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:

2A3, Out-of-State Service
2B-1, Nursing Facilities
3A, Home Health Services
3D, Hospice Services
3G, Private Duty Nursing
3H-1, Home Infusion Therapy
5A, Durable Medical Equipment
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
10C, Local Education Agencies

1.0 Description of the Procedure, Product, or Service

The Community Alternatives Program for Disabled Adults (CAP/DA) is a Medicaid Home and Community-Based Services (HCBS) Waiver authorized under section1915(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 this targeted individual 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. The CAP/DA HCBS (referred to as CAP/DA for the purpose of this policy) is a waiver that serves an **adult with disabilities 18 years of age and older** who is at risk of institutionalization. To receive services from this waiver program as listed on the service plan, the individual shall meet the Medicaid eligibility requirements for long-term care.

Pursuant to 42 CFR§ 431.10, NC Medicaid is the administrative authority of the waiver and outlines the policies and procedures governing the waiver. NC Medicaid appoints local entities to provide the day-to-day operation of the waiver to ensure the primary six waiver assurances are met.

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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 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/DA 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 statuary 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, 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/DA beneficiary.

The three participation options under the CAP/DA Waiver are:

a. Provider-led (in-home aide and home care providers);
b. Consumer-led (consumer-directed); and
c. Coordinated Caregiving.

The CAP/DA waiver services are:

a. Adult day health;
b. CAP In-home aide I & II;
c. Equipment, modification and technology;
d. Meal preparation and delivery;
e. Respite services - Institutional respite and In-Home Aide respite;
f. Personal Emergency Response Services (PERS);
g. Specialized medical supplies;
h. Goods and services – Participant, Individual-directed, Pest eradication, Nutritional services, Non-medical transportation and Chore services-declutter and garbage disposal;
i. Community transition;
j. Community integration;
k. Training, education and consultative;
l. Coordinated caregiving;
m. Case management – case management and care advisement;
n. Personal assistance; and
o. Financial management.

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

1.1 Definitions

None Apply

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).
b. Provider(s) shall verify each Medicaid 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.

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 to an individual who:

1. is enrolled in fee-for-services (Medicaid Direct);
2. is determined to require a level of institutional care under the NC State Medicaid Plan;
3. is a member of a target group documented in the approved waiver application;
4. meets applicable Medicaid eligibility criteria in **Section 2.1.2b**;
5. exercises freedom of choice by choosing to enter the waiver or maintain enrollment in the waiver when determined to meet a level of care consistent with institutional care and have a reasonable indication of need for at least one of the covered waiver services;
6. is assigned a CAP/DA waiver slot;
7. is able to have their health, safety and well-being maintained at their primary residence or an approved location with the use of both formal and informal supports, refer to **Appendix F** for definition of informal supports; and
8. is age 18 years old and older.

b. Medicaid Eligibility Requirements

A waiver beneficiary is determined to have met all the eligibility requirements for enrollment in the CAP/DA waiver and obtained approval to receive long-term care (LTC) Medicaid in one of the categories listed below prior to the receipt of one of the home and community-based services approved in the CAP/DA waiver:

a. Medicaid to the Aged (MAA)
b. Medicaid to the Blind (MAB)
c. Medicaid to the Disabled (MAD)
d. Health Care for Workers with Disabilities (HCWD)

Note: It is not appropriate to consider an individual for participation in one of the physical disabled HCBS waivers who is not at-risk of institutionalization simply to qualify him or her for Medicaid.

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 clinician).This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain their 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 shall 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 and CAP/DA Participation

A beneficiary between the ages of 18-20 approved to participate in the Community Alternatives Program for Disabled Adults (CAP/DA) waiver is entitled to receive Durable Medicaid Equipment, Home Health Services, pharmacy and other State Plan services when the eligibility requirements are met containing an evaluation through the EPSDT review process. A CAP/DA beneficiary who was receiving an expanded Medicaid service through EPSDT may not be eligible to receive that expanded Medicaid service through ongoing participation in CAP/DA after the 21st birthday.

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

The funding of services requested or approved for a CAP/DA beneficiary between the ages of 18-20, in the school setting or listed in an Individualized Education Plan (IEP) or Individualized Health Plan under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA) is the responsibility of state and 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 shall cover procedures, products, and services related to this policy when they are 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 Medicaid

a. Medicaid shall cover **CAP/DA** when the beneficiary meets the following specific 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, as assessed quarterly;
    2. The completed CAP assessment finds there is a reasonable indication that the individual would need a service plan for at least one of the CAP/DA HCBS within 30 calendar days of the evaluation. Refer to **Appendix F for reasonable indication of need**;
    3. Have a signed service plan that authorizes one or more waiver services to be rendered on a monthly basis, that mitigates institutionalization through coordinated case management;
    4. Have a signed service plan that authorizes an installation of equipment, modification or technology, on a short-term basis, to return to or remain in the primary private residence to prevent an institutional placement (the installation of equipment or modification must be completed within three calendar months of service plan approval);
    5. Able to maintain health, safety and well-being at their primary private residence or an approved location with the use of both formal and informal supports, refer to **Appendix F** for definition of informal supports;
    6. Paid care needs can be maintained within the average institutional cost of the CAP/DA waiver;
    7. Has a primary physician that can link and coordinate all medical services;
    8. 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), when the primary caregiver is experiencing an emergency, and when there is a public health emergency such as a weather event or pandemic.

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/DA service plan approval. The emergency and disaster plan must be updated quarterly or during an emergency or pandemic.

b. Medicaid shall cover Consumer-Directed services when a beneficiary meets **all** of the above and the following criteria:

   1. Understands the rights and responsibilities of directing their own care as evidenced by the completion of a mandatory self-assessment questionnaire and successful completion of an introductory consumer direction training and orientation Refer to **Appendix C**;
   2. Willing and emotionally capable to assume the responsibilities of an employer under the consumer-directed care by ensuring health and safety and identifying training opportunities to build competencies for him or herself and hired personal assistants as evidenced by a completed mandatory self-assessment questionnaire, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care; and

c. Meets the specific criteria listed in **Subsection 3.2.2(a) (b),** and the following requirements:

   1. Must have an approved service plan that identifies the amount, duration, frequency, and national provider identifier (NPI) of CAP/DA services and non-CAP/DA services as indicated in the beneficiary's service plan and approved by the Case Management Entity (CME);
   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. Must sign and adhere to Beneficiary Rights and Responsibilities to indicate willingness to participate in CAP/DA.

3.2.2 Specific criteria covered by Medicaid

None Apply.

3.2.3 Level of Care Determination Criteria

The HCBS level of care targets an applicant and an active CAP/DA beneficiary who meets a nursing facility level of care (such as Medicaid Agency State Plan nursing facility level of care, 2B-1 Clinical Coverage Policy, with minor differences as described in the criteria below), due to a medical diagnosis or physical disability. Professional judgment and a thorough evaluation of the waiver participant's medical condition and psychosocial needs are required to differentiate between the need for nursing facility care and other health care alternatives. The HCBS LOC 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 activities of daily living (ADLs) deficits that signal the need for the types of supplemental and supportive services this HCBS waiver can offer.

The HCBS LOC determination must address interventions, safeguards (health, safety and well-being) and the stability of each potential and actively approved CAP/DA beneficiary to ensure community integration and prevention of institutionalization because of chronic medical and physical disabilities.

A LOC determination must be completed at initial enrollment. An annual LOC is determined during the annual continued need review assessment. Changes to a beneficiary's condition that may cause the CAP/DA beneficiary to no longer meet HCBS LOC may result in disenrollment from waiver participation.

a. **Qualifying Conditions:**

CAP/DA uses the following LOC criteria in addition to a comprehensive assessment to evaluate and reevaluate LOC a reasonable need for services. HCBS Nursing Facility Level of Care Criteria requires a need for any **one** of the following:

1. Need for services, by physician's 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 assists an applicant or active CAP/DA beneficiary 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 applicant or CAP/DA beneficiary 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 the licensed nurse:
   A. Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration;

B. The use of 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 administered through the tube; when beneficiary is on a dysphagia diet, pureed diet or soft diet with thickening liquids; and
   C. Tube with flushes.
8. Respiratory therapy: oxygen as a short-term or intermittent therapy or for an applicant or CAP/DA 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 if they have 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 assistant.
   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 (IV) or Intramuscular (IM) or oral intervention.
   F. Treatments: 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 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 applicant or CAP/DA beneficiary to reach their maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the applicant or CAP/DA beneficiary's participation in the program and document the applicant or CAP beneficiary's progress.
   C. Factors to consider along with the applicant or CAP/DA 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 documented diagnosis, treatment 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).

Consumer-directed care allows the CAP/DA beneficiary a choice of service providers; therefore, supervision of a registered nurse or licensed practical nurse; and other personnel working under the direct supervision of a registered nurse or licensed practical nurse is not a requirement.

3.2.4 Priority Consideration for CAP/DA Participation

The CAP 1915 (c) HCBS waiver arranges for service consideration on a first-come first-serve basis due to similar care needs of individuals applying for participation in the CAP/DA Waiver. Individuals meeting specific criteria shall be prioritized to the top of an existing waitlist for consideration of CAP/DA participation. Priority consideration applies to individuals meeting any **one** of the following:

a. Age 18-20 transitioning from the Community Alternatives Program for Children (CAP/C) waiver;
b. An active Auto Immune Deficiency Syndrome (Aids) diagnosis with a T-Count of below 200;

c. Transitioning from a nursing facility with Money Follows the Person (MFP) designation or Division of Vocational Rehabilitation transition services;
d. Transitioning from a nursing facility utilizing service of community transition;
e. An eligible CAP/DA beneficiary who is transferring to another county or CME;
f. A previously eligible CAP/DA or Consumer-directed beneficiary transitioning from a short-term rehabilitation placement within 90 calendar days of the placement;
g. Individual identified at risk by their local Department of Social Services (DSS) who has an order of protection by Adult Protective Services (APS) for abuse, neglect and exploitation and the CAP/DA services can mitigate risk;
h. A previous CAP/DA Medicaid beneficiary who was actively participating in one of North Carolina's 1915(c) HCBS waivers and transitioning back to North Carolina from another State due to a military assignment;
i. Individual with a diagnosis of Alzheimer's disease or related disorder. There are Four-hundred and thirty-four (434) slots reserved for this priority group;
j. A beneficiary age 18 and over currently participating in an approved 1915(c) HCBS waiver managed by NC Medicaid and who wants to make the transition to CAP/DA, when eligibility requirements are met; or
k. A beneficiary enrolled in Hospice Services with an expected expiration date within six (6) months and who is in jeopardy of entering a non-Hospice institution.

3.3 Transfers of Eligible Beneficiaries

When a transfer request is received, by the Case Management Entity (CME), the CME shall coordinate the transfer of an eligible CAP/DA beneficiary to another county or entity within the approved, agreed upon transition date or less than 30 calendar days of the request to transfer.

a. CME shall coordinate the transfer to prevent gaps in service provisions. The following steps must be completed prior to the transfer:
    1. determine anticipated start date of service;
    2. coordinate transition plan between provider agencies;
    3. discuss and plan for the health, safety and well-being of the beneficiary;
    4. initiate in the CAP Business System (e-CAP/DA) the transfer of the electronic health records to the receiving county;
    5. arrange for a home visit within five (5) business days of the date the CAP/DA beneficiary moves to their new primary residence by the receiving entity to assess the home environment identifying any health and welfare concerns and planning for mitigation and safety; and
    6. coordinate and plan the provision of services to start on the first date of the transfer.
b. For a CAP/C beneficiary aging out of CAP/C and wishes to transfer to CAP/DA:
    1. The CAP/C CME designee shall implement a transition, transfer plan 12 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 after the age of 21.

2. Three months (90 calendar days) prior to the birth month or identified transfer month, a multidisciplinary team meeting must be convened 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 must be notified of the need to change the CAP evidence code for CAP/DA participation for the identified CAP/DA effective start date.
4. On the first day of the birth month or identified transfer month, CAP/DA services are authorized and provided to the beneficiary.

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

c. For a CAP/DA 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 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/DA beneficiary moves in their 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/DA can continue to participate in the program when a transfer to another county occurs. A transferring beneficiary continues to be eligible for CAP/DA regardless of their county of residence. Ongoing Medicaid eligibility is determined at the next Medicaid certification period.

When a waitlist is active in the transferring county, the CAP/DA beneficiary is considered in a priority category and guaranteed a slot immediately in the receiving county.

3.4 Medicaid Additional Criteria

Refer to Appendix B for detailed Waiver Service Definitions
In addition to the specific criteria covered in **Subsection 3.2.2** of this policy, Medicaid shall cover the following CAP/DA services and other Medicaid services as approved and authorized in the annual, reevaluation, change of status and revised CAP/DA plan of care (POC).

3.4.1 Adult Day Health Services

Medicaid shall cover a service for a CAP/DA beneficiary to attend a certified Adult Day Health Care facility. The service cares for a beneficiary who does not have other appropriate day supports and who needs a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting. The program supports the CAP/DA beneficiary's independence and promotes social, physical, nutritional needs and emotional well-being. Services are health services and consist of a variety of program activities designed to meet the CAP/DA beneficiary's needs and interests. Nutritional needs are met through personally prepared meals and snacks consistent with medical needs and dietary restrictions. The meals received as a part of adult day health services do not constitute a full nutritional regimen (three meals per day).

3.4.2 Coordinated Caregiving

Medicaid shall cover supportive services for all beneficiaries that assist with the acquisition, retention, or improvement of skills related to living in the community. This includes such supports as:

a. adaptive skill development,

b. assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs),

c. linkage to local resources such as adult educational opportunities, social and leisure skill development, protective oversight and supervision.

This service is intended to promote the beneficiary's independence and provides in-home supportive services for personal care and basic home management tasks due to the beneficiary's inability to perform these tasks independently as a result of a disabling condition. Coordinated caregiving integrates the beneficiary into the usual activities of family and community life.

3.4.3 Meal Preparation and Delivery

Medicaid shall cover meal preparation and delivery, a service for a CAP/DA beneficiary who requires special assistance with nutritional planning per an assessment of needs. This service is often referred to as "Meals on Wheels" and provides for the preparation and delivery to the CAP/DA beneficiary's primary residence of one nutritious meal per day. A special diet for a CAP/DA beneficiary is available using this service.

3.4.4 Community Services

a. **Community Transition**

1. Medicaid shall cover Community Transition, a service for a prospective CAP/DA beneficiary transitioning from an institutional setting to a community setting. This service may be used for a duration of one year of the transition to the community to pay for necessary and documented expenses for a CAP/DA beneficiary who make the transition from an institution.
2. These expenditures are for initial set-up expenses to establish a basic living arrangement.

b. **Community Integration:**
   1. Medicaid shall cover community integration service for an active CAP/DA beneficiary who is in jeopardy of losing their community placement due to tenancy related issues.

3.4.5 Equipment, Modification and Technology

Medicaid shall cover a service that provides equipment, physical adaptations, minor modifications, devices, supplies, monitoring systems, specialized accessibility, as identified during the comprehensive assessment. These services are intended to:

a. improve, maximize or enhance the CAP/DA beneficiary's mobility, safety, independence;
b. improve integration into the community;
c. improve the CAP/DA beneficiary's environmental and community accessibility; or
d. address 24-hours a day,7 days a week CAP/DA beneficiary's coverage concerns.

3.4.6 Respite Care

a. **Institutional Respite Services**
   Medicaid shall cover a service that provides temporary relief to a caregiver in an institutional setting. This service may be used to meet a wide range of needs, such as family emergencies; planned special circumstances (vacations, hospitalizations, or business trips); relief from the daily responsibility and stress of caring for a beneficiary with a disability; or the provision of time for the caregiver(s) to complete essential personal tasks. Institutional respite is computed on a daily rate.

b. **In-Home Respite Services**
   Medicaid shall cover a service that provides temporary relief to a caregiver in an in-home setting. These services are provided through direct-led, consumer-led or coordinated caregiving providers and authorized by the case manager to provide temporary care. This service may be used to meet a wide range of needs, such as family emergencies; planned special circumstances (vacations, hospitalizations, or business trips); relief from the daily responsibility and stress of caring for a beneficiary with a disability; or the provision of time for the caregiver(s) to complete essential personal tasks.

   Note: 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 (July-June).

   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.

3.4.7 Goods and Services

a. **Individual-directed goods and services**

Medicaid shall cover services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan for a CAP/DA beneficiary directing care, and the CAP/DA 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/DA beneficiary or responsible party does not have resources to obtain the necessary item or service that shall aid in the prevention or diversion of institutional placement. Individual-directed goods and services are items that are intended to: increase the CAP/DA beneficiary's ability to perform ADLs or IADLs and decrease dependence on personal assistant services or other Medicaid-funded services.

b. **Nutritional Services**

A service for a CAP/DA beneficiary that provides coverage for physician ordered health supplements, vitamins or mineral supplements, herbal preparations and over-the-counter medications (OTC) 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/DA beneficiary to maintain community placement and for the management of health and safety as identified in the person-centered service plan.

c. **Pest Eradication**

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

d. **Participant Goods and Services**

Medicaid shall cover a service for a CAP/DA beneficiary that provides services, equipment, or supplies not otherwise provided through CAP/DA or through the Medicaid State Plan. This service helps assure health, safety and well-being when the beneficiary or responsible party does not have resources to obtain necessary item or service that shall aid in the prevention or diversion of institutional placement. Participant goods and services are items that are intended to: increase the beneficiary's ability to perform ADLs or IADLs and decrease dependence on personal assistant services or other Medicaid-funded services.

e. **Non-medical Transportation**
Medicaid shall cover a service for a CAP/DA beneficiary to assist the CAP/DA beneficiary with transportation to complete activities that promote community inclusion; physical and emotional health; and access to social and community services. Transportation providers are public transit (bus, train, rail system) or private carriers (taxicab services). Waiver funds for transportation consist of the purchase or pre-purchase of items such as tickets, passes, vouchers, or direct payment to transportation providers as listed above.

f. **Chore Services– Declutter and garbage disposal**
Medicaid shall cover a service for a CAP/DA beneficiary to assist the waiver beneficiary with:
1. One-time garbage disposal when there is a health hazard that exacerbates health care condition;
2. One-time decluttering of the home when there is a health hazard that exacerbates health care condition;

3.4.8 CAP/DA In-Home Aide Service I

Medicaid shall cover a service for a beneficiary that, during the hours-of-service provision, provides limited to greater assistance with or monitoring of a minimum of two Activities of Daily Living (ADLs). The CAP/DA beneficiary must be unable to perform these tasks independently due to a medical condition identified and documented on a validated assessment. The need for assistance with or monitoring of ADLs relates directly to the beneficiary's physical, social, environmental and functional condition. In-Home Aide Services, when listed in the service plan, are provided in the community, home, workplace, or educational settings.

The provider(s) 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.

CAP In-home Aide II

Medicaid shall cover a service for a beneficiary that provides assistance or monitoring with at least two limited to severe activities of daily living (ADLs), during the hours-of-service provision. In addition to carrying out tasks such as oxygen therapy, break up and removal of fecal impaction, sterile dressing change, wound irrigation, I.V fluid assistance activities, nutrition activities, suctioning, tracheostomy care, elimination procedures, and urinary catheters due to the beneficiary being unable to perform these tasks independently. Medical intervention must be due to a medical condition identified and documented on a validated assessment.

The need for assistance with or monitoring of ADLs relates directly to the beneficiary's physical, social, environmental and functional condition. In-Home Aide Services, when listed in the service plan, are provided in the community, home, workplace, or educational settings.

The provider(s) 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.

3.4.9 Personal Emergency Response Services (PERS)

Medicaid shall cover a service for a CAP/DA beneficiary that pays the monthly service charges for electronic device that enables CAP/DA beneficiary to secure help in an emergency. The beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the beneficiary's phone and programmed to signal a response center once a "help" button is activated.

