address: _____

Primary Telephone #: _____ Secondary Telephone #: _____

My Primary Physician is: _____

The Hospital/ER of My Choice is: _____

The Pharmacy of My Choice is: _____

My Home Health/In-Home Aide Provider is: _____

My Durable Medical Equipment Vender is: _____

My Medications are Kept: _____

My Essential Medical Equipment and Supplies are Kept: _____

Those equipment and supplies are Listed Below:

My Dietary Needs are: _____

I am allergic to the Items Listed Below:

My Emergency Evacuation Plan is: _____

The Emergency Shelter/Safe Place of My Choice is: _____

I attend _____ School; and My primary teacher name is:

I have a pet; and the plans for my pet are: _____

My Plans for when my In-Home Aide, Personal Assistant or my Primary Caregiver/Parent/Legal Guardian is Unavailable, _____ will help with my Activities of Daily Living.

IMPORTANT TELEPHONE NUMBERS:

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____

Name: _____ Telephone #: _____