3.4.10 Specialized Medical Supplies

Medicaid shall cover specialized medical supplies for a CAP/DA beneficiary, as follows:

a. **Oral Nutritional Supplement:** Provided to promote the health and well-being by increasing the ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). These supplements are necessary to avoid institutionalization and promote continuous community integration.

   A signed physician's order certifying medical necessity for the supply is required.

b. **Incontinence Supplies:** These supplies assist with bowel and bladder management and skin integrity which are necessary to avoid institutionalization.

   A signed physician's order certifying medical necessity for the incontinence supply is required.

3.4.11 Training, Education and Consultative Services

Medicaid shall cover a service for a CAP/DA beneficiary that provides training, orientation, and treatment regimens, regarding the nature of the illness or disability and its impact on the beneficiary, family and individuals (such as neighbors, friends, or companions) who provide unpaid care, support, training, companionship, or supervision. The purpose of this training is to enhance the decision-making ability of the beneficiary, the ability of the beneficiary to independently care for themselves, or the ability of the family member or personal assistant in caring for the beneficiary.

Training and education consists of information and techniques for the use of specialized equipment and supplies and updates as necessary to maintain health, safety and well-being. All training and education services are documented in the service plan as a goal with the expected outcomes. This service covers conference registration and enrollment fees for classes.

This service is provided by community colleges, universities, or an organization with a training or class curriculum approved by NC Medicaid.

3.4.12 Case management Services

Waiver case management services are defined as services furnished to assist a beneficiary in gaining access to needed medical, social, educational and other services

a. **Case Management:**
Medicaid shall cover case management which consists of assessing, care planning, referral or linkage and monitoring and follow-up. Case management services are necessary to identify needed medical, social, environmental, financial, and emotional interventions. These services are provided to maintain community integration while safeguarding the beneficiary's health, safety, and well-being. A case management activity must be performed at least monthly with the beneficiary.

b. **Care Advisor:**
Medicaid shall cover a service that provides advisement to the employer of record in gaining access to needed medical, social, educational and other services. The care advisor focuses on empowering a CAP/DA beneficiary to define and direct their own personal assistance needs and services. The care advisor guides and supports the beneficiary, rather than directs and manages the beneficiary, throughout the service planning and delivery process. These functions are done under the guidance and direction of the beneficiary or responsible party.

3.4.13 Personal Assistance Services

Medicaid shall cover a service that provides assistance with or monitoring of personal care and basic home management tasks to the CAP/DA beneficiary who is unable to perform these tasks independently due to a medical condition identified and documented on a comprehensive need-based assessment. The need for assistance must be related directly to the CAP/DA beneficiary's physical, social, environmental, and functional condition as indicated in the comprehensive need-based assessment. Personal assistant services may be provided in the community, home, workplace, or educational settings at the discretion of the CAP/DA beneficiary or designated representative.

The provider(s) 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.

3.4.14 Financial Management Services

Medicaid shall cover a service that provides financial assistance and advice to a beneficiary who is directing their care to ensure that consumer-directed funds outlined in the service plan are managed and distributed as intended.

Financial managers provide education and training to orient the beneficiary to the roles and requirements of the consumer-directed model of care. Financial managers facilitate the employment of the personal assistant and pays the personal assistant.

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

a. the 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 Medicaid

Medicaid shall not cover CAP/DA participation and services for any **one** of the following:

a. The Community Alternatives Program (CAP) special indicator code has not been entered or has been removed from the eligibility information system (NC FAST) and cannot be reentered;
b. The HCBS Service Request Form is incomplete or has been denied; or a request for additional information was not received within the specified timeframe;
c. The required annual assessment recertification was not approved or completed within 12 months of the annual assessment at no fault of the beneficiary or applicant;
d. If an assessment of medical and functional needs has not been completed by a nurse or social worker to determine reasonable indication of need of CAP/DA services at no fault of the beneficiary or applicant, defined in **Appendix F**;
e. The beneficiary's health and well-being cannot be met through an individualized person-centered service plan or the support from a risk agreement when the beneficiary resides in an unsafe home environment placing the eligible beneficiary at risk, listed in **Subsection 7.3;**
f. The beneficiary or responsible party refuses to sign or cooperate with the established plan of care (POC) and any other required documents, placing the eligible beneficiary's health, safety and well-being at risk, listed in **Subsection 5.4.2;**
g. The case management entity (CME) has been unable to establish contact with the beneficiary or their responsible party to monitor the provision of care to ensure the health and well-being for more than 90 calendar days, despite more than two (2) verbal and (2) written attempts;
h. The beneficiary's Medicaid eligibility is terminated and cannot be reactivated;
i. The beneficiary's Medicaid is not active; in one of the non-approved Medicaid categories; or is in a Medicaid sanction period;

j. The beneficiary or responsible party demonstrates, as evidence through written correspondence, a continued inability or unwillingness to adhere to the rights and responsibilities as outlined in the "Beneficiary Rights and Responsibilities" form signed by the beneficiary during the admission and readmission process **in Appendix E**;
k. The beneficiary enters a non-eligible residential placement, nursing facility for a short-term rehabilitation stay or long-term nursing facility stay. When a beneficiary enters a skilled nursing facility or rehabilitation center for a short-term rehabilitative stay, CAP/DA services are suspended until discharged from the facility. The beneficiary is eligible to be reinstated into the program upon discharge. A beneficiary is eligible to be reinstated upon discharge if the short-term rehabilitation does not exceed 90 calendar days of placement;
l. The annual paid expenditure exceeds the average per capita cost of expenditure for an individual receiving institutional services and the ongoing average cost of care cannot be provided at a cost less than the average cost of institutional services;
m. The applicant or active beneficiary's currently approved services (Medicaid and non-Medicaid) are meeting assessed care needs, and the applicant or beneficiary is determined to not have a reasonable need for one waiver service if the home and community-based services were terminated (refer to **Appendix F**);
n. When the only assessed need is a home or vehicle modification or assistive technology, and evidence is provided of the installation and a claim has been adjudicated by NCTracks, and no other waiver service was assessed to be needed at the next scheduled quarterly monitoring visit;
o. The applicant or active beneficiary does not exercise their agreement through freedom of choice to participate in the CAP/DA waiver;
p. The beneficiary has not completed an emergency or disaster plan within 30 calendar days of the approved service plan;
q. The beneficiary or responsible party cannot demonstrate willingness or intellectual capability to assume the responsibilities of consumer-directed care as evidenced by re-completion of self-assessment questionnaires, training and orientation and coaching and guidance;
r. The beneficiary does not sign the person-centered service plan to agree to the service interventions to maintain community placement to avoid an institutional placement; or
s. the beneficiary does not reside in an approved primary private residence or other designated location.

Note: The beneficiary shall be eligible to participate in the CAP/DA waiver when in deductible status; however, CAP/DA services are not reimbursed by Medicaid until Medicaid services are incurred and documented through receipts or invoices.

4.2.2 Specific Criteria Not Covered by Medicaid

None Apply.

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/DA. The provider shall obtain prior approval before rendering CAP/DA:

a. HCBS nursing facility LOC for CAP/DA participation; and
b. All waiver service authorization limits.
c. The provider(s) 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 Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary have met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

The Comprehensive Independent Assessment Entity (CIAE) or the Case Management Entity (CME) shall submit to the CAP Business System the following:

a. HCBS Service Request Form (SRF) along with the Physician's Worksheet is used to assist in determining clinical eligibility for participation in the CAP/DA Waiver**.** The SRF establishes the level of care and is the first indicator of whether a beneficiary is appropriate for CAP/DA services. The SRF must be completed within 14 business days from receipt of the beneficiary's consent by the CIAE and 45 calendar days by the CME. An SRF that is incomplete after the established 14 business days, or 45 calendar days is voided. The SRF does not progress through the next eligibility steps of obtaining an assessment slot assignment.

   Note: Individuals transitioning from an institution, or a 1915(c) waiver shall receive an expedited level of care evaluation using the medical documentation from the previously validated level of care decision.

   All sections and required fields on SRF must be completed in its entirety to establish eligibility determination for LOC. The eligibility sections and fields are:

   1. Service request;
   2. Beneficiary demographics;
   3. Beneficiary conditions and related support needs;
   4. Medications;
   5. Sensory and Communication Limitation;
   6. Mood, Behavior and Interpersonal functioning;
   7. Cardio-Respiratory support needs;
   8. Nutrition-related support needs;

9. Ancillary therapies and other support needs;
10. Functional limitation;
11. Support Network;
12. Attestation by Physician; and
13. Date of LOC request.

b. The multidisciplinary comprehensive assessment identifying assessed needs and 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.

Note: DHHS's designated contractor shall submit an electronic prior approval (PA) transfer to NCTracks of approval or denial of CAP/DA 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/DA 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/DA Participation

5.3.1 Approval Process

a. **Inquiries and Referrals:**
The Comprehensive Independent Assessment Entity (CIAE) and the Case Management Entities (CMEs) responsibilities include:

1. LOC evaluations in combination with NC Medicaid;
2. Validation of service plans;
3. Slot utilization management through the completion of assigned assessments; and
4. Beneficiary waiver enrollment is consistent with an assessment that identifies a reasonable indication of need for HCBS waiver services. The comprehensive independent assessment entity or case management entity assist with making initial level of care decisions about waiver participation by processing the Service Request Form (SRF) and conducting the in-person needs-based eligibility enrollment paperwork (comprehensive assessment).

When a referral is submitted to the CIAE or CME for CAP/DA services, the CIAE 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 CIAE or CME within seven business days of the dated letter.

Upon receipt by the CIAE or CME of the consent form, the CIAE or designated entity initiates processing of the SRF. If the consent form is not received within the required timeline of seven business days, the referral request is voided.

Upon the completion and processing of the SRF, the CIAE or designated entity notifies the applicant by mail or other approved method using the CAP Business System Contractor's generated notification letter.

b. **Assessment Approval:**
When a CAP/DA assessment slot is available, the approved applicant is placed in an assessment assignment queue or in an assessment assignment status which notifies the CIAE or the CME to arrange an in-person visit within two business days to initiate the completion of the assessment. The assessment for initial and ongoing applicants must be completed within 14 business days of the placement in the assessment assignment queue by the CIAE and 45 calendar days by the CME. When the analysis of the assessment determines reasonable indication of need for at least one CAP/DA service, the applicant or active CAP/DA beneficiary must sign and agree to participate in the CAP/DA waiver.

c. **Coordinate with Medicaid Eligibility Staff:**
When the applicant is placed in Assessment and Assignment, the CIAE or the CME assists the applicant to initiate the Long-Term Care Medicaid application process online with the consent of the applicant or notifying the DSS of the interest of the applicant in applying for CAP/DA services, when the applicant is eligible for Medicaid. The county DSS is notified of the on-line application by the CIAE or the CME through a template letter.
The CME shall follow up with DSS to ensure that the application is being processed during the service plan development.

Note: The CME is responsible for confirming the approval of Long-term Care Medicaid eligibility for the approved applicant to receive CAP/DA services.

d. **Completion of the Assessment:**
Upon the approval of **initial** waiver participation, the beneficiary is required to select a Case Management Entity (CME) to assist with the development of the person-centered service plan. Upon completion of the comprehensive assessment by the CIAE or designated entity, the selected case management entity is provided with access to the completed comprehensive assessment along with a summary of findings and recommended waiver services.

e. **Person-Centered Service Plan:**
The selected CME meets with the beneficiary and their 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 beneficiary and, when applicable, their chosen representative shall lead the service plan development process.

f. **Coordinate with Medical Professionals and Tribal Option:**
The CIAE and CME shall coordinate and collaborate with the local CCNC networks, Tribal Option, and Managed Care entities, when applicable, to obtain medical history data and assistance with care coordination to assure appropriate linkage to medical and other professional services.

5.3.2 Minimum required documents for CAP/DA participation approval:

a. **Initial:**
Contact information for the beneficiary and primary caregiver; an approved SRF; signed physician's attestation; signed consent to release information; signed participant's rights and responsibilities; signed freedom of choice for waiver participation; signed freedom of choice form with selected providers; completed comprehensive assessment with summary details; approved signed service plan that outlines service needs and cost of services; emergency and disaster plan, when determined and applicable, job or school verification statement, Physician's order, individual risk agreement and self-assessment questionnaire, consumer-direction training and orientation, competency validation for each employee, confirmation from financial manager of employability of selected personal assistant, consumer rights, employer agreement, employer-employee agreement, referral to financial management and financial management budget.

b. **Annual:**
Updated contact information for the beneficiary and primary caregiver; signed consent to release information; signed participant's rights and responsibilities; signed freedom of choice for waiver participation; signed freedom of choice form with selected providers; completed comprehensive assessment with summary details; approved signed service plan that outlines service needs and cost of services; emergency and disaster plan, when determined and applicable, job or school verification statement, Physician's order, individual risk agreement and self-assessment questionnaire, consumer-direction training and orientation, competency validation for each employee, confirmation from financial manager of employability of selected personal assistant, consumer rights, employer agreement, employer-employee agreement, 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 beneficiary and primary caregiver; signed consent to release information; signed participant's rights and responsibilities; signed freedom of choice form with selected providers; when determined and applicable an updated emergency and disaster plan, job or school verification statement; Physician's order; individual risk agreement and self-assessment questionnaire, competency validation for each employee, confirmation from financial manager of employability of selected personal assistant, consumer rights, employer agreement, employer-employee agreement, referral to financial management, financial management budget and nurse notes, documentation or summary for IHA services provided over a period of 90 consecutive days.

5.4 CAP Comprehensive Multidisciplinary Needs Assessment

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 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 an in person visit to assess the home environment to assure planning for the health, safety, and well-being of the beneficiary. A conclusion summary of the assessment findings must be completed after the multidisciplinary team meets.

Note: Notwithstanding the foregoing, an initial assessment may be conducted by telephone to ensure the health, safety, and well-being of the Medicaid beneficiary. Health, safety, and well-being includes the need for timely access to care to prevent institutionalization, injury, or loss of function. The reason for the telephonic assessment must be documented in the assessment record. The Medicaid beneficiary must agree to the telephonic assessment. When the telephonic assessment results in a potential denial, reduction, or termination, a face-to-face assessment must be conducted within 5 business days to evaluate the Medicaid beneficiary's needs. An initial telephonic assessment that does not result in a denial, reduction, or termination must be followed by a face-to-face assessment within two to three months from the completed telephonic assessment.

The comprehensive need-based assessment is completed on each beneficiary to determine medical, functional and social 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. Medications and Precautions;
d. Skin;
e. Neurological;
f. Sensory and Communication;
g. Pain;

h. Musculoskeletal;
i. Cardio-Respiratory;
j. Nutritional;
k. Elimination;
l. Mental Health;
m. Informal Support;
n. Housing and Finances;
o. Provider Agencies; and
p. Other Planning Considerations.

5.4.1 Initial Multidisciplinary Comprehensive Assessment

The initial multidisciplinary assessment is conducted after the determination of level of care derived from the Service Request Form. The initial assessment is completed by the Comprehensive Independent Assessment Entity (CIAE) or a designated entity.

The CIAE or a designated entity shall conduct the initial comprehensive assessment activities to:

a. Address all aspects of the applicant's risk factors pertaining to medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational and other areas;
b. Identify conditions and needs for risk mitigation;
c. Analyze in a multidisciplinary format the current assessment, a previous assessment completed by other program(s), when applicable, and other pertinent information to determine risk indicators, health and safety concerns and potential services to mitigate risk factors to generate a summary of assessment details for the CME.

The multidisciplinary comprehensive assessment must be completed within 14 business days by the CIAE and 45 calendar days by the CME of the placement in assessment and assignment.

Note: When a Service Request Form is approved, the applicant with the assistance of the CIAE or the CME initiates an on-line Medicaid application to begin processing the required Long-term Care Medicaid eligibility determination for participation in the CAP/DA waiver.

5.4.2 CAP/DA Person-Centered Service Plan Requirements

The service plan approval date is assigned after an approved assessment. The effective date of the service plan is the first day of the next eligible month or the first day of the next eligible month after approval of Medicaid eligibility, if Medicaid eligibility is not established before the CAP approval date.

The initial service plan must be completed within 30 calendar days of the assignment to the Case Management Entity (CME).

The CME shall work closely with the applicant or beneficiary to develop an initial or annual person-centered service plan based on the needs identified in the comprehensive 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 contains a plan of care (POC) that lists all approved CAP/DA and Medicaid State Plan services in the type, amount, frequency and duration. The annual average per capita cost for these services shall be listed in the POC to evaluate the annual cost of care needs.

The CME uses 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 and objectives based on the assessment and identified needs;
c. Develop a comprehensive list of CAP/DA waiver services and non-waiver services, medical supplies and durable medical equipment (DME), and document the authorized provider name, amount, frequency and duration of each service;
d. Calculate the monthly beneficiary cost of care for all CAP/DA waiver services and State Plan services.
e. Ensure the beneficiary's right to choose among providers as evidenced by a signed freedom of choice form;
f. Ensure the beneficiary's right to choose between CAP/DA, institutionalization, and from among Medicaid-enrolled providers as evidenced by a signed Freedom of Choice form;
g. Identify health and welfare monitoring priorities during the mandatory monthly and quarterly timelines; and
h. Soliciting the agreement through a signature from the CAP/DA beneficiary that the service plan meets the assessed needs in the type, amount, frequency and duration.

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

5.4.3 Continued Need Review (CNR) Assessment Requirements

A CNR assessment must be completed every 12 consecutive months to determine the continued medical, functional, and psychosocial care needs of the beneficiary for safe community living. The CNR assessment must be completed within the month of the initial CAP/DA effective month. A best practice initiative to ensure the service plan is completed timely, is to complete the assessment by week three (3) of the CAP/DA 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 whether the level of care (LOC) continues to be met. When the multidisciplinary assessment cannot clearly validate that LOC is met, a new SRF is processed by the Comprehensive Independent Assessment Entity (CIAE) or the Case Management Entity (CME) to validate the LOC.

5.4.4 Annual Person-Centered Service Plan Requirements

The annual service plan must be approved by the first day of the month following the CNR assessment. The annual service plan must have an effective date for the first day of the month following the initial CAP/DA effective month. The service plan expires 13 calendar months after the service plan effective date, if the beneficiary is not determined to meet the eligibility requirements of program participation.

The Case Management Entity (CME) works closely with the beneficiary to develop a person-centered service plan based on the needs identified in the comprehensive assessment. A person-centered service plan allows the beneficiary to identify preferences, likes and dislikes to create a care plan of both formal and informal supports. The completed person-centered plan contains a plan of care (POC) that lists all approved CAP/DA and Medicaid State Plan services in the type, amount, frequency and duration. The annual average per capita cost for these services is listed in the POC to evaluate the annual cost of care needs.

The CME shall use the service plan to achieve the items listed in **Subsection 5.4.2**.

5.4.5 Changes and Revision to the Service Plan

A plan of care (POC) revision is required when a request is made to add, reduce, increase, delete a CAP/DA service or Medicaid State service, or when there are changes in a service provider. The Case Management Entity (CME) designee is responsible for revising the POC when there is a change in the beneficiary's needs.

Service plan revisions are approved by unbiased personnel within the CME. Revisions for an urgent need because of a critical change in status may be approved retroactively for up to 30 calendar days prior to the date that the plan is revised. The beneficiary or the primary caregiver shall agree to and sign and date the service plan acknowledging changes for CAP/DA provisions.

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/DA beneficiary at risk of losing their 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/DA provision.

Note: The items listed above as exclusion for retroactive approval, may be considered for urgent approval based on necessary need. The POC must be submitted into the CAP Business System along with supporting documentation.

Documenting a change in services:
The CME designee shall revise the POC as the beneficiary's needs change. Changes to the POC are submitted in the CAP Business system within 15 calendar days of the request by the beneficiary needs. The CME shall assign a staff who is not involved in the change in status assessment to approve the request for services within 30 calendar days of the initial request. Revisions for an urgent need because of a critical change in status may be approved retroactively for up to 30 calendar days prior to the date that the plan is revised. The beneficiary or the primary caregiver shall agree to and sign and date the service plan acknowledging changes for CAP/DA provisions.

Documenting a change of provider agency:
A POC update is required for a change in provider agency, but the change is not considered a revision. The CME designee obtains a signed freedom of choice form from the beneficiary or the responsible party consenting to the change in providers.

5.5 CAP/DA Effective Date

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

a. the date of the Medicaid LTC application upon the approval of the assessment if the applicant was not previously eligible for Medicaid;
b. the date the assessment was approved after being placed in assessment and assignment in the CAP Business System (e-CAP);
c. the date of deinstitutionalization; or
d. in the event of an appeal, the date the court issued the order, settlement decision, other document concluding the appeal.

5.6 Authorization of Services

If the beneficiary or legal representative agrees with the service plan, they shall sign the person-centered service plan to receive the CAP/DA waiver services and sign the rights and responsibilities form to willfully agree to participate in the CAP/DA waiver. The Case Management Entity (CME) shall authorize selected providers according to the approved service plan through service authorizations. The service authorization must detail the authorization period for each approved CAP/DA service. The service authorization reports the specific benefit services, service and provider type and the tasks to be provided in the amount, duration, and frequency. The CME shall follow-up with authorized service providers of CAP/DA services within 72 calendar hours of service plan approval.

The authorized Medicaid provider shall accept or reject the service authorization within three (3) business days and within five (5) business days initiate the care plan development process. Once the authorized Medicaid provider accepts a service authorization, the CAP Business System (e-CAP) issues a prior approval record for the approved waiver service to the fiscal agent.

The service authorization expires thirteen (13) consecutive months from the effective date of the initially approved service plan. 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 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/DA beneficiary receive a participation notice acknowledging medical necessity has been met to receive the service as outlined in the provider's plan of care.

The provider(s) 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.

5.7 Person-Centered Service Plan Denial

If a service plan is denied, the CAP Business system generates a denial letter to be mailed by the CIAE or the CME to the applicant or beneficiary by trackable mail on the date the decision was made. The CME notifies the Department of Social Services' (DSS) eligibility unit of the service plan denial decision using a templated notice letter.

If an initial person-centered service plan is not submitted with an authorized signature (beneficiary or legal representative) the CAP/DA beneficiary's services are suspended until a signature is obtained. When after 90 calendar days, an authorized signature is not obtained, the CAP/DA beneficiary becomes ineligible for participation in the CAP/DA Waiver. If an annual person-centered service plan is not submitted with authorized signature (beneficiary or legal representative) services are suspended until a signature is obtained. When after 90 calendar days, an authorized signature is not obtained the beneficiary becomes ineligible for continuation of participation in the CAP/DA Waiver until a signature is obtained. If a signature is not obtained within 30 calendar days of the service plan effective date, CAP/DA beneficiary becomes ineligible for continuation of participation. The DHHS designated contractor or NC Medicaid disenrolls the CAP/DA beneficiary from the CAP/DA Waiver. The CAP/DA beneficiary is notified in writing of the disenrollment. The DSS is notified of the CAP/DA disenrollment and the DSS notifies the beneficiary of their ongoing Medicaid eligibility status.

If the CAP/DA beneficiary willfully withdraws from the CAP/DA waiver and requests to re-enter, they may re-enter within 90 calendar days of their withdrawal. Reenrollment paperwork, that includes the assessment (full or abbreviated depending on the reentry timeframe), service plan, rights and responsibility form and freedom of choice form, is required to be completed for CAP/DA services to begin. CAP/DA services are not approved or retro-approved during the period before the reentry process.

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

5.8 CAP/DA Waiver Benefit Specific Service Limitations

Refer to Appendix B for detailed Waiver Service Definition.

5.8.1 Adult Day Health

Adult Day Health Services are organized and provided for a minimum of four hours per day on a regularly scheduled basis for one or more days per week. Refer to **Appendix B** for detailed **Waiver Service Definition**.

5.8.2 Equipment, Modification and Technology

Equipment, modification and technology services are limited to $28,000 over the waiver approval cycle.

The Case Management Entity (CME) shall track the cost of procured Equipment, modification and technology during each waiver participation year, to avoid exceeding the $28,000 limit. Those items that are not of direct medical or remedial benefit to the beneficiary are excluded.

Items that are covered through DME, orthotics and prosthetics, home health supplies, and EPSDT are obtained through the respective programs. CAP/DA does not cover items that are covered by one of these programs but were denied for lack of medical necessity.

5.8.3 Respite Care

The combined use of both institutional respite care and in-home respite care must not exceed 30 calendar days for institutional respite or 720 hours in one fiscal year. A day of institutional respite counts as 24 hours or 96 units towards the annual limit.

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.

In addition to the above, the following limitations apply to non-institutional respite:

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

5.8.4 Personal Emergency Response Services (PERS)

PERS does not cover the purchase and installation of equipment in the beneficiary's primary residence.

5.8.5 Goods and Services

a. Participant Goods and Services
b. Individual-directed Goods and Services
c. Nutritional Services
d. Pest Eradication
e. Non-medical transportation
f. Chore-Declutter and garbage disposal

The cost of the above listed goods and services for each beneficiary must not exceed $800.00 annually (July –June) for all goods and services, collectively. Products and items listed on the State Medicaid Plan are prohibited from being reimbursed by this service unless approved by NC Medicaid.

5.8.6 Transition Services

a. Community transition services are available to cover initial set-up expenses, not to exceed $2,500 within 365 consecutive days from the date of the beneficiary's discharge from an institution.
b. Community Integration services are available to cover tenancy-related issues, not to exceed $2,500 over the CAP/DA Waiver approval cycle.

These services do not cover room and board.

The cost of the above listed goods and services for each beneficiary must not exceed $2,500, collectively.

5.8.7 Training, Education and Consultative Services

This service is limited to $500 per fiscal year (July-June). Paid service providers cannot be trained or educated using this service.

5.8.8 Case Management Services

Service utilization limitation cannot exceed the Medicaid maximum limit per calendar month**:**

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

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.

Refer to **Appendix B** for detailed Waiver Service Definitions.

Case management service does not consist of:

a. outreach;
b. travel time;
c. activities after the beneficiary's discharge, termination, or death;
d. activities such as taking the referral and obtaining the Service Request Form, that occur prior to the CAP/DA enrollment date;
e. attending training;
f. completing time sheets;
g. recruiting, training, scheduling, and supervising staff;
h. billing Medicaid;
i. documenting case management activities; and
j. gathering information to respond to quality assurance requests.

5.8.9 Financial Management Services for Consumer-Directed

Financial management services are limited to one monthly unit per month for monthly financial management.

One monthly unit during the enrollment month is included in the service plan and approved.

One (1) monthly unit of transfer financial management fees is approved when a new FI provider is approved. A half (1/2) monthly unit of transfer financial management fees is approved when transitioning to previously approved financial manager (FM) provider. Refer to **Appendix B** for detailed Waiver Service Definitions.

5.8.10 CAP In-Home Aide I Services

The number of hours of this CAP/DA service is authorized based on assessed needs, caregiver's ability, composite score and other available resources.

A spouse, parent, step-parent, child, sibling, or other relatives can be hired as the employee when a CAP/DA beneficiary is 18 years of age and older and the employee:

a. Is at least 18 years of age; and
b. Meets the qualifications based on need-based assessment.

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

c. A legal guardian may be hired as the employee if they meet anyone of the following special circumstances or extraordinary conditions:
    1. There are no available certified nursing assistants I (CNAs) in the beneficiary's county or adjunct counties through a Home Health Agency or an In-Home Aide Agency due to a lack of qualified providers, and the CAP/DA beneficiary needs extensive to maximal assistance with activities of daily living and associated instrumental activities of daily living such as bathing, dressing, toileting and eating daily to prevent an out-of-home placement.

2. The CAP/DA beneficiary requires short-term isolation, 90 calendar days or less, due to experiencing an acute medical condition or health care issue requiring extensive to maximal assistance with bathing, dressing, toileting and eating, and the CAP/DA beneficiary chooses to receive care in their home instead of an institution.
3. The CAP/DA beneficiary requires physician-ordered 24-hour direct observation or supervision specifically related to the primary medical condition(s) to assure the health and welfare of the beneficiary to avoid institutionalization, and the legal guardian is not able to maintain full or part-time employment due to multiple absences from work to monitor or supervise the CAP/DA beneficiary; regular interruption at work to assist with the management of the CAP/DA beneficiary's monitoring and supervision needs; or an employment termination.
4. The CAP/DA beneficiary has specialized health care needs that can only be 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 beneficiary and avoid institutionalization.
5. Other documented extraordinary circumstances not previously mentioned that places the CAP/DA beneficiary's health, safety and well-being in jeopardy resulting in an institutional placement.

When an individual meets the extraordinary circumstances described above, the maximum number of hours that can be 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 legal guardian does not receive payment for only completing instrumental activities of daily living such as meal preparation, laundry, money management, home maintenance, shopping, and medication management.

When the legal guardian is authorized to receive payment for providing personal assistance services, the CAP/DA beneficiary is enrolled in the coordinated caregiving waiver service.

5.8.11 CAP In-Home Aide II Services

The number of hours of this CAP/DA service is authorized based on assessed needs, caregiver's ability, composite score and other available resources.

A spouse, parent, step-parent, child, sibling, or other relatives can be hired as the employee when a CAP/DA beneficiary is 18 years of age and older and the employee:

a. Is at least 18 years of age; and
b. Meets the qualifications based on need-based assessment.

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

A legal guardian, Power of Attorney, or Health Power of Attorney may be hired as an employee if they meet any ONE of the following:

a. There are no available In-Home Aide II staff in the beneficiary's county or adjunct counties through a Home Health Agency or an In-Home Aide Agency due to a lack of qualified providers, and the CAP/DA beneficiary needs extensive to maximal assistance with activities of daily living and associated instrumental activities of daily living such as bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
b. The CAP/DA beneficiary requires short-term isolation, 90 calendar days or less, due to experiencing an acute medical condition or health care issue requiring extensive to maximal assistance with bathing, dressing, toileting and eating, and the CAP/DA beneficiary chooses to receive care in their home instead of an institution.
c. The CAP/DA beneficiary requires physician-ordered 24-hour direct observation or supervision specifically related to the primary medical condition(s) to assure the health and welfare of the beneficiary to avoid institutionalization, and the legal guardian is not able to maintain full or part-time employment due to multiple absences from work to monitor or supervise the CAP/DA beneficiary; regular interruption at work to assist with the management of the CAP/DA beneficiary's monitoring and supervision needs; or an employment termination.
d. The CAP/DA beneficiary has specialized health care needs that can only be 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 beneficiary and avoid institutionalization.
e. Other documented extraordinary circumstances not previously mentioned places the CAP/DA beneficiary's health, safety and well-being in jeopardy resulting in an institutional placement.

When an individual meets the extraordinary circumstances described above, the maximum number of hours that can be 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 legal guardian does not receive payment for only completing instrumental activities of daily living such as meal preparation, laundry, money management, home maintenance, shopping, and medication management.

When the legal guardian is authorized to receive payment for providing personal assistance services, the CAP/DA beneficiary is enrolled in the coordinated caregiving waiver service.

5.8.12 Personal Assistance Services

The number of hours of this CAP/DA service is authorized based on assessed needs, caregiver's ability, composite score and other available resources.

A spouse, parent, step-parent, child, sibling, or other relatives can be hired as the employee when a CAP/DA beneficiary is 18 years of age and older and the employee:

a. Is at least 18 years of age; and
b. Meets the qualifications based on need-based assessment.

A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide personal care services to a CAP/DA beneficiary. However, due to special circumstances or extraordinary conditions, a legal guardian, Power of Attorney, Health Power of Attorney may be hired as the employee when one of the special circumstances or extraordinary conditions in **Subsection 5.8.10** is met.

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

CAP/DA funding cannot be used to pay for services provided in public schools when educational support services are determined to be needed under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

5.8.13 Coordinated Caregiving

The reimbursement rate for a CAP/DA beneficiary assessed at the low, moderate and high service intensity need is published on the Division of Health Benefit website as a daily rate. Caregiver is paid a stipend for providing needed service interventions. The stipend to the caregiver must be at least 50 percent of the approved utilization amount.

A CAP/DA beneficiary receiving coordinated caregiving services shall be restricted to specific HCBS services when indicated by the assessment and service plan. Room and board payment is excluded.

5.8.14 Meal Preparation and Delivery

One (1) meal per day; oral nutritional supplements are excluded from meal preparation and delivery services.

5.8.15 Specialized Medical Supplies

Approval for medical supplies is provided through a physician's order. Items available are limited to incontinence supplies, and oral nutritional supplements.

5.9 Waiver Service Requests and Required Documentation

5.9.1 Equipment, Modification, Technology and Supplies

For requests for assistive technology equipment, supplies and home 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 or home modification being requested. The recommendation must state the cost of an item that a beneficiary requires;

b. a plan for how the beneficiary and family is to be trained on the use of the equipment (the training must be documented by the case manager as completed and signed by the CAP/DA beneficiary or responsible party);
c. statement of need identified in the service plan;
d. evidence of medical need recommended by the MDT or by a physician, when applicable;
e. shipping costs itemized in the proposal request;
f. other information as required for the specific equipment requested;
g. when quotes are required for purchase, adaptation or modification, NC Medicaid determines how many quotes are required; and
h. NC Medicaid or its designee determines the appropriate professional(s) that make written recommendations for services that are required when special circumstances are presented.

5.9.2 Supportive Services

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

a. **Transition Services**;
An itemized Community Checklist.

b. **Training, Education and Consultative Services**;
Short and long-range outcomes directly related to the needs of the beneficiary and primary caregiver(s) or other identified supporter's ability to provide care and support the CAP/DA beneficiary.

c. **Consumer-directed Care election**:
1. A completed self-assessment questionnaire;
2. Representative Needs Assessment and Representative Designation or Agreement, as applicable;
3. Verification of completed training of both beneficiary and hired workers;
4. Verification of the submission of personal assistant competency forms confirming ability of hired staff to perform in designated role;
5. Authorization from the financial manager (FM) of employability of the selected personal assistant; and
6. Consumer-directed Agreement packet and required forms obtained by the financial management agency; and
7. A favorable background check for hired workers.

The consumer-directed beneficiary shall maintain timesheets and workflow sheets of their hired assistants that are consistent with the record and retention policy.

If the consumer-directed beneficiary transfers to provider-led or coordinated caregiving waiver planning, the Case Management Entity (CME) shall take possession of those files and maintain those files consistent with the record and retention policy.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed 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

Medicaid providers seeking to provide CAP/DA services shall meet all requirements for provider enrollment established by DHHS fiscal contractor and have an approved managed change request for specific taxonomies listed in the CAP benefit plan. Each selected Medicaid provider of CAP/DA services shall undergo a CAP/DA overview and orientation training prior to rendering authorized services, and annually thereafter.

Federally Recognized Tribes are eligible to provide all CAP/DA 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 shall be deemed to have been met regardless of whether the entity obtains a license or other documentation under State or local law.

NC Medicaid requires the following supervision to be performed as listed:

Supervision of the CNA minimally every 90 calendar days, in the home, by the RN Supervisor.

The following types of staff provide CAP/DA waiver services:

a. Certified Nursing Assistant I;
b. Certified Nursing Assistant II;
c. Personal assistant for consumer-directed care; or
d. Live-in caregiver for coordinated caregiving services.

Providers(s) shall comply with Section 12006(l) (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.

Providers of in-home aide and personal assistance services to the CAP/DA beneficiary shall:

a. have written documentation that recipients of in-home aide and personal assistance services were informed of the EVV requirement;
b. complete all required EVV trainings prior to providing in-home aide and personal assistance services;
c. train staff on use of selected EVV system; and
d. ensure administrator, essential personnel and staff within an organization participate in initial EVV training; and annual and refresher training in EVV, when applicable.

The CAP/DA Direct Service provider shall provide a copy of the agency policies and procedures that identify the assurance of nonuse of restraints and seclusion and critical incident management.

The CAP/DA Direct and Coordinated Caregiving service providers shall attest that hired workers have a criminal history and health care registry check free from the offenses found in **Appendix B** prior to rendering CAP/DA services.

6.2 Comprehensive Independent Assessment Entity (CIAE) Responsibilities

NC Medicaid is the administrator of the CAP/DA waiver. NC Medicaid awards an CIAE to perform waiver participation eligibility decisions for interested applicants. The responsibilities include:

a. Act in the role of front door for waiver inquires;
b. Develop case management procedures according to NC Medicaid standards and local policy and share these procedures with the appropriate providers and organizations;
c. Educate the caregiver of children, the elderly and disabled adult about CAP/DA Waiver;
d. Process referrals received from the CME and other providers for individuals seeking to participate in the CAP Waiver;
e. Coordinate with the interested applicant to obtain consent forms to collaborate with health care professionals to obtain necessary information or documentation to complete the service request form (SRF).
f. Conduct a multidisciplinary assessment on all initial applicants and for active CAP beneficiary on an annual basis when requested by NC Medicaid to determine ongoing appropriateness for CAP/DA services;
g. Distribute notification letters to the identified recipient from the prompts and templates generated through the CAP Business System;
h. Address complaints and grievances voiced by applicants, beneficiary, and providers; and
i. Complete critical incident reports within 72-hours of the incident.

The CAP/DA CIAE shall comply with the following NC Medicaid guidelines:

a. CAP/DA application, rules, policy and procedures;
b. Provider enrollment;
c. Authorization of qualified CME providers for the development of the service plan;
d. Program rates and limits;
e. CAP/DA enrollment;
f. Level of care evaluation;
g. Beneficiary service plans;
h. Prior authorization of services;
i. Utilization management;
j. Quality assurance and quality improvement strategies;
k. Performance benchmarks; and
l. Audits and reports.

6.3 Case Management Entity (CME) Qualifications

Local case management entities are appointed by NC Medicaid to provide day-to-day oversight of CAP/DA in the community. Competencies of appointed case management entities are evaluated quarterly and documented by a compliance score.

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/DA beneficiaries and their services. The CME must maintain Medicaid Provider Enrollment to continue in the role of a CME.

If a CME does not meet the requirement of five (5) years of experience, NC Medicaid may 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/DA beneficiaries and their services independently. NC Medicaid shall approve the CME when it demonstrates the ability to coordinate and manage CAP/DA beneficiaries and services.

6.4 Case Management Entity Responsibilities

NC Medicaid is the administrative authority of the CAP/DA waiver. NC Medicaid appoints CAP/DA Case Management Entity (CME) to provide the following specific day-to-day administrative responsibilities:

a. Develop case management procedures according to NC Medicaid standards and local policy and share these procedures with the appropriate providers and organizations;
b. Educate the caregiver of children, the elderly and disabled adult community about CAP/DA Waiver;
c. Submit and process service request and referrals for individuals seeking to participate in the CAP/DA Waiver;
d. Provide help in obtaining documentation from medical staff to monitor ongoing care needs;
e. Assess an applicant initially and a beneficiary on an annual basis to determine ongoing appropriateness for CAP/DA services;
f. Provide case management to the CAP/DA beneficiary;
g. Provide advisement to a beneficiary directing care through consumer direction;
h. Ensure waiver and non-waiver services are accurately listed on the POC initially, annually and during a POC revision;
i. Provide regular and routine beneficiary monitoring to assure health, safety and well-being, quality assurance reporting and beneficiary risk mitigation;
j. Complete critical incident reports within 72-hours of the incident; and
k. Maintain an Advisory Committee that would support the local program in developing and improving resources for a CAP/DA beneficiary; and advocating for the CAP/DA program within the community. Other tasks are working as a liaison between program and community by providing feedback and input on growth and direction of program. This Advisory Committee consists of representatives from the community.

The CAP/DA CME shall comply with the following NC Medicaid guidelines:

a. CAP/DA 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/DA enrollment;
f. Level of care reevaluation;
g. Beneficiary service plans;
h. Prior authorization of services;
i. Utilization management;
j. Quality assurance and quality improvement strategy;
k. Adherence to performance benchmarks; and
l. Audits and reports.

6.4.1 CAP/DA Mandated Requirements to be an Appointed Case Management Entity

Qualified case management entities shall have:

a. direct connection to the service area to provide continuity and appropriateness of care;
b. business management experience with adults 18 years of age and older with medical complexities or physical disabilities;
c. policies and procedures that align with the CAP/DA policies and procedures;
d. ability to provide case management services through approved qualified professionals;
e. architectural requirement to support the requirement of current and future automated programs;
f. adequate staff to participant ratio based on acuity of need (appropriate case mix);
g. ability to collaborate with a network of providers, to ensure services the service authorization can be accepted within three (3) business days of submission;
h. qualified staff as described above;
i. ability to make home visits as required and requested within established timeline;
j. provider enrollment, recertification, claim submission and prior approval inquiry training provided by NCTracks (GDIT);
k. evidence of fiscal soundness (evidence of financial statements) by having financial reserves on hand up to at least $60,000 or more; and
l. maintain an Advisory Committee to review, discuss and plan HCBS in the CME's community.

6.4.2 Case Manager Staff Qualifications

a. The case manager or care advisor shall meet one of the following qualifications and successfully pass a background check that includes an abuse registry check:

1. 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 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;
2. 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;
3. 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;
4. Nurse who holds a current North Carolina license with two (2) year or four (4) year degree and one (1) 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; or
5. 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 or a trainee and shall be hired to act in the role of case manager. The supervisor of the case manager shall provide direct supervision and approve all waiver workflow documentation and tasks.

   Note: Candidates with a higher educational background than listed shall also have one (1) year of community experience (preferably case management in the health or medical field directly related to homecare, long-term care, or personal care).

b. Case Management Entity (CME) Supervisor Qualifications
The case manager or care advisor supervisor shall meet one of the qualifications of a case manager or case advisor, possess three (3) or more years of directly related experience in the health or medical field directly related to homecare, long-term care, or personal care, one (1) of those years to have been in case management and successfully pass a background check that includes health care registry.

Note: Case managers without a college degree who were employed with an existing CAP/DA CME on or before October 1, 2013, are eligible for a grandfathering clause.

6.5 Medicaid Provider Requirement to Provide CAP/DA Waiver Services

Qualified NC Medicaid providers are granted approval to render CAP services through a managed change request. Providers are approved based on their approved Medicaid provider application and their qualifying taxonomies. Each qualified provider must adhere to the following when selected to render a CAP/DA service:

a. register as a user of the CAP Business System (e-CAP) and participate in required trainings.
b. accept, decline, or acknowledge service authorizations within three (3) business days of submission in the e-CAP system.
c. complete a CAP/DA overview and orientation training prior to rendering authorized services, and annually thereafter for updates and refresher of CAP/DA policies.
d. attest to having policies and procedures that identifies the assurance of nonuse of restraints and seclusions and critical incident management.
e. attest that hired workers successfully pass a background check that includes a health care registry.
f. comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments, when applicable.

6.5.1 Adult Day Health Services

Adult Day Health Centers providing Adult Day Health services must be certified by the Division of Aging and Adults Services in compliance with North Carolina Statute 131-D-6 and 10A NCAC 06 AGING - PROGRAMS OPERATIONS, Subchapters R and S. The adult day health center shall comply with the federal HCB Setting requirements at the time of submission and ongoing. The Case Management Entity (CME) shall provide a service authorization to the freedom of choice provider that bills Medicaid for this service.

Adult Day Health Provider must meet the following requirements:

a. Meet and maintain the HCBS Final Rule requirements;
b. 10A NCAC Chapter 06 Subchapters R and S; and
c. Certified by the NC Division of Aging and Adult Services, according to NC General Statutes 131-D-6

6.5.2 Equipment, Modification and Technology

The provider of equipment, modification and technology services must hold an applicable state and or business license and demonstrate the capacity to make the needed modifications and install equipment according to applicable local and state building codes and other administrative laws or rules. The provider shall have a taxonomy to render these services as a NC Medicaid Durable Medical Equipment and Supplies provider or CAP/DA service provider with approved taxonomies to render this service. Providers shall have the ability to install items according to the manufacturer's specifications and requirements. The Case Management Entity (CME) shall provide a service authorization to the selected provider to render the CAP/DA service and submit a claim for reimbursement, when applicable. Refer to **Appendix B f**or additional specifications for home modifications.

6.5.3 Case Management Services

A provider of case management services shall be an NC Medicaid approved Case Management Entity (CME). Social workers and registered nurses shall provide case management services. Case managers shall meet the educational and work experience requirements, and the training requirements listed in **Subsections 6.6 and 6.7**. The CAP Business System provides a service authorization to the selected CME to render this service and to submit a claim to Medicaid for reimbursement.

6.5.4 Transition and Integration Services

Medicaid providers who have the capacity as verified by the Case Management Entity (CME) to provide items and services of sufficient quality to meet the need for which they are intended, shall provide transition and integration services. The items and services must be of sufficient quality and appropriate to the needs of the beneficiary. A receipt must be provided for each purchase or invoice for which Medicaid reimbursement is being requested. Some items may be purchased directly through a retailer, as long as the item meets the specifications of this service definition.

The CME shall provide a service authorization to the selected provider to render the CAP/DA service and submit a claim to Medicaid for reimbursement, when applicable.

6.5.5 Respite Services

Institutional respite services must be provided in a Medicaid certified nursing facility or in an Adult Day Health Center that meets regulatory requirements and certified by the Division of Aging and Adult Services (DAAS). An institutional facility and the Adult Day Health provider shall have a managed change request with the institutional respite provider taxonomy code (385H00000X).

The Case Management Entity (CME) shall provide a service authorization to the selected provider to render the CAP/DA services and to submit a claim to Medicaid for this service.

In-Home Respite services must be provided by a homecare agency licensed by the State of North Carolina in accordance with 10A NCAC 13J.1107 when directed by an In-Home Aide Agency. In-Home respite for consumer direction cannot be provided by the primary hired personal assistance.

The CME shall provide a service authorization to the selected provider to render the CAP/DA service and to submit a claim to Medicaid for reimbursement.

Provider(s) subject to the EVV requirement shall comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments, when applicable.

Note: CME shall be responsible for monitoring the respite hours so not to exceed maximum limits.

6.5.6 Meal Preparation and Delivery

Agencies and organizations providing nutrition services shall meet DAAS requirements for home delivered meals in compliance with 10A NCAC Chapter 06, Subchapter 06K.0101.

The Case Management Entity (CME) shall provide a service authorization to the selected provider to render the CAP/DA service and to submit a claim to Medicaid for reimbursement.

6.5.7 CAP In-Home Aide Services I & II

CAP In-Home aide I & II services are provided by home care agencies licensed by the North Carolina Health Service Regulation who comply with NC General Statutes 131E-135 through 142 and 21 NCAC 36.0403 (a) and 21 NCAC 36.0403 (b) Provider(s) subject to the EVV requirement shall comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments, when applicable.

The employment of a spouse, parent, child or sibling of the CAP/DA or Consumer directed beneficiary is eligible for hire when the following eligibility requirements are met:

a. Is at least 18 years of age;
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;
c. When other employment responsibilities do not interfere with or negatively impact the provision of the approved CAP/DA in-home aide services; nor supersede the identified care needs of the CAP/DA beneficiary.
d. This restriction applies to other relatives and hired personnel;
e. Meets the special circumstances or extraordinary condition described in **Subsections 5.8.11** when the individual is a legal guardian, Power of Attorney, Health Power of Attorney; and
f. Has a criminal history and health care registry check free from the offenses found in **Appendix B** that are verified by a Home Health Agency or In-Home Care Agency.

6.5.8 Goods and Services

a. Participant Goods and Services
b. Individual-directed Goods and Services
c. Nutritional Services
d. Pest Eradication
e. Non-medical transportation
f. Chore-Declutter & garbage disposal

These services, equipment, and supplies are authorized by the Case Management Entity (CME) to a qualified service provider with an approved managed change request authorizing the CAP/DA taxonomy for this service.

Medicaid providers who have the capacity as verified by the CME shall provide items and services of sufficient quality and appropriate to the needs of the beneficiary. Some items may be purchased directly through a retailer as long as the items meet the specifications of the service definition.

When transportation is an approved service through goods and services, the approved transporter shall have a valid driver's license and liability insurance on their own transporting vehicle.

The CME shall provide a service authorization to the selected provider to render the CAP/DA service and to submit a claim to Medicaid for reimbursement, when applicable.

6.5.9 Personal Emergency Response Services (PERS)

The emergency response provider must have the capability to provide a 24-hour monitoring system according to the service definition.

The monitoring system must be UL/ETL Approved Emergency Device.

The CME shall provide a service authorization to the qualifying selected provider to render the CAP/DA service and to submit a claim to Medicaid for reimbursement.

6.5.10 Specialized Medical Supplies

The CME shall provide a service authorization to the qualifying selected provider to render the CAP/DA service and to submit a claim to Medicaid for reimbursement.

6.5.11 Training, Education and Consultative Services

The CME shall provide a service authorization to the qualifying selected providers to render the CAP/DA service and submit a claim to Medicaid for reimbursement. An organization with a training or class curriculum including universities, colleges and community colleges shall provide training and education services.

6.5.12 Personal Assistance Services (Consumer-directed)

Personal care services are provided by an individual who is determined to meet competency requirements and can meet **all** employment requirement coordinated by the FM. The employment of a spouse, parent, child or sibling of the consumer-directed beneficiary is eligible for hire when the following eligibility requirements are met:

a. Is at least 18 years of age verified by the FM; and
b. Other employment responsibilities do not interfere with or negatively impact the provision of the approved CAP/DA in-home aide services; nor supersede the identified care needs of the CAP/DA beneficiary.
c. This restriction applies to other relatives and hired personnel.

d. Is not a representative, legal guardian, Power of Attorney, or legally responsible person to the beneficiary, unless they meet the special circumstances or extraordinary conditions described in Subsection 5.8.10 under a legal guardian, Power of Attorney, or legally responsible person may be hired as the employee if they meet any one of the special circumstance or extraordinary conditions;
e. Has a criminal history and health care registry check free from the following findings, verified by FM;
    1. Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
    2. More than one felony conviction related to health care fraud;
    3. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree);
    4. Fraud or theft against a minor or vulnerable adult;
    5. Felony or misdemeanor patient abuse;
    6. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
    7. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry;
    8. Felony or misdemeanor involving cruelty or torture;
    9. Misdemeanor healthcare fraud; or
    10. 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.

    Provider(s) subject to the EVV requirement shall comply with Section 12006 1903(l) of the 21st Century Cures Act and any subsequent amendments, when applicable.

    Note: A potential personal assistant with offenses that are not outside of Medicaid guidelines nor related to abuse, neglect, criminal sexual conduct, or exploitation may qualify for an exemption and be eligible for employment under the direction of the CAP/DA beneficiary or designated representative if the offense occurred 10 years or more prior. A potential personal assistant who has findings from the health care registry checks that prevents him or her from working in the healthcare field is permanently banned from providing services to a CAP/DA beneficiary.

6.5.13 Financial Management Services (Consumer Direction)

The provider for financial management shall:

a. be approved as an NC Medicaid provider and have a managed change request with an approved taxonomy for these services and have the capacity to provide financial management services through both Fiscal and Employer Agent model;
b. be authorized to transact business in the State of North Carolina, according to all State laws and regulations;
c. have three years of home and community-based financial management experience;

d. be approved by the Internal Revenue Service (IRS) to be an employer agent according to Section 3504 of the IRS Code and IRS Revenue Procedure 70-6;
e. be accountants, financial advisors or managers, attorneys, or other individuals meeting qualifications of financial management;
f. have a minimum of three years of experience in developing implementing and maintaining a record management process that includes written policies and procedures;
g. maintain current and archived CAP/DA beneficiary, attendant, service vendors and FMS files as required by Federal and State rules and regulations, along with HIPAA requirements. Internal controls for monitoring this process must be part of the system and described in the policies and procedures; and
h. The FMS shall have experience and knowledge of the following:
    1. Automated standard application of payment;
    2. Check Claims;
    3. Electronic Fund Transfer;
    4. Electronic Fund Account;
    5. International Treasury Service;
    6. Invoice processing platform;
    7. Judgment Fund;
    8. Payment Application Modernization;
    9. Prompt Payment;
    10. Automated Clearing House;
    11. Cash Management Improvement Act;
    12. GFRS/FACTS;
    13. Government wide Accounting;
    14. Intergovernmental Reconciliation;
    15. Standard General Ledger; and
    16. Taxpayer Identification Number.

6.5.14 Coordinated Caregiving

Coordinated caregiving providers providing service at the low and high acuity level shall be enrolled as an Atypical NC Medicaid Provider, unless currently possesses a license to render nurse type services and have three (3) years of demonstrated experience delivering HCBS to adults with chronic and serve medical conditions who are at risk of institutionalization.

The provider of coordinated caregiving service providing service at the skilled acuity level complies with 10A NCAC Chapter 13 Subchapter J; and is in compliance with North Carolina Health Services Regulation in the management of this service.

Coordinated Caregiving Provider Qualifications:
a. An NC Medicaid Provider
b. 3 years of delivering Home and Community-Based Services (HCBS) to individuals with disabilities and their caregivers.

c. Develop, implement and provide ongoing management and support of a person-centered service plan that addresses the CAP/DA beneficiary's level of service needs which consists of an agreement with caregivers describing their roles and responsibilities for the care and support provided to the CAP/DA beneficiary.
d. Agency providers shall conduct home visits based on the CAP/DA beneficiary's assessed needs and caregiver coaching needs.
e. Agency providers shall provide the caregiver with a minimum of 8 hours of annual training that reflects the CAP/DA beneficiary's and caregiver's assessed needs. Training may be delivered during monthly home visits, through secure electronic communication methods or in another manner that is flexible and meaningful for the caregiver.
f. Agency providers shall provide education and coaching to lay caregivers that is based on the beneficiary's and caregivers' assessed needs, including managing health-related needs; personal care; cognitive, behavioral and social needs of a CAP/DA beneficiary and interventions to reduce behavioral problems for a CAP/DA beneficiary with mental disabilities and who need restorative services. Training and coaching must occur at a minimal monthly.
g. Agency providers shall work with the CAP/DA beneficiary and caregiver to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care and ensure that caregivers understand how to manage medical and other incidents and emergencies as they may occur and report such situations to the provider agency, as soon as possible.
h. The provider shall have the ability to perform competency evaluation on hired staff.
i. The provider shall perform background checks to include on all hired supportive caregivers to validate no finding were entered on the registry or convictions that are outlined on the HCBS banned list.
j. The provider shall assure the health and safety needs of the CAP/DA beneficiary are met in conjunction with the case manager.
k. The provider shall ensure that coaching to the supportive caregiver includes the importance of providing nutritionally balanced meals and healthy snacks each day to the CAP/DA beneficiary, as dictated by their medical or nutritional needs.
l. The provider shall engage in regular review of caregiver notes to understand and respond to changes in the CAP/DA beneficiary's health status and identify potential new issues to better assist with the coordination of care to avoid unnecessary hospitalizations or emergency room use.

Conducting competency validation of the live-in caregiver:

a. Provider agency shall assure that each caregiver has the demonstrated competency to perform the personal care activities specified in the CAP/DA service authorization.
b. Documentation Requirement- Documentation to support service rendered that consists of:
    1. Electronic caregiver notes that record and track the CAP/DA beneficiary's status, updates or significant changes in their health status or behaviors and participation in community-based activities and other notable or reportable events;
    2. Medication management records, when applicable;

3. Critical incidents;
4. Grievances and complaints;
5. Home visits conducted by provider agency;
6. Education, skills training and coaching conducted with the caregiver; and
7. Multidisciplinary team meetings demonstrate collaboration and communication with other service providers and healthcare professionals (as appropriate), CAP/DA case managers and other caregivers or individuals important to the CAP/DA beneficiary regarding changes in the CAP/DA beneficiary's health status and reportable events.

The coordinated caregiver provider shall provide the approved live-in caregiver with a minimum of 8 hours of annual training that reflects the CAP/DA beneficiary's and caregiver's assessed needs. Training can be delivered during home visits, through secure electronic communication methods or in another manner that is flexible and meaningful for the caregiver.

A live-in caregiver shall meet the following requirements:

a. Is at least 18 years of age; and in good health and able to follow written and verbal instruction; and
b. Pass a criminal background and health care registry checks

Federally Recognized Tribes- Any requirement under a Federal health care program that a provider as under NC 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.

Caregiver eligible for hire through this service shall meet the following requirements:

a. Is at least 18 years of age; and in good health and able to follow written and verbal instruction; and
b. Pass a criminal and health care registry checks as described in **Subsection 6.4.12.**

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.

Note: The Case Management Entity (CME) shall provide a service authorization to the qualifying selected provider to render the CAP/DA service to submit a claim to Medicaid for reimbursement.

6.6 Contract Requirement for e-CAP Portal

The DHHS designated contractor shall:

a. Processes participant waiver enrollment;
b. Data-mines waiver enrollment against approved limits (includes management of a wait list);
c. Data-mines waiver expenditures against approved limits;
d. Processes level of care evaluation;
e. Creates prior authorization transmittals for use by the CAP/DA approved service providers;
f. Data-mines utilization management;
g. Data-mines critical incident reports and associated root-cause analysis;
h. Generates notification letters and adverse notices that comply with NC Medicaid's Due Process procedures;
i. Provides access to frequently asked questions (FAQs) and CAP/DA memos and trainings; and
j. Abides by confidentiality regulations and protects health information.

6.7 Care Coordination Performed by the Case management entity

A CAP/DA beneficiary is 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 Case Management Entity (CME) is responsible for the following activities: 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 the CAP/DA Waiver that a case management activity is performed at least monthly, and a multidisciplinary case management assessment of health, safety and well-being is performed quarterly.

The principle activities of case management are:

a. Assessment

Case managers shall conduct an annual comprehensive assessment 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 from the CIAE and other summary information to assist with identifying care needs, risk indicators and support system; and
5. Reassess periodically to determine whether a beneficiary's needs or preferences have changed to make a recommendation for change in status assessment of need.

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.
3. Knowledge of Motivational Interviewing Techniques.

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 beneficiary and family to elicit, gather, evaluate, analyze and integrate pertinent information, and form assessment conclusions.
4. Recognize indicators of risk (health, safety, mental health and 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.
7. Discuss findings and recommendations with the beneficiary and 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.

Services are provided according with all requirements specified in this policy: all applicable federal and state laws, rules, and regulations.

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 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;
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.
2. Develop an individualized care plan with a beneficiary and their supports based on assessment findings that include 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 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 beneficiary;
2. Maintain consistent, collaborative contact with other health care providers and community resources;
3. Initiate services in the service plan 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 the case managers or care advisors to identify what services and interventions do and do not work and what other potential service and intervention can be arranged to address an ongoing or newly assessed need. When a case manager is performing monitoring and follow-up activities, announced and unannounced visits with the beneficiary, responsible party, and service providers can 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 whole person care 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 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 their supports; and
5. Encourage and assist a beneficiary to be a self-advocate for quality care.

Note: Case Manager shall complete monthly contact by telephone or other secured means of contact with the beneficiary. Case Managers shall make sufficient (more than quarterly) face to face contacts contingent on the risk factors and other factors that may jeopardize the health safety and well-being of the beneficiary.

Face to face contact can be completed by Facetime, Skype, Video chat, and Remote Patient Monitoring system. These types of monitoring tools must be secured and permission to use such devices is granted by the beneficiary. If these methods are used, the beneficiary must show that the aide is present by a virtual walk through (directing the device/camera throughout the home environment). This type of monitoring may only occur twice in the quarterly monitoring regimen which begins after the completion of the initial or annual assessment. Take for example, the first quarterly visit after the execution of the service plan must be face-to-face. The second and third quarterly visits may be conducted through technology when there is no evidence of a critical incident between the two monitoring periods. The fourth quarterly visit must be performed by a face-to-face visit.

6.8 Case Manager Continuing Education Requirements

As arranged by the CME, the CAP case manager or care advisor shall be responsible for ensuring and documenting that each case manager or case advisor participate in and complete minimum training requirements for Home and Community Based Services as identified by NC Medicaid. The case manager or care advisor shall complete nine (9) contact hours or continuing education hours per year of which person-centered training (initial and refreshers); legislation training related to health care disability and reimbursement strategies; abuse, neglect, exploitation, and program integrity (PI) are mandatory.

The required training curriculum is listed below:

a. Bloodborne Pathogens and Infection Control;
b. Health Insurance Portability Accountability Act (HIPAA);
c. End of Life planning;
d. Cultural Diversity; and
e. Completion of the following NC Medicaid program-specific training modules (training slides in the CAP Business System) within one year of implementation of this clinical coverage policy and within one year for a newly hired case manager or care advisor:
    1. Person-centered thinking and planning training (initial and refresher as indicated through Quality Assurance reviews);
    2. Abuse, neglect, exploitation (initial);
    3. Program integrity (PI) (initial to bring awareness to fraud, waste and abuse and how to report and manage occurrences and suspicions);
    4. Conflict resolution (initial for the case managers and the consumer-directing beneficiary to assist in identifying strategies to manage a difficult beneficiary or workers.);
    5. Mental Health First Aid (initial for the case manager to assist in providing a resource of what to do if a CAP/DA beneficiary is experiencing a mental health crisis and needs intervention);
    6. Critical incident reporting (initial and annual);
    7. Service plan to address Health, Safety and Well-being and to create additional support using an Individual Risk Agreement (initial and annual refresher);
    8. Fair hearing and EPSDT (initial and refresher);
    9. Consumer Direction (initial and refresher);
    10. Quality Assurance and Performance Outcomes (initial and refresher);
    11. Cultural Awareness (initial and refresher);
    12. Motivational Interviewing or a similar training (initial and refresher); and
    13. How to use and navigate e-CAP (initial and refresher).

    Note: The case management entity is responsible for arranging training independently or participating in training offered by NC Medicaid to meet the requirement.

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; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, DHHS, its divisions or its fiscal agent.
c. Case Management Entity (CME) shall enter all CAP/DA workflow requirements in the CAP Business System within the specified timeline. The workflow requirements are the following: referrals to CIAE, assessments, assessor summaries, service plan

development, critical incident reports, grievances and complaints, case notes, monitoring visits notes and other supportive documentations.

d. The CIAE shall enter all CAP/DA workflow requirements in the CAP Business System within a specified timeline. The workflow requirements are the following: referrals, assessments, assessor summaries, service plan approvals, critical incident reports, grievances and complaints, and quality assurance activities.
e. CAP/DA approved service providers shall use the CAP Business System to accept or reject service authorizations and participation notices, submit referrals to the CIAE and enter critical incident reports, grievances and complaints and participate in multidisciplinary treatment team quarterly assessment meetings and questionnaires.

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 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 contractor for the timeframe listed in the audit.

A service record shall be maintained on each CAP/DA beneficiary by the CAP Business system. A service record is a collection of either electronic or printed material that provides a documentary history of the CAP/DA 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.

7.2 Budget and Use of Funds

The CAP/DA beneficiary service plan is developed on an annual basis or revised as needed by the CME designee. Service plans are approved by the designated entity. NC Medicaid shall closely monitor average per capita care expenditures for all CAP beneficiary to ensure the cost for the CAP/DA waiver is less than the cost of institutional settings.

To assure cost neutrality of the waiver, a cost analysis of the total waiver budget and the average per capita expenditure for each CAP/DA beneficiary is performed on a quarterly basis. When claims of the average per capita cost of waiver services are 110 percent over claims of the average per capita cost of the institutional setting, NC Medicaid must do the following:

a. Develop a cost utilization plan with a timeline of 90 calendar days to align the care needs within the CAP/DA budgetary limits;
b. Implement a 90-calendar day cost adjustment plan if the previous 90 calendar day cost utilization plan is not able to align with the established budgetary limits; and
c. At the end of the 90 calendar days, if the cost adjustment plan fails to align the care within the established budgetary limit, individual CAP/DA beneficiary's service utilization limits shall be closely monitored until the waiver is within the cost neutrality limits.

7.3 Health, Safety, and Well-being

The primary consideration underlying the provision of CAP/DA services and assistance for a CAP/DA beneficiary is their desire to reside in a community setting. Enrollment and continuous participation in CAP/DA services may be denied based upon the determination that the CAP/DA 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 the beneficiary's medical, mental, psychosocial, physical condition, and functional capabilities may indicate inability to participate in the CAP/DA Waiver when any of the following conditions cannot be mitigated for the CAP/DA beneficiary:

a. CAP/DA beneficiary cannot cognitively and physically devise and execute a plan for safety if left alone, with or without a Personal Emergency Response System;
b. The beneficiary has been deemed to need 24-hours hands-on support or supervision due to debilitating medical and functional needs, but lacks the emotional, physical, and protective support of a willing and capable caregiver to provide adequate care and to ensure the health, safety, and well-being of the beneficiary;
c. The beneficiary's needs cannot be met and maintained by the system of providers and services that are currently available to ensure health, safety, and well-being;
d. The beneficiary's primary private residence is not reasonably considered safe to ensure health, safety, and well-being due to any one of the following:
    1. a heating and cooling system that exacerbates the 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 the medical condition which results in multiple hospital admissions and emergency room visits;
    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 individual, paid providers, case manager staff 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, the primary residence;
    2. threatening or physically or verbally abusive behavior by the beneficiary, the beneficiary's family member(s) or other persons who live in the home exhibited on more than two (2) occasions. If the abusive behavior meets the definition of a level 2 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. CAP/DA beneficiary's safety of self and others is impeded by the beneficiary's, legally responsible person's, caregivers' or other persons who are in the home:
    1. intrusive and oppositional 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 an 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 the terms of the service plan;
   2. refusal to follow the service plan and, when applicable, an agreed upon risk agreement;
   3. refusal to sign a plan and, or other required documents;
   4. refusal to keep the case management entity informed of changes in the status of the beneficiary; or
   5. refusal to remove or lessen the risk or hazard that create an unsafe environment; or

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 an Adult Protective Services (APS) assessment or care plan, or the parent or responsible party refuse to comply with Adult Protective Services when there is a high-risk factor of existing conditions of abuse, neglect, or exploitation.

   If a CAP/DA beneficiary experiences any one of the above listed health, safety and well-being items listed above, the service plan and the addition of a short-term risk agreement may be able to mitigate the assessed health, safety and well-being concerns, refer to **Subsection 7.6**.

   For new applicants with any of the listed conditions addressed above, a 90-day calendar service plan 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 as evidenced by continuous monitoring and support, the 90-day service plan shall end, and a recommendation of disenrollment shall be issued. A fair hearing process shall be initiated.

7.4 Emergency and Disaster Planning

Mandatory Requirement for program participation:

The Case Management Entity (CME) designee shall ensure that a comprehensive emergency and disaster plan is created initially and reviewed at least quarterly. A copy of the emergency and disaster plan must be provided to the beneficiary or primary caregiver 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 adult health service providers. The plan must document family, friends, neighbors, community volunteers, IHA agencies, and licensed home care agencies, when possible, in the event of an emergency or an unplanned occurrence. An emergency (backup plan) 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 in due to a disaster. The emergency plan is used for times when the formal (In-home aide, coordinated caregiving, or personal assistant) arranged support system is unavailable during regularly scheduled work hours and when the unpaid informal support system is unavailable.

7.5 Critical Incident Reporting

To safeguard the health and welfare of each approved CAP/DA beneficiary, the State Medicaid Agency, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation (ANE) and other critical incidents.

a. Level of reporting is managed by two incident levels, Level I and Level II. Level of the incident is determined by severity.
b. The following incidents types must be reported to the state:
    1. Level I: accident or injury resulting in the need for medical care beyond first aid, planned hospitalizations, ER visits not resulting in hospitalization, inpatient psychiatric hospitalization, death by natural causes, failure to take medication as ordered by the physician
    2. Level II: APS referrals (abuse, neglect, exploitation), injuries of unknown source, death other than expected or by unnatural causes, restraints and seclusions, documented of misappropriation of consumer-directed funds or other forms of exploitation, all falls including those that require hospitalization or resulting in death, unplanned hospitalizations, traumatic injury, treatment or medication administration errors that result in injury or hospitalization, missing person, homicide, suicide, three (3) consecutive missed IHA visits, and media-related events.
c. Incident reporting and management expectations;
d. The case management entity shall provide training and education initially, quarterly, annually, and as needed to inform CAP/DA beneficiary, responsible parties and service providers on:
    1. Types of critical incidents;
    2. How to make a report; and
    3. The timeframe in which to make a report.

a. Case managers are responsible for reporting all critical incidents within 72 hours of becoming aware of the incident.
    1. Level I incidents must be reported within 72 hours in the CAP Business System.
    2. Level II incidents must be reported to the State Medicaid Agency by email or phone within 72 hours, with an accompanying report in the CAP Business System.
b. Incident reports are to be submitted in the CAP Business System. Each case management entity is provided with access to the critical incident report (CIR) developed by the State Medicaid Agency through the CAP Business System.
c. When an incident is identified by, or reported to a case management entity, a root cause analysis must be conducted to identify potential remediation efforts and mitigate risks to the CAP/DA beneficiary's health and welfare and prevent future incidents.
d. All level II incidents require investigation by the case management entity. The investigation must contain the following steps:
    1. Contact the reporter, if applicable, to discuss the incident;
    2. Contact with involved service providers listed on the POC to discuss CAP/DA beneficiary care needs and any concerns related to the incident report;
    3. Home visit with the CAP/DA beneficiary to conduct a risk assessment of needs;
    4. Review of past incident reports, hospitalizations, ER visits and other data elements to identify trends;
    5. Contact with pertinent individuals or agencies to identify concerns; and
    6. Follow-up to assure the CAP/DA beneficiary is receiving necessary services as identified through the recommendations of the incident report.

The CAP/DA program complies with the definition of restraint as stated in the June 22, 2007, memo to State Survey Agency Directors, Ref S&C-07-22; and re: Clarification of Terms Used in the Definition of Physical Restraints as applied to the Requirements for

Long Term Care Facilities. CAP/DA does not permit the use of restraints or seclusion, including:

a. personal restraints;
b. drugs used as restraints;
c. mechanical restraints; or
d. seclusion.

Refer to: http://www.cms.gov/surveycertificationgeninfo/downloads/SCletter07-22.pdf

CAP/DA provider or beneficiary's caregiver shall not use interventions that:

a. restrict the beneficiary's movement;
b. restrict the beneficiary's access to other individuals, locations, or activities;
c. restrict beneficiary's rights; or
d. employ aversive methods to modify behavior, (unless provided for a beneficiary for whom it is not used as a restraint, but for safety such as bed rails, Gerri chair, lift chair, and safety straps on wheelchairs.

7.6 Individual Risk Agreement

An Individual Risk Agreement (IRA) is used in combination with a person-centered service plan and 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 individuals to accept responsibility for their choices personally, through surrogate decision makers, or through planning team consensus.

If a CAP/DA applicant's assessment identified concerns with the services offered in the waiver or State Plan to maintain the health, safety and well-being due to home environmental concerns, lack of staffing, or the health, safety and well-being requirements listed in **Subsection 7.3** 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 is 90 calendar days. After the 90th day, a reevaluation of the condition must be conducted, at which time another IRA can be implemented, if needed.

When a CAP/DA beneficiary or primary caregiver makes a decision that could lead to an adverse consequence, or the likelihood of harm to self or others, the Case Management Entity (CME) designate personnel shall engage the CAP beneficiary or primary caregiver 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 beneficiary or primary caregiver on strategies to mitigate the issues concerning using a revised service plan, and when applicable, an individual risk agreement.

Note: For an active CAP/DA 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.

7.7 Absence from CAP Participation

7.7.1 Hospital Stays of 30 Calendar days or Less

When a CAP/DA beneficiary is temporarily absent from CAP/DA participation as well as a break in services, the case manager or care advisor shall take the following course of action:

If a hospital admission of 30 calendar days or less is anticipated, the case manager does the following:

a. Determines the reason for the admission, the prognosis, and anticipated length of the absence from the primary private residence;
b. Suspends all CAP/DA services except for case management, financial management and PERS;
c. Notifies the discharge planner that the beneficiary is a CAP/DA 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/DA providers when to resume care;
i. Informs the DSS Medicaid staff that the beneficiary continues on CAP/DA; and
j. Revises the POC, if needed, and sends notices of change to service providers.

7.7.2 Hospital Stays Longer than 30 Calendar days

Hospital stays of more than 30 calendar days affect Medicaid eligibility and CAP/DA participation. If the beneficiary is hospitalized for more than 30 calendar days, the CAP/DA Case Management Entity (CME) shall contact the local DSS staff to learn when the beneficiary's Medicaid status changes to long-term-care budgeting. The CME shall coordinate with the Medicaid worker the effective date of disenrollment from the CAP/DA waiver based on the date of the change in Medicaid eligibility for the beneficiary. The CME initiates the disenrollment at the instruction of the Department of Social Services (DSS).

7.7.3 Nursing Facility Admissions

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

7.7.4 Temporary Out of Primary Private Residence

If a beneficiary temporarily (for 30 calendar days or less) leaves their primary private residence, the case manager or care advisor shall suspend the delivery of CAP/DA services by contacting the provider agencies. No CAP/DA services can be provided during this absence. The local DSS Medicaid eligibility staff is notified when an extended absence occurs. The CAP/DA slot remains available to the beneficiary. The case manager or care advisor shall track the absence, since an extended absence can affect Medicaid eligibility and continued CAP/DA participation. Unless prior approved by the case manager or care advisor, CAP/DA participation is terminated after 90 calendar days of absence from the primary private residence.

7.8 Voluntary Withdrawals

A CAP/DA beneficiary can decide to withdraw from CAP/DA participation at any time. The CAP/DA beneficiary shall submit a written notice containing the date of withdrawal from CAP/DA and the beneficiary's or their responsible party's signature to the Case Management Entity (CME). The CME coordinates the CAP/DA disenrollment activity. The planning process for disenrolling the CAP/DA beneficiary must coincide with the date the beneficiary makes the request.

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

7.9 Disenrollment

The Case Management Entity (CME) shall disenroll the beneficiary when CAP/DA is no longer appropriate, according to CAP/DA policies and procedures implemented by NC Medicaid as listed in **Subsections 4.2.1** and **4.2.2.** When a CAP/DA 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;
b. The beneficiary's physician does not recommend nursing facility level of care (LOC);
c. The service request form (SRF) is not approved for nursing facility LOC;
d. DSS removes the CAP/DA evidence;
e. The CAP/DA CME has been unable to establish contact with the beneficiary or the primary caregiver(s) for more than 60 calendar days despite two written and verbal attempts;
f. The beneficiary fails to use CAP/DA services as listed in the service plan during a 90 consecutive-day time of CAP/DA participation;
g. The beneficiary's health, safety, and well-being cannot be mitigated through a service plan or an individual risk agreement, when applicable;
h. The beneficiary or primary caregiver does not agree to or sign the service plan within 60 calendar days of its development;
i. The beneficiary or primary caregiver(s) repeatedly fails to comply with all program requirements, such as failure to arrive home at the end of the approved hours of service, or overtly disregard the approved coverage schedule without contacting the case manager or home care agency for change approvals; or

j. The beneficiary or primary caregiver demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP/DA Waiver as outlined in the "Beneficiary Rights and Responsibilities," form signed by the CAP/DA beneficiary or primary caregiver.

Note: Disenrollment from CAP/DA, 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 or primary caregiver engages in abusive, exploitative or neglectful behavior and refuses intervention to safeguard health and welfare or mitigate risk.

7.10 General Documentation Requirements

The minimum service documentation requirements of the CAP/DA Waiver 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/DA 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 confirmation that 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.
d. 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 Adult Day Health, bill the days that the CAP/DA beneficiary received Adult Day Health services at the Adult Day Health Care Facility. If the CAP/DA beneficiary attended only part of the day and the center has a partial day rate, bill that rate. Documentation must comply with NC General Statures 1321-D-6.

For Specialized medical supplies, 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 **Appendix B.**

For Equipment, Modification and Technology, bill cost for the item, including applicable installation and delivery charges, taxes, and permit fees. The cost is what is invoiced by the supplier or installer.

For Meals Preparation and Delivery, bill the customary charge for the preparation and delivery of the meal for each day a meal is supplied. Documentation must comply with 10A NCAC Chapter 06 Subchapter K.

For Institutional Respite Care, bill the Medicaid Nursing Facility rate for the CAP/DA beneficiary's catchment area for the calendar-day(s) of respite provided to the CAP/DA beneficiary. Documentation must comply with **Appendix B.**

For Personal Emergency Response Services, bill the customary monthly service charge for each month the CAP/DA beneficiary receives the service. Documentation must comply with **Appendix B.**

For In-Home Aide and Personal Assistance, bill the customary charge for the units provided to the CAP/DA beneficiary for each date of service**.** Billing must comply with the requirements in **Attachment A and Appendix B.**

Respite for CAP In-Home Aide, bill the customary charge for the units provided to the CAP/DA beneficiary for each date of service**.** Documentation must comply with **Appendix B.**

For Financial Management, bill Medicaid rate for units provided to the CAP/DA beneficiary for each month financial management services are provided. Documentation must comply with **Appendix B**.

For Community Transition, community integration, good and services and training, education and consultative services, bill the cost for the item, consisting of applicable delivery charges, and taxes. The cost is what is invoiced by the supplier. Documentation must comply with **Appendix B.**

For Coordinated Caregiving, bill the customary charge for the daily rate provided to the CAP/DA beneficiary for each day of service**.** Billing must comply with the requirements in **Attachment A and Appendix B**

Service Note Documentation

The documentation for CAP waiver 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 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/DA 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 calendar days of the actual service date when other supporting documentation is available to confirm the service intervention.

Signatures

All entries in the CAP Business electronic record 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 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.

7.11 Frequency of Monitoring of Beneficiary and Services

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

a. a monthly contact by telephone or in person with the CAP/DA beneficiary and the service provider to monitor and assess CAP/DA services;
b. a monthly or quarterly (based on 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;
    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/DA beneficiary or responsible party, to monitor health and well-being and assess CAP/DA services;
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 should complete monthly contact via telephone or other secured means of contact with the CAP/DA beneficiary. Case Managers shall make sufficient (more than quarterly) face to face contact contingent to the risk factors and other factors that may jeopardize their health safety and well-being of the CAP/DA beneficiary. Face-to-face contact can be completed by the listed engagement when approved by the CAP/DA beneficiary, protections are in place to secure privacy of the beneficiary and ensuring the use of the CAP/DA beneficiary electronic devices:
a. Facetime;
b. Skype;
c. Microsoft Team;
d. Zoom;
e. Video chat; or

f. Remote Patient Monitoring system.

These types of monitoring tools must be secured and permission to use such devices granted by the CAP/DA beneficiary. If these methods are used, the beneficiary must show the aide is present, and a virtual walk through, when applicable, shall be completed either by the beneficiary, aide, caregiver directing the device/camera throughout the home environment. The type of monitoring may only occur twice in the quarterly monitoring regimen which begins after the completion of the initial or annual assessment. For example, the first quarterly visit after the execution of the service plan that incorporates the risk mitigation plan must be a face-to-face visit. The second and third quarterly visits may be conducted through technology when there is no evidence of a critical incident between the two monitoring periods. The fourth quarterly visit must be performed by an in-person visit.

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 CAP/DA 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 CAP/DA beneficiary, an ad-hoc multidisciplinary team meeting must be scheduled within 15 days of awareness to discuss the concerns and to create a plan to mitigate risk and monitor care needs.

Additional monitoring requirements includes completion of critical incident reports, completion of monthly and quarterly monitoring templates, upload of information in a communication log and technical assistance support from NC Medicaid. Each case manager is required to complete a critical incident report for both Level I and II incidents within the specified timeframe. Completed reports are automatically transmitted to the state CAP/DA unit for monitoring health, safety and well-being. The monthly and quarterly monitoring tools are programmed with risk indicator algorithms that provide a summary of risk factors based on the responses to the questions being asked. The summary report is transmitted to NC Medicaid for monitoring as well as to the case manager (CM). The summary report also provides the next steps for the CM to perform to ensure a plan is executed to mitigate the identified risk factors.

7.12 Service Record

A service record must be maintained on each CAP/DA beneficiary by the case management entity and approved CAP/DA provider(s). A service record is a collection of either electronic or printed materials that provide a documentary history of the CAP/DA beneficiary's home and community-based services (HCBS) participation and service interventions. The documentation in the service record must comply with all applicable federal and state laws, rules, and regulations.

The Case Management Entity (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 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 contractor for the timeframe listed in the audit.

7.13 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 licensure or certification rules governing the CAP/DA waiver service. Whenever corrections are necessary in the beneficiary's record, the Case Management Entity (CME) shall seek technical assistance from the CAP Business System Contractor to make the changes to the electronic record and CAP/DA providers shall follow their internal policies and procedures.

7.14 General Records Administration and Availability of Records

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

a. Service authorization submitted by the Case Management Entity (CME); and
b. Service documentation 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 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.

7.15 Quality Assurance

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

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

Appointed case management entities are designated to assure the quality and performance of the waiver program**.** Each Case Management Entity (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 a new beneficiary. A performance score of less than

90 percent for three consecutive months can result in disenrollment as an appointed CME.

The Comprehensive Independent Assessment Entity (CIAE) shall validate randomly selected annual and change in status assessments and service plans, all types, completed by the CME on a quarterly basis, to ensure compliance with business rules and the CAP/DA beneficiary's assessed needs were adequately planned.

7.15.1 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 deem necessary.

State Assurances:

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

The following are quality assessment and quality improvement activities of the CAP/DA Waiver:

a. Review of initial applications and continued need reviews for appropriateness, accuracy and outcomes;
b. Review of effectiveness of and compliance to authorized CAP/DA services on a quarterly basis;
c. Annual Beneficiary experience survey sent by NC Medicaid to a representative sample of CAP/DA beneficiaries;
d. Critical incident reporting; complaints and grievances management; and
e. Site or desk-top audits of case management entities and CAP/DA 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 exposure to abuse, neglect and exploitation;
d. Implement strategies to avoid unplanned hospitalizations;
e. Reduce 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 of 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.

7.15.2 Mandated Waiver Assurances

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

a. Level of Care

1. CAP/DA 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/DA beneficiary is reevaluated at least annually or as specified in the approved waiver; and
3. The processes and instruments described in the approved waiver are applied to LOC determination.

b. Service Plan

1. Service plans address all CAP/DA beneficiary's assessed needs, as found in **Subsection 5.4.2** and person-centered goals, either by the provision of CAP services or through other means;
2. The state monitors service plan development according to its policies and procedures;
3. Service plans are updated or revised in the same month as the CAP/DA effective date or when warranted by changes in health status of CAP/DA beneficiaries;
4. Services are delivered according to the service plan, which lists the type, scope, amount, duration and frequency of the services; and
5. A CAP/DA beneficiary is afforded choice between CAP/DA services and institutional care and between and among CAP/DA 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 furnishing CAP/DA services;
2. The state monitors non-licensed and noncertified providers to assure adherence to CAP/DA requirements; and

3. The state implements its policies and procedures for verifying that training is provided according to state requirements and the approved waiver application.

d. Administrative Authority

1. NC Medicaid retains administrative authority and responsibility for the operation of the CAP/DA Waiver by exercising oversight of the performance of CAP Waiver functions performed by other state, local and regional non-state agencies and contracted entities.

e. Financial Accountability

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

f. Health and Welfare

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

CIAE, CME, coordinated caregiver and financial management providers 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

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 CME shall review with the beneficiary information about disclosure of potential conflict of interest.
b. The HCBS providers shall review with the CAP/DA 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's file, on a quarterly basis, to assess concerns of conflict and that 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 CMEs meet the dual role requirement. Assigning a CME as a dual role entity shall 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 CMEs 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/DA beneficiary when they are biologically related.

7.15.3 Home and Community Characteristics

a. CAP/DA service providers shall adhere to the home and community characteristics in all service settings by assuring:
    1. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community;
    2. Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources;
    3. Individuals receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
    4. 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);
    5. Each individual's rights of privacy, dignity, respect and freedom from coercion and restraint are protected;

6. Settings optimize, but do not regimen, individual initiative, autonomy and independence in making life choices; and
7. The direct provider facilitates individual choice regarding services and supports, as well as who delivers them.

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

Residential Settings:

1. 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;
2. Provide privacy in sleeping or living unit;
3. Provide freedom and support to control individual schedules and activities, and to have access to food at any time;
4. Allow visitors of choosing at any time; and
5. 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; https://www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule.

c. Monitoring for Home and Community Character:

Adult Day Health Facilities shall follow the Home and Community Based Services Final Rule as outlined in North Carolina's DHHS State Transition Plan.

7.16 Program Integrity (PI)

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

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

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

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

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

7.17 Use of Telephony and Other Automated Systems

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

7.18 Electronic Visit Verification Technology Options and 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 the provider selects an 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.

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.

7.19 Beneficiaries with Deductibles

A CAP/DA beneficiary who has a deductible can participate in the CAP/DA waiver; however, the beneficiary as well as the service provider or personal assistant must understand and agree to the conditions of incurring and paying a monthly deductible. The deductible is met monthly, and the CAP/DA beneficiary may use the cost of CAP/DA services approved on the POC when they are provided during the deductible period.

The CAP/DA beneficiary shall understand that when participating in the consumer-directed or live-in caregiver options, they are solely responsible for paying their deductible for the service provider and personal care assistant to get reimbursed for services rendered while the beneficiary is in the deductible status. The service provider and personal assistant shall understand and accept that if the CAP/DA beneficiary does not pay for the incurred services rendered, the service provider or personal care assistant is not paid for service rendered during the deductible status. The service provider and personal assistant bills the beneficiary, and it is the responsibility of the CAP/DA beneficiary to pay the service provider or personal assistant directly. Medicaid does not pay for services while in the deductible status.

7.20 Marketing Prohibition

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

Case management entities shall comply with the waiver mandate of conflict-of-interest requirements as found in 42 CFR 441.301(1)(vi), Home and Community-Based Services: Waiver Requirements and HCBS Final Rule.

8.0 Policy Implementation/Revision Information

Original Effective Date: October 1, 1982

Revision Information:

Date	Section Revised	Change
03/01/2012	All sections and attachment(s)	Initial promulgation of current program coverage.
03/01/2012	All sections and attachment(s)	Technical changes to merge Medicaid current coverage into one policy.
03/01/2012	All sections and attachment(s)	Waiver renewal
10/01/2013	All sections and attachment(s)	Policy name changed from, "Community Alternatives Program for Disabled Adults and Choice Option (CAP/DA-Choice)" to "Community Alternatives Program for Disabled Adults (CAP/DA)."
10/01/2013	All sections and attachment(s)	Policy revision for waiver renewal.
10/01/2013	All sections and attachment(s)	Updated policy template language
10/01/2013	Section 1.0	The Clinical Coverage Policy name was changed to Community Alternatives Program for Disabled Adults (CAP/DA). The target population was defined to be adults with disabilities 18 years of age and older. The description of the procedure, product or service were revised and expanded. Two service options under the waiver were identified, CAP/DA and CAP/Choice. The CAP/DA specific benefit services were renamed to include: a. Home modification and mobility Aid to Home accessibility and adaptation; b. Waiver supplies to Specialized medical equipment and supplies; c. Transition services to Community transition services; and d. Training and education to Training, education and consultative services. A note was added to give the website where information about Nursing Facilities, Home Health Services, Hospice Services, Home Infusion Therapy, and Durable Medical Equipment and supplies, could be found.
10/01/2013	Subsections 1.1.1-1.1.30	Expanded some existing definitions and added new definitions.
10/01/2013	Subsection 1.1.2	The definition of beneficiary added.
10/01/2013	Subsection 1.1.5	Header changed to CAP/Choice (Consumer-Directed Care). The definition in this section was changed to reflect a more comprehensive description of CAP/Choice.

Date	Section Revised	Change
10/01/2013	Subsection 1.1.6	Header changed to Comprehensive Interdisciplinary Needs Assessment. This definition is new to the policy.
10/01/2013	Subsection 1.1.7	Header was changed to Disenrollment.
10/01/2013	Subsection 1.1.8	Header changed to Division of Medical Assistance (DMA). This changed to provide a more comprehensive description.
10/01/2013	Subsection 1.1.9	Header was changed to e-CAP Web-based Tool. This definition is new to the policy. E-CAP will replace the functionality of AQUIP.
10/01/2013	Subsection 1.1.10	Header changed to Emergency Back-up plan. This definition is new to the policy. The definition of participant was deleted from the policy.
10/01/2013	Subsection 1.1.11	Header was changed to Financial Management Services. This definition is new to the policy.
10/01/2013	Subsection 1.1.12	Header was changed to Free Choice of Provider. This definition of Free Choice of Providers is new to the policy.
10/01/2013	Subsection 1.1.13	Header was changed to Freedom of Choice. This definition of Freedom of Choice is new to the policy. The definition of Recipient was deleted from this section.
10/01/2013	Subsection 1.1.14	Header was changed to Health and Welfare. This definition of Health and Welfare is new to the policy.
10/01/2013	Subsection 1.1.16	Header was changed to Individual Risk Assessment. This definition of Individual Risk Agreement is new to the policy.
10/01/2013	Subsection 1.1.17	Institutional Respite Care added. This definition is new to the policy.
10/01/2013	Subsection 1.1.18	Instrumental Activities of Daily Living (IADLs) was added.
10/01/2013	Subsection 1.1.19	Level of Care for the CAP/DA Program was added.
10/01/2013	Subsection 1.1.20	Meal Preparation and Delivery added. This definition of Meal Preparation and Delivery is new to the policy.
10/01/2013	Subsection 1.1.21	The definition of NC Tracks added.
10/01/2013	Subsection 1.1.22	Non-Institutional Respite Services added. This definition is new to the policy.
10/01/2013	Subsection 1.1.25	The definition of Permanent Private Place of Residence (Home) added. The title of this section was changed from Primary Residence (Home).
10/01/2013	Subsection 1.1.26	Personal Care Aide was added.
10/01/2013	Subsection 1.1.27	The definition of Personal Care Assistant added.
10/01/2013	Subsection 1.1.28	The definition of Responsible Party added. This definition of Responsible Party is new to the policy.
10/01/2013	Subsection 1.1.29	Risk of Institutionalization was added. This definition was amended to provide a more comprehensive description.
10/01/2013	Subsection 1.1.30	The definition of Service Request Form added. This definition of Service Request Form is new to the policy.
10/01/2013	Section 2.0	The title of this section was changed from Eligible Recipients to Eligibility Requirements.
10/01/2013	Subsections 2.1 2.1.1, 2.1.2.	Was divided into subsections: General, and Specific.
10/01/2013	Subsection 2.1.2	New section; EPDST lists specific Medicaid criteria for the CAP/DA Program. It replaces Subsection 2.4 in the previous policy.

Date	Section Revised	Change
		A Note was added to this section to emphasize that it is not appropriate to consider a person for CAP/DA simply to qualify him or her for Medicaid.
10/01/2013	Subsection 3.2.1	The criteria that a beneficiary be 18 years of age or older and eligible for Medicaid in one of the specified benefit categories, has been removed from this section and referenced in Subsection 2.1.2. Another criterion for the beneficiary to meet was added to this section before Medicaid will pay for CAP/Choice waiver services. The completion of a self-assessment questionnaire was added to this section and removed from a note in Subsection 3.2 in the previous policy. The Level of Care (LOC) Determination Criteria is a new section in this policy. It tells the minimum requirement of LOC necessary to qualify for participation in the CAP/DA program. This section also explains how often an evaluation of LOC should occur. The Level of Care Criteria for CAP/DA describes the Home and community-based care nursing facility LOC criteria for CAP/DA which is comparable to 2B-1, Nursing Facility Clinical coverage policy. A listing of exceptions of the HCBS LOC to 2B-1 clinical coverage policy is identified. Added a Note: When a waiver beneficiary is participating in the consumer-directed option (CAP/Choice), supervision of a registered nurse or licensed practical nurse; and other personnel working under the direct supervision of a registered nurse or licensed practical nurse is not a requirement. Consumer-directed care allows choice of service providers. The area listing the conditions that must be present in combination to justify nursing facility level of care has been moved. This information was in Subsection 5.4.1.2 of the previous policy. Diabetes was also added to the list of conditions. The Expedited Criteria (Prioritization) area in this section is new. This section lists situations in which an individual would be placed at the top of CAP/DA waitlist.
10/01/2013	Subsection 3.2.2	Expands description of Case Management services, which was originally located in Subsection 5.19. A definition for waiver case management services has been placed in this section.

Date	Section Revised	Change
		The section introduces and describes four principles of Case Management: Assessing, Care Planning, Referral/Linkage and Monitoring and follow-up, have been updated, and formatted differently. Each Section now contains an area listing the core skills and competencies of that case management component. These sections were previously located in Subsections 5.19.1, 5.19.2, 5.19.3, and 5.19.4 of the prior policy.
10/01/2013	Subsection 3.2.3	New section; Medicaid Additional Criteria describes additional CAP/DA waiver services that may be covered by Medicaid. The Adult Day Health Services area in this section was located in Subsection 5.7 of the previous policy. The website where additional information can be found about the Adult Day Health Services has been updated. The Assistive Technology area in this section was located in Subsection 5.18 in the previous policy. The Community Transition area in this section was located in Subsection 5.16 of the previous policy The Home Accessibility and Adaptation (previously known as Home Modification and Mobility Aids) area was in Subsection 5.9 of the previous manual. The description of Institutional Respite Care has been clarified. This information was located in Subsection 5.11 in the previous policy. The description of Non-Institutional Respite Care has been updated. This information was located in Subsection 5.12 of the previous policy. The information about Participant Goods and Services in this section remains the same. It was located in Subsection 5.15 of the previous policy. The information about Personal Care Aides was located in Subsection 5.8 of the previous policy. The area discussing Specialized Medical Equipment and Supplies was titled Waiver Supplies in the previous policy; it was located in Subsection 5.14. The area in this section discussing Training, Education and Consultative Services was in Subsection 5.17 of the previous policy.
10/01/2013	Subsection 3.2.4	CAP/Choice (only), new section

Date	Section Revised	Change
		The information about the Care Advisor, Personal Assistant Services, and Financial Management Services was previously located in Subsections 5.20, 5.21, and 5.22 of the previous policy.
10/01/2013	Subsection 3.2.5	New section to the policy and describes the Medicaid State Plan Services. This Home Health Services information was previously located in Subsection 5.23.2 of the previous policy.
10/01/2013	Subsection 4.2.1	Added to the policy: a. Termination of Medicaid; b. The required annual LOC determination was not approved; c. A timeline to return back to the CAP/DA program of not to exceed 90-days for short-time rehabilitation; d. An assessment of medical and functional needs has not been completed by an RN or social worker to determine risk of institutionalization, defined in Subsection 1.1.29; e. The beneficiary does not require and use case management and one or more waiver services monthly (excludes incontinence products, personal emergency response system and meal preparation and delivery); f. The beneficiary resides in an unsafe home environment placing the eligible beneficiary's health, safety and well-being at risk, listed in Subsection 7.4; and g. More than two verbal and written attempts added to establishing contact with the beneficiary.
10/01/2013	Subsection 4.2.2	Medicaid additional Criteria Not Covered; a listing **of** items is identified.
10/01/2013	Subsection 5.1	Updated to: Medicaid shall require prior approval for: a. HCBS nursing facility LOC for CAP/DA participation; and b. All waiver service limits.
10/01/2013	Subsection 5.2.2	Specific added as a header.
10/01/2013	Subsection 5.3	Header changed to CAP/DA Comprehensive Interdisciplinary Needs Assessment**.**
10/01/2013	Subsection 5.3.1	Header added: Initial Interdisciplinary Comprehensive Assessment**.** **Added:** Note: Upon the completion and approval of the Service Request Form, a referral for long-term care Medicaid for waiver participation must be made by the lead agency.
10/01/2013	Subsection 5.3.2	Header added: CAP/DA Plan of Care (POC)**.**
10/01/2013	Subsection 5.3.3	Header added: Continued Need Review (CNR).
10/01/2013	Subsection 5.3.4	Header added: Continued Need Review Plan of Care (CNR POC).
10/01/2013	Subsection 5.3.5	Header added: Changes and Revision to the Plan of Care.
10/01/2013	Subsection 5.4	Header changed to CAP Effective date.
10/01/2013	Subsection 5.5	Header changed to Authorization of services.
10/01/2013	Subsection 5.6	Header changed to Transfer of Eligible Beneficiaries.
10/01/2013	Subsection 5.7	Header changed to CAP/DA Waiver Benefit Specific Service Limitations.
10/01/2013	Subsections 5.7.1-5.7.12	Specific CAP/DA Waiver Benefits limitation added.

Date	Section Revised	Change
		Statement added to 5.7.10- The FI service is an administrative activity for initial consumer-direction financial management start-up and monthly ongoing financial management. This service can be included in the cost summary of the POC. Specific guidance will be provided on an annual basis.
10/01/2013	Subsection 5.7.12	Program Administration Authority Responsibility is new.
10/01/2013	Section 6.0	Header changed to Provider Qualifications and Occupational Licensing Entity Regulations.
10/01/2013	Subsections 6.1.1-6.1.16	The CAP/DA waiver specific services updated.
10/01/2013	Subsection 6.3	Lead agency Responsibility
10/01/2013	Subsection 6.4	Staff Qualification added.
10/01/2013	Subsection 6.5	Training Requirements added.
10/01/2013	Subsection 7.1	Compliance updated and expanded to include record retention.
10/01/2013	Subsection 7.3	Header changed to Budget and Use of Funds.
10/01/2013	Subsection 7.4	Header changed to Health, Safety and Well-being.
10/01/2013	Subsection 7.5	Individual Risk Agreement added; new to the policy.
10/01/2013	Subsection 7.6	Header changed to Absence from CAP/DA Participation; new to policy.
10/01/2013	Subsections 7.6.1-7.6.4	Added to policy
10/01/2013	Subsection 7.7	Header changed to Voluntary Withdrawals. The section is new to the policy.
10/01/2013	Subsection 7.8	Header changed to Disenrollment
10/01/2013	Subsection 7.9	Header changed to Documentation Requirements; new to the policy.
10/01/2013	Subsection 7.10	Quality Assurance added.
10/01/2013	Subsection 7.10.1	Quality Assurance Objectives added.
10/01/2013	Subsection 7.10.2	Quality Assurance Components added.
10/01/2013	Subsection 7.11	Program Integrity
10/01/2013	Subsection 7.12	Use of Telephony and Other Automated Systems
10/01/2013	Attachment A	The billing methodology for HIT was added in letter C (codes).
10/01/2013	Attachment A - Letter E	Billing Units updated.
10/01/2013	Attachment A- Letter F	Place of Service updated.
10/01/2013	Attachment A- Letter G	Header changed to Co-payments or Deductibles; provides instructions on deductible for CAP/DA and ~~CAP/Choice~~ beneficiaries.
10/01/2013	Attachment A- Letter H	Reimbursement was updated.
10/01/2013	Appendix A	Added to the policy
10/01/2013	Appendix B	Added to the policy
10/01/2013	Appendix C	Added to the policy
02/22/2017	All Sections and Attachments	Amended policy posted on this date, with an **EFFECTIVE Date** of 10/1/2013.

Date	Section Revised	Change
01/01/2017	Section 1.0	Non-waiver services available to CAP beneficiaries were updated. The description of 1915(c) HCBS waiver and assurances of the waiver were updated. Definitions in this section were moved to Appendix F.
01/01/2017	Section 2.0	Updated the note in this section to read: It is not appropriate to consider a person for CAP who is not at-risk of institutionalization simply to qualify him or her for Medicaid.
01/01/2017	Section 3.0	This section was updated to clarify eligibility criteria of when CAP is covered. Some items in this area were moved to another section for clarity of waiver processes.
01/01/2017	Section 4.0	This section was updated to clarify when CAP services are not approvable.
01/01/2017	Section 5.0	This section was updated to describe CAP 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. This section was updated to clarify the role of the CAP lead agency's responsibilities.
01/01/2017	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 CAP services. This section was updated to include the care coordination responsibilities of the CAP lead agency.
01/01/2017	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 and corrections made to the service record was added to this section.
01/01/2017	Attachment A	This section updated to identify new processes for claim-related information.
01/01/2017	Appendix A	Form was replaced with newly revised Service Request Form
01/01/2017	Appendix B	Self-Assessment Questionnaire for Consumer-Direction was updated with newly revised questionnaire.
01/01/2017	Appendix C	Individual Risk Agreement was updated with newly revised form.
01/01/2017	Appendix D	Self-Assessment Questionnaire for Consumer-Direction was updated with newly revised questionnaire.
01/01/2017	Appendix E	Appendix added to identify the updated Beneficiary Rights and Responsibilities requirements to participate in CAP program.
01/01/2017	Appendix F	Appendix added to define CAP terms and to replace definitions in Section 1.
04/18/2017	All Sections and Attachments	Amended policy posted on this date, with an **EFFECTIVE Date** of 01/01/2017.
07/21/2017	Appendix G	Corrected page numbering. No change to Amended Date.
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.

Date	Section Revised	Change
03/01/2020	All Sections and Attachments	Lead agency was changed to Case Management Entity
03/01/2020	All Sections and Attachments	Changed in accordance with to according to
03/01/2020	All Sections and Attachments	Removed the word CAP when used before beneficiary. Added DA before the word CAP when describing participation activities and services for individuals participating in this policy program waiver.
03/01/2020	All Sections and Attachments	Used a singular tense for beneficiary instead of plural; beneficiaries were changed to beneficiary.
03/01/2020	All Sections and Attachments	The word including was replaced with consisting of when providing examples.
03/01/2020	1.0	Addition of new information to describe the two waiver service options; update to waiver service names, refer to High-Level Crosswalk Document for specific changes. Requirement was replaced with the term of eligibility criteria The options under the CAP/DA waiver was added to this section for clarity. New services were added to this section.
03/01/2020	2.1.1(a) #4 & 5	Addition of new information for the determination of LOC and reasonable indication for waiver participation, refer to High-Level Crosswalk Document for specific changes.
03/01/2020	2.1.1(b)	New information was added to this section to clearly explain the Medicaid eligibility requirements.
03/01/2020	2.1.2(d)	Addition of new information on the Medicaid eligibility categories, refer to High-Level Crosswalk Document for specific changes.
03/01/2020	2.2.4	New Section to provide clarity of EPSDT and CAP participation
03/01/2020	2.2.5	New section to provide clarity of LEA and CAP participation
03/01/2020	3.2.2(a): # 1 & 5 new 6 & 7 updated information	This section was updated to add new information on the determination criteria for waiver participation eligibility.
03/01/2020	3.2.2(b) 1 and 2 Note – new information	Update to existing information for participants choosing consumer-direction.
03/01/2020	3.2.2(c)	This section was updated to provide clarity waiver participation eligibility.
03/01/2020	3.2.3 – updated criteria for LOC	Addition of new information for the determination of LOC; instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information.
03/01/2020	3.2.4 3.2.4 (k) and (l) new information	Expedited criteria were changed to Priority Consideration and clarifying information was provided.
03/01/2020	3.3 New	Added new section named, Transfer of Eligible Beneficiaries.
03/01/2020	3.4	This section was updated to clarify annual average cost budget.
03/01/2020	3.5	This section was deleted and moved to section 6.0.

Date	Section Revised	Change
03/01/2020	3.4 New section This section spans through 3.4.1-3.4.14	All waiver service descriptions were updated in this section to reflect the amendments in the waiver application. Instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information. In this section a brief description was added for Adult Day Health, Meal Prep, Care advisor and Financial management. One new service description, coordinated caregiving was added.
03/01/2020	4.1	Add applicant and active
03/01/2020	4.2.2 a-k were added	Update to existing information to clearly describe when waiver participation and services are not covered, refer to High-Level Crosswalk Document for specific changes.
03/01/2020	4.2.3.	This information was deleted from this section and added to Appendix B, refer to Equipment, modification and technology, Community Transition and Integration services. 4.2.3(d) was removed from this section and added to section 5.9.9
03/01/2020	5.2.2(a) & (c)	Update to information to include CIAE requirements, refer to High-Level Crosswalk Document for specific changes.
03/01/2020	5.3.1	New information to existing policy requirements to include CIAE requirements, refer to High-Level Crosswalk Document for specific changes.
03/01/2020	5.3.2	Update to existing information to include all required documents. Instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information.
03/01/2020	5.4	New and updated information to existing information to include CIAE requirements and new assessment processes, refer to High-Level Crosswalk Document for specific changes.
03/01/2020	5.4.1	New information added to this section to include CIAE requirements, refer to High-Level Crosswalk Document for specific changes.
03/01/2020	5.4.2	Update to existing information to reflect roles and responsibilities of CME. Instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information.
03/01/2020	5.4.3	Update to this section to reflect new roles and responsibilities of the CME due to CIAE initiative. Letters a & b were deleted.
03/01/2020	5.4.4	Update to this section to reflect correct name for annual service plans and the new roles and responsibilities of the CME. Instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information.
03/01/2020	5.4.5	New information was added to this section to update the new requirements of the CME in performing revisions to service plans.
03/01/2020	5.5 (d)	Addition of new information to identify one additional waiver effective date.
03/01/2020	5.6.	New information added to update existing information on how to authorize services.

Date	Section Revised	Change
03/01/2020	5.7	New information added to existing information on the policy procedure for a service plan denial.
03/01/2020	5.8	Original information in Section 5.8 was deleted and moved to 3.3. New waiver benefit service limitation added to 5.8. This section now expands through 5.8.16
03/01/2020	5.9	All waiver service limitations in this section were updated to reflect amendments in the waiver application. Instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information.
03/01/2020	5.9.3	This section was moved to 6.3-6.3.3
03/01/2020	5.9.4	This section was moved to 6.3-6.3.3
03/01/2020	5.10	New information for identify workflow requirement for CIAE and updates to business rules for required documentation.
03/01/2020	6.0	Update to this section to include clarifying information on qualified providers.
03/01/2020	6.1.1	Case Management Entity qualifications moved to this section.
03/01/2020	6.2 New	New section to identify Independent Assessment Entity
03/01/2020	6.3– 6.3.3 New	New section to identify Case Management Entity
03/01/2020	6.4-6.4.18	All waiver service provider qualifications in this section were updated to reflect amendments in the waiver application. Instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information.
03/01/2020	6.5	New and updated information to existing contractual information for the CAP Business System.
03/01/2020	6.6	New and updated information to existing information of CME's roles and responsibilities as result of CIAE initiative. Instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information.
03/01/2020	6.7	This section was moved to 6.3
03/01/2020	6.8	New and updated training information. Instead of building off the existing information to add newly updated processes, the old information was completely stricken to add the new information.
03/01/2020	7.0	New (letters c, d and e) and updated information for waiver compliance as result of CIAE initiative.
03/01/2020	7.2	This section was moved to 6.6
03/01/2020	7.3	New and updated information to describe management of CAP/DA beneficiary's budget.
03/01/2020	7.4	New and updated information to waiver safeguards for health and well-being. Instead of building off the existing information to add newly updated processes, the old information was completely stricken. Numbers 6 and 8 include new information. Required emergency planning was added to this section.
03/01/2020	7.5 new	New section added call Emergency and Disaster Planning
03/01/2020	7.6	New information added to this section to include critical incident management. Sections 7.6-7.19 were shifted due to adding this new section.

Date	Section Revised	Change
03/01/2020	7.7	Updated information on how to manage beneficiary risk. Instead of building off the existing information to add newly updated processes, the old information was completely stricken.
03/01/2020	7.8	Section changed to Absence from CAP Participation
03/01/2020	7.9	Section changed to Voluntary Withdrawals
03/01/2020	7.10	Section changed to General Documentation Requirement
03/01/2020	7.11	Section changed to Frequency of Monitoring of Beneficiary and Services
03/01/2020	7.12	Section changed to Service Record
03/01/2020	7.13	Section changed to Correction in the service record
03/01/2020	7.14	Section changed to General Records Administration and Availability of Records
03/01/2020	7.15	Section deleted and incorporated in section 5.3.2 and Appendix B This section was renamed to Quality Assurance.
03/01/2020	7.16	Section changed to Program Integrity
03/01/2020	7.17	Section changes to Use of Telephony and other Automated systems
03/01/2020	7.18	Section changed to Beneficiaries with Deductibles
03/01/2020	7.19	Section changed to Marketing Prohibition
03/01/2020	Attachment A -C	New codes added for Coordinated Caregiver – G9003 and G9004
03/01/2020	Attachment A	Case management activities or task section was deleted
03/01/2020	Appendix B – Adult Day Health	Update to existing information and addition of new information for this waiver service.
03/01/2020	Appendix B - Respite	Update to existing information and addition of new information for this waiver service.
03/01/2020	Appendix B – In-Home Nurse Aide	Update to existing information and addition of new information for this waiver service.
03/01/2020	Appendix B – Personal Assistance Services	Update to existing information and addition of new information for this waiver service.
03/01/2020	Appendix B – Coordinated Caregiving	New waiver service
03/01/2020	Appendix B – Financial Management	Update to existing information and addition of new information for this waiver service.
03/01/2020	Appendix B – Equipment, modification and technology	Update to existing information and addition of new information for this waiver service.
03/01/2020	Appendix B – Participant Goods & Services	Update to existing information and addition of new information for this waiver service.
03/01/2020	Appendix B – Specialized Medical Supplies,	Update to existing information and addition of new information for this waiver service.

Date	Section Revised	Change
03/01/2020	Appendix B – Community Transition and Integration Services,	Update to existing information and addition of new information for this waiver service.
03/01/2020	Appendix F	New definitions added: Activities of Daily Living Employer Authority General Utility Independent Assessment Independent Assessment Entity Portable generator Reasonable indication of need Recreation in nature Respite care Short-term intensive Unplanned occurrence
03/01/2020	Attachment A	Updated policy template language to reflect, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
03/01/2020	Table of Contents	Updated policy template 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."
03/01/2020		Policy posted 3/20/2020 with an effective date of 3/1/2020
05/08/2020	Section 7.10	Corrected issue with section 7.10; no change to amended date
07/01/2021	3.4.6	New section to provide guidance for providers subject to the EVV mandate
07/01/2021	5.0 (c)	New section to provide guidance for providers subject to the EVV mandate
07/01/2021	5.8.10	Added requirements for providers of In-home aide agencies that are subject to the federal mandate for the Electronic Visit Verification under the 21st Century Cures Act.
07/01/2021	6.1	Added requirements on the federal mandate for the Electronic Visit Verification under the 21st Century Cures Act.
07/01/2021	7.10	Added requirements on the federal mandate for the Electronic Visit Verification under the 21st Century Cures Act.
07/01/2021	7.10	Added requirements on the federal mandate for the Electronic Visit Verification under the 21st 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 21st Century Cures Act.

Date	Section Revised	Change
07/01/2021	Attachment A	Added requirements on the federal mandate for the Electronic Visit Verification under the 21st Century Cures Act. Updated HCPC Code table
07/01/2021	Appendix B	Added Nurse Aide requirements on the federal mandate for the Electronic Visit Verification under the 21st 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 21st Century Cures Act.
07/01/2021	All sections	This policy was posted on July 1, 2021, but the EVV requirements have a retro approval date effective January 1, 2021.
11/15/2024	1.0	Correction made to the three service options types. Direct was deleted from provider in number 1.
11/15/2024	2.0	Medicaid- Direct was added as new information in number 1. Number 5 was updated to add a new description for freedom of choice. Number 6 added information about the waiver slots. Numbers 8 and 9 were added. Letter b was updated to provide clarity about the Medicaid category types to reimburse waiver services.
11/15/2024	3.2.2a	This section updated to provide clarity of covered services while enrolled in the CAP/DA waiver. Number 3 and 10 were deleted.
11/15/2024	3.2.3a	Number 7 was updated to read information that was accidentally deleted in previous policy revision.
11/15/2024	3.2.3c	New information was added (documented diagnosis, treatment).
11/15/2024	3.2.4	Letter I was updated to indicate the new slot allocation.
11/15/2024	3.4	This section was updated to provide clarity to the policy requirement.
11/15/2024	3.4.8	This section was updated to provide clarity of the covered services.
11/15/2024	3.4.13	This section was updated to provide clarity of the covered services.

Date	Section Revised	Change
11/15/2024	4.2.1	Updates were made to letters a, c, l, m, q, r, s. to ensure that the language is clear and concise. A new note regarding eligibility status in relation to deductible status was added.
11/15/2024	5.2.2	This section was updated to provide the process of using a physician's worksheet. A note was added to this section.
11/15/2024	5.3.1f	This section was updated to add Tribal Option.
11/15/2024	5.4.2	New information about the plan of care approval date was added to this section.
11/15/2024	5.5	New information about the LTC Medicaid application date as it related to the CAP Effective date was added to this section.
11/15/2024	5.8.8	New information was added to this section to provide clarity about utilization limits.
11/15/2024	5.8.12	This section was updated to remove rates and respite.
11/15/2024	6.1	Letters c and d were added to this section. To address staffing types for consumer-directed and coordinated caregiving services were added.
11/15/2024	6.3	This section was updated to provide a clear and concise definition of Case Management (CME) Qualifications.
11/15/2024	6.7	A note was added to this section related to the method and cadence of the case manager's contact with the beneficiary.
11/15/2024	7.11	Two additional electronic engagement platforms were added to this section.

Date	Section Revised	Change
11/15/2024	Appendix B	New information was added to provide clarity, expanded coverage and new requirements through edits made within the definitions or from a note. The definitions updated are listed below. Coordination of Care: Case management and Care Advisement to. Respite CAP/DA In-home Adie services Coordinated Caregiving Community Transition Community Integration Equipment, modification and technology Meal preparation and delivery Goods and services Training, education, and consultative services
11/15/2024		The Centers for Medicare and Medicaid Services (CMS) approved an amended waiver application for the CAP/DA HCBS waiver to incorporate new service options that were implemented during the public health emergency. All sections in the policy were updated to align with the newly approved waiver application effective 11/01/2022
11/15/2024	Appendix B Equipment, Modification, and Technology	The following services were added: Hypoallergenic filters Replacement of fixtures, mirrors and storage space when removed, dismantled or damaged during an approved modification.
11/15/2024	Appendix B Meal Preparation and Delivery	A service clarification was added.
11/15/2024	Appendix B Goods and Services	Additional services were added Waiver specific protective equipment: Hypoallergenic pillows, blinds and housing safety and quality inspections.
11/15/2024	Appendix B Training, Education and Consultative Services	Additional services were added Violence Intervention services Payment to a direct care worker, not hired through a provider agency.
11/15/2024	Appendix E	Updated language for clarity in understandings.
11/15/2024	Appendix F	Change of terms from “e-CAP Web based Business Toll” to “CAP Business System”
11/15/2024	Appendix F	An update was made to language under In-Home Aid

Date	Section Revised	Change
11/15/2024	Appendix F	An update was made to list identifiers under Significant Change in Acuity.
11/15/2024	Appendix I	CAP/DA resource page added.
09/01/2025	All sections and attachments	The Centers for Medicare and Medicaid Services (CMS) approved the CAP/DA renewal waiver, effective 11/1/2024. The following sections were revised to align with the newly approved waiver renewal, effective 11/1/2024.
09/01/2025	All sections and attachments	Typographic errors corrected throughout the policy.
09/01/2025	All sections and attachments	Added "CAP-In home Aide II "language throughout policy to align with new service level effective 11/1/2024
09/01/2025	Section 3.3b	Added "birth" to "month".
09/01/2025	Section 3.4.7	Medication dispensing boxes are no longer a standalone service under specialized medical supplies. Medication dispensing boxes can be purchased using funding from goods and services, effective 11/01/2024.
09/01/2025	Section 3.4.8	Added new CAP-In home Aide II new service level, effective 11/1/2024
09/01/2025	Section 3.4.10	Removed medication dispensing box from this section, effective 11/01/2024.
09/01/2025	Section 5.2.2	The following duplicate note was removed: "DHHS's designated contractor shall submit an electronic prior approval (PA) transfer to NCTracks of approval or denial of CAP/DA participation, when the SRF, multidisciplinary comprehensive assessment, and signed person-centered service plan are finalized."
09/01/2025	Section 5.8.10	Clear and concise language added to identify the maximum number of hours a legally responsible person can serve as a paid caregiver.
09/01/2025	Section 5.8.11	Added new service level, CAP-In home Aide II, to the waiver benefit specific service limitations, effective 11/01/2014.
09/01/2025	Section 6.3 & Appendix B	Replaced "CAP/C" with CAP/DA."
09/01/2025	6.5.12e	Removed "Felony health care fraud" and "More than one felony conviction" and replaced with "More than one felony conviction related to health care fraud."
09/01/2025	Section 6.5.14	Removed "medically fragile children" and replaced with "to adults with chronic and serve medical conditions who are at risk of institutionalization."
09/01/2025	Section 6.5.7	Incorporated CAP In-home Aide II to existing CAP In-home Aide language within this section.
09/01/2025	Section 6.5.8	Medication dispensing boxes are no longer a standalone service under specialized medical supplies. Medication dispensing boxes can be purchased using funding from goods and services, effective 11/01/2024.
09/01/2025	Section 7.4	Revised language to clarify mandatory participation requirements related to emergency disaster planning.

Date	Section Revised	Change
09/01/2025	Section 7.5	Planned Hospitalizations added to level I incidents and unplanned hospitalizations added to level II incidents, effective 11/01/2024. "Documented" was added here as well.
09/01/2025	Attachment A	Added New CAP In-home Aide II and In-home Aide II-Respite HCPCS Codes added, effective 11/01/2024.
09/01/2025	Attachment A	To ensure clarity and conciseness, the last three sentences on page 95 were revised as follows: "…subsequently carried over to the CAP/DA service plan resulting in a prior approval. Billing for these prior approved services is available once the CAP evidence code is entered into the Medicaid system."
09/01/2025	Appendix B	Increased the budget limits for equipment, modifications and technology service limits from 13,000 to 2,8000 within the limits, amount and frequency section, effective 11/01/2024.
09/01/2025	Appendix B	Medication dispensing boxes are no longer a standalone service under specialized medical supplies. Medication dispensing boxes can be purchased using funding from goods and services, effective 11/01/2024.
09/01/2025	Appendix B	Removed "Felony health care fraud" and "More than one felony conviction" and replaced with "More than one felony conviction related to health care fraud;" within the CAP In-home I and CAP In-home Aide II service definitions.

Attachment A: Claims-Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with the 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 Codes	
B4150BO	S5135
B4152BO	S5150
B4153BO	S5161
B4154BO	S5165
B4155BO	S5170
B4157BO	T1016
B4158BO	T2025
B4159BO	T2028
B4160BO	T2029
B4161BO	T2038
B4162BO	T2040
H0045	T2041
S5102	T4535
S5111	T4539
G9003	G9004
A0090	T5999
T1020	H2010

T2033	T9122
T1020	S5125
S5125UN	S5135UN
T1019	T1004

Home and Infusion Therapy (HIT) drug therapies are covered under a per diem charge. The per diem covers the therapy administration, supplies, and the nursing component (teaching, monitoring) of the therapy. HIT drug therapy must be billed using two HCPCS codes for each day of service to comply with national coding standards, according to HIPAA requirements. The applicable therapy code plus the nursing component code must be used for each day of therapy.

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/DA and CAP/CD fee schedules for current rate and billing units: https://medicaid.ncdhhs.gov/

The Case Management Entity (CME) or designated entity shall bill for case management services, Equipment, modification and technology, training and education services, community transition and integration services according to this CAP/DA policy and its own agency policy.

F. Place of Service

Case management services are provided in the case manager's office, a beneficiary's primary private residence, Acute Inpatient Hospital, or Nursing Facility. Acceptable places for all other waiver 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.

Note: A beneficiary may be living in an institution such as nursing facilities at the time of application, screening, and assessment, but shall be discharged to a primary private residence before they can receive home and community-based services.

G. Co-payments or Deductible

Medicaid shall not pay for services while in deductible status.

H. Reimbursement

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

For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/
Date of Service: Date of service billed must be the date the service is provided or rendered.

CAP/DA Claim Reimbursement

The Case Management Entity (CME) may bill for case management services, equipment, modification and technology, training and education services, community transition services, community integration services 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/DA providers shall bill for adult day health, financial management, In-Home aide, equipment, modification and technology, meal preparation and delivery, specialized medical supplies and personal emergency response, respite and when authorized training and education services, community transition services, community integration services goods and services service according to **Subsection 5.8**, 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 – In-home aide services I
b. S5125 UN – Congregate In-home aide services
c. S5150 – In-home respite care
d. S5135- Personal Assistance Services
e. S5135 UN – Congregate personal assistance services
f. T1019 – In-home aide services II
g. T1004 – In-home aide services II respite

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/DA services are provided by the type, amount, duration, and frequency, consistent with the CAP/DA 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/DA service plan, unless the unplanned occurrence criteria is met. A provider shall not bill for a service if the procedure is not valid for the CAP/DA benefit program, or if the policies and procedures relevant to that service were not adhered to. CAP/DA providers shall not file a claim for a beneficiary who is ineligible for CAP/DA services.

A request for payment for an assessment of an individual who does not become a CAP/DA beneficiary can be made if all of the following conditions are met:

a. The individual has a properly approved SRF.
b. The assessment was completed according to CAP/DA policies, procedures and timelines.
c. The assessment is documented and certified by the assessment multidisciplinary team on the CAP/DA assessment form.
d. The individual is notified in writing of the reason they cannot enroll in the CAP/DA.

A claim for the assessment of an individual who does not be participating in CAP/DA is called an "assessment only" claim. The claim is paid directly by NC Medicaid instead of through NCTracks. To submit an "assessment only" claim:

a. Prepare a paper claim for the service
b. Prepare a cover letter that includes:
    1. The Individual's name and Medicaid ID number; and
    2. The reason the individual cannot participate in CAP/DA.

A beneficiary in a facility (nursing home or hospital) shall receive CAP/DA services on the date of admission and the date of discharge. Specific CAP/DA services can be provided prior to 30 or 60 calendar days of a discharge from a facility placement when the CAP/DA services assist with transitional planning. An individual in an institutional setting may be authorized to use home and community-based services to assist with the transition to a more independent and less restrictive living arrangement. Certain CAP/DA services such as community transition and specific modification services may be furnished in advance of the discharge of the person from the institutional setting. All transition and modification services must be reasonable and necessary, not available to the CAP/DA applicant through other means, clearly specified in a discharge or transition plan, and subsequently carried over to the CAP/DA service plan resulting in a prior approval. Billing for these approved services is available once the CAP evidence code is entered into the Medicaid system.

Appendix A: CAP/DA Service Request Form

* = Required

Request Date *	
Service Requested	☐ *CAP Children* ☐ *CAP Adults* ☐ *Private Duty Nurse* ☐ *PACE*

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

Applicant Address	
Address 1	
Address 2	
City	
State	
Zip	
Phone	
Legal guardian in place? *	☐ *Yes* ☐ *No*

Legal Guardian Details	
Legal guardian in place? *	☐ *Yes* ☐ *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.	☐
An individual with an active AIDS diagnosis with a T-count of 200 or lower.	☐
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.	☐
An individual identified at risk by their Department of Social Services who has an order of protection by Children or Adult Protective Services for abuse, neglect or exploitation.	☐
An individual with Alzheimer's Disease or a related disorder.	☐
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.	☐
Has the applicant previously been a CAP beneficiary?	☐ *Yes* ☐ *No*
If Yes, is the applicant returning to CAP due to military service redeployment of the applicant's primary caregiver?	☐ *Yes* ☐ *No*

Beneficiary Conditions and Related Support Needs

Diagnosis Information	
Diagnosis Entry Screen	
Diagnosis	
ICD10 Code *	
Is this diagnosis the primary dx? *	☐ *Yes* ☐ *No*
Date of Onset	
Has this diagnosis lasted more than 12 months?	☐ *Yes* ☐ *No*
Is this diagnosis anticipated to last more than 12 months?	☐ *Yes* ☐ *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? *	☐ *Yes* ☐ *No*
If the applicant had less than three hospital stays in the last year, were any of the stays greater than 10 days?	☐ *Yes* ☐ *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?	☐ *Yes* ☐ *No*

Medications	
Meds Entry Screen	
Medication Name	
Other	☐ *Medication Name*
PRN *	☐ *Yes* ☐ *No*

If PRN, freq > every 4 hrs.?	☐ *Yes* ☐ *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)	☐ *Yes* ☐ *No*
Hearing (Severe difficulty or none)	☐ *Yes* ☐ *No*
Vision (Severe difficulty or blind)	☐ *Yes* ☐ *No*

Mood			
Unrealistic fears	☐	Crying/tearfulness	☐
Sad, pained, worried facial expressions	☐	Negative statements	☐
Persistent anger	☐	Anxious non-health concerns	☐
Elevated mood, euphoric	☐	Expansive	☐
Unpleasant mood in morning	☐	Hallucinations	☐
Excessive irritability	☐		

Behavior			
Wandering	☐	Verbal expressions of distress	☐
Repetitive verbalizations	☐	Angry outbursts	☐
Repetitive physical movements	☐	Dangerous to self	☐
Self-deprecation	☐	Withdrawal from activities of interest	☐
Insomnia/disturbed sleep patterns	☐	Paranoid ideation	☐
Suicide attempt/ideation	☐		

Interpersonal Functioning			
Homicidal	☐	Combative/Hx of Altercations	☐
Dangerous to others	☐	Physically abusive	☐
Verbally abusive	☐	Socially inappropriate behavior	☐
Resists care	☐	Fear of strangers	☐
Illogical comments	☐	Reduced social interaction/isolation	☐

Cardio-Respiratory Support Needs					
Suctioning - Oral	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *3-6 times per week* ☐ *1-2 times per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*

Suctioning - Oropharyngeal	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *3-6 times per week* ☐ *1-2 times per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*
Suctioning - Nasotracheal	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *3-6 times per week* ☐ *1-2 times per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*
Suctioning - Nasal	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *3-6 times per week* ☐ *1-2 times per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*
Ventilator dependent	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *During Sleep* ☐ *Being weaned* ☐ *PRN* ☐ *Other*
		Stable?	☐ *Yes* ☐ *No*		
		Vent Type	☐ *Negative pressure* ☐ *Pressure-cycled* ☐ *Volume-cycled*	☐ *Combination pressure and volume cycled* ☐ *Flow-cycled* ☐ *Time-cycled*	
Pulse oximetry	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day*	☐ *3-6 times per week* ☐ *1-2 times per week* ☐ *Once per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*
Non-vent tracheostomy	☐	*Problems with weaning?*		☐ *Yes* ☐ *No*	
Nebulizer usage	☐	*At least 2 schedule/day & 1 PRN/day?*		☐ *Yes* ☐ *No*	

Cardiac monitoring	☐		
Chest physiotherapy/use of chest PT vest	☐		
Use of cough assist device	☐		
Apnea monitoring	☐		
CPAP/BiPAP	☐	*Help getting device on?*	☐ *Yes* ☐ *No*
Oxygen therapy	☐	*Requires rate adjustments?*	☐ *Yes* ☐ *No*
Respiratory assessment	☐	*Multiple times/day?*	☐ *Yes* ☐ *No*
Is respiratory pacer required?	☐ *Yes* ☐ *No*		
Does applicant need on-going physician ordered care by a nurse to prevent advancement of cardio-respiratory care needs?	☐ *Yes* ☐ *No*		

Nutrition-Related Support Needs						
Enteral Feeding/Tube Feeding	☐	*Frequency*	☐ *Continuous* ☐ *Continuous during sleep* ☐ *Every hour* ☐ *Every two hours* ☐ *Every four hours*	☐ *Every six hours* ☐ *Every eight hours* ☐ *Every 12 hours* ☐ *Every 24 hours* ☐ *Less than once a day* ☐ *3-6 times per week*	☐ *1-2 times per week* ☐ *Less than weekly* ☐ *PRN* ☐ *Other*	
% of daily nutrition/fluids	*%*	*Feeding Tube Type*	☐ *DT (duodenal)* ☐ *GJ tube (gastrostomy-jejunostomy)* ☐ *GT (gastrotomy)* ☐ *JT (jejunostomy)*	☐ *Low profile GT* ☐ *NG (nasogastric)* ☐ *0G (orogastric)* ☐ *Other*		
Parenteral Nutrition (TPN)	☐					
Soft/Mechanical Soft	☐					
Thickened Diet	☐					
Pureed Diet	☐					
Supplemental formula diet physician prescribed	☐					
Diabetes management (daily)	☐	*Insulin use*	☐ *Yes* ☐ *No*	*Sliding Scale*	☐ *Yes* ☐ *No*	
Weight management	☐					
Fluid mgmt./force fluids	☐					
Input/output monitoring	☐					
Other nutrition treatment/Diet?	☐					
Other, Desc						

Ancillary Therapies Being Received				
Physical Therapy	☐	*Frequency*	☐ *More than once a week* ☐ *Weekly* ☐ *Every two weeks*	☐ *Monthly* ☐ *Less than monthly*
Physical Therapy Details				
Occupational Therapy	☐	*Frequency*	☐ *More than once a week* ☐ *Weekly* ☐ *Every two weeks*	☐ *Monthly* ☐ *Less than monthly*
Occupational Therapy Details				
Speech Therapy	☐	*Frequency*	☐ *More than once a week* ☐ *Weekly* ☐ *Every two weeks*	☐ *Monthly* ☐ *Less than monthly*
Speech Therapy Details				
Other	☐	*Other, Desc*		
Other Therapy Details				

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

Functional Limitations	
ADL Limitations	
Are there non-age appropriate hands-on care needs, not previously mentioned, to prevent deterioration of health conditions?	☐ *Yes* ☐ *No*
If Yes, describe the hands-on care needs	

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

Additional Comments about Treatment Needs	
Additional Comments	

Support Network	
Primary Caregiver Lives in an Applicant's Home?	☐ *Yes* ☐ *No*
If No, how far away does the primary caregiver live (in approximate miles)?	
Primary Caregiver's Health is Stable?	☐ *Yes* ☐ *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 their local Department of Social Services and any agency or organization responsible for enrolling or assisting the applicant in enrolling in CAP. *	☐ *Yes* ☐ *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:	

Appendix B: Waiver Service Definitions

3K-2 CAP/DA Waiver Service Definitions and Provider Requirements for each definition:

ADULT DAY HEALTH

A service for a CAP/DA beneficiary to attend certified Adult Day Health Care facilities. The service cares for persons who do not have other appropriate day supports and who need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting. The program supports the CAP/DA beneficiary's independence and promotes social, physical, nutritional needs and emotional well-being. Services are health services and a variety of program activities designed to meet the CAP/DA beneficiary's needs and interests. Nutritional needs are met through personally prepared meals and snacks consistent with medical needs and dietary restrictions. The meals received as a part of adult day health services do not constitute a full nutritional regimen.

Limits, Amount And Frequency

Services are organized and provided for four (4) hours minimum per day on a regularly scheduled basis for one or more days per week.

Qualified Provider(s)

Must meet the following requirements:

a. Meet and maintain the Home and Community-Based Final Rule requirements;
b. 10A NCAC Chapter 06 Subchapters R and S; and
c. Certified by the NC Division of Aging and Adult Services, according to NC General Statutes 131-D-6;

OR

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.

COORDINATION OF CARE: CASE MANAGEMENT AND CARE ADVISEMENT

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

The Case Management Entity (CME) shall retain the following documents:

a. Service Request Form (SRF);
b. all assessments;
c. service plan;
d. case management notes;

e. service authorizations;
f. copies of claims generated by the case management entity;
g. any required documents generated by other providers and approved by the case management entity; and
h. related correspondence in compliance with all applicable federal and state laws, rules and regulations.

Case management is a CAP/DA service offered to a CAP/DA beneficiary to assist in navigating community systems and gaining access to Medicaid services to meet their identified needs. The comprehensive interdisciplinary assessment identifies the lack of an informal support system and the need for intervention by a case manager. When the assessment identifies a CAP/DA beneficiary to be at risk of institutionalization, case management must be listed in the service plan on a monthly basis. The CAP/DA beneficiary has the option to select an approved case management provider, which is the sole case management provider for that CAP/DA beneficiary. If a request is made to transfer to another case management entity, a root cause analysis must be performed within five business days to assure the health and well-being of the CAP/DA beneficiary, as well as to identify utilization limits and assess the performance of the newly selected case management entity. 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/DA beneficiary participating in provider-led services.
b. **Care Advisor** provides specialized case management to a CAP/DA beneficiary participating in consumer-directed care. The care advisor focuses on empowering beneficiary to define and direct their own personal assistance needs and services. The care advisor guides and supports the CAP/DA beneficiary, rather than directs and manages the CAP/DA beneficiary, throughout the service planning and delivery process. These functions are done under the guidance and direction of the CAP beneficiary or responsible party.

There are Four Principle Activities of Case Management:

a. Assessment
b. Care planning
c. Referral and Linkage
d. Monitoring & Follow-up

When the case management entity is authorized to be the "HCBS passthrough provider" to ensure access to needed services as identified in an approved plan of care (POC), the case management entity can develop a one-time purchase order for the obtainment of the approved waiver item by giving the beneficiary a check made out to the provider.

The provider must provide an invoice to the case management entity within 15 business days. A second option a case management entity can use is to set up a purchase account at a retailer. The beneficiary and provider must sign an invoice to validate obtaining the approved waiver items.

A third option that can be used is online purchases using a VISA card. Each beneficiary is assigned their own VISA card if online purchasing is approved. Funds are loaded to the VISA card when a waiver item is approved. The funds can only be loaded to the VISA card when a waiver service is approved. The exact amount of the approved waiver item can only be loaded onto the card. The beneficiary is given a VISA gift card. The case manager documents the VISA account number and associated pin in the beneficiary's record to assist with loading funds for future approved waiver items.

Limits, Amount And Frequency

Service utilization limitation: the Medicaid maximum limit is published on posted Fee Schedule**:**

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

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

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.

Qualified Provider(s)

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

a. The case management entity shall be an organization with three 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 case management entity shall enroll as a NC Medicaid provider and be approved through an agreement by the State Medicaid Agency to provide lead entity CAP/DA services. The CME shall recertify as a Medicaid provider, when applicable.

Qualified Case Management Entities (CME) shall have:

a. Resource connection to the service area to provide continuity and appropriateness of care;
b. Experience in geriatrics and physical disabilities;
c. Policies and procedures in place that align with the governance of the state and federal laws and statues;
d. Three 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 and IT web-based connectivity to support the requirement of current and future automated programs;
h. Met the regulatory criteria under DHHS and DHSR;
i. Appropriate staff to participant ratio;
j. Evidence of fiscal soundness (financial statements); and
k. Ability to implement services within five (5) calendar days of POC approval.

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 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 an NC Medicaid-certified training program within three consecutive months 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 a health or medical field directly related to homecare, long-term care, or personal care and the completion of an NC Medicaid-certified training program within three consecutive months;

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 a health or medical field directly related to homecare, long-term care, or personal care and the completion of an NC Medicaid-certified training program within three consecutive months; or

d. Registered nurse who holds a current North Carolina license, two year or four year degree, one year case management experience in homecare, long-term care, personal care or related work and the completion of an NC Medicaid-certified training program within three 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; e-CAP trainings and refreshers; recognition and reporting of abuse, neglect and exploitation; and program integrity (PI).

RESPITE

Respite care provides short-term-temporary 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 overnight for any increment of time in the beneficiary's home, current approved residential accommodations or in a facility licensed to provide the LOC required by the beneficiary (such as a nursing facility or hospital). Caregiver relief can be used for a wide range of needs including family emergencies, planned special circumstances (such as vacations, hospitalizations, or business trips); relief from the daily responsibility and stress of caring for a beneficiary with a disability; or the provision of time for the caregiver(s) to complete essential personal tasks.

Institutional Respite is a service for a CAP/DA beneficiary 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 Fee Schedule.

In-Home Respite is for a CAP/DA 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, including 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.

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

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

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

Respite hours are indicated on the cost summary and service authorization as a "per year" allotment. However, the use of respite services must be communicated to the CAP/DA case manager within 12 hours of need, unless due to an emergency. The utilization of this service must be documented by the assigned CAP case manager. 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 basis, but not as additional hours of In-Home or personal care assistance services.

Respite Service

The Case Management Entity (CME) 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/DA 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 and hours for respite include both institutional respite care and in-home respite; in a situation of more than one CAP/DA beneficiary in a household, respite hours are assigned per household. When acute care needs of one beneficiary in the household are identified, an assessment is performed to determine if additional respite hours are needed.

Respite hours must not be used for situations in which short-term-intensive hours could be approved, usually for an emergency.

Respite hours shall not be approved to provide oversight of minor children, spouses, other relatives in the home or to relieve other paid providers.

Respite hours arranged during a scheduled family vacation when the CAP/DA beneficiary is present cannot total, in combination with in-home aide or personal assistance, 24 hours in one day.

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.

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 cannot be approved.

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

The additional limitations apply to In-home respite:

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

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

CAP/DA IN-HOME AIDE I SERVICE

In-home aide service is a range of assistance to enable CAP/DA beneficiaries to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cueing to prompt the beneficiary to perform a task, supervision of a task, or monitoring. In-home aide services may be provided on an episodic or on a continuing basis. In-home aide services may provide limited to greater assistance with or monitoring of a minimum of two Activities of Daily Living (ADLs) and basic home management tasks when documented in the comprehensive assessment that evaluates physical, social, environmental, and functional condition. Support, monitor, supervision, and assistance are provided for seven keys ADLs: bathing, dressing, eating, toileting, hygiene, mobility and transfer, and key Instrumental Activities of Daily Living (IADLs) to include: light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication, and money management). Such assistance also may include the supervision of beneficiaries as provided in the service plan.

In-home aide service needs must fall within the Nurse Aide I scope of nursing practice or greater, per the North Carolina Board of Nursing. In-home aide services may be provided in the community, home, workplace, or educational settings at the discretion of the Home Care Agency. In-home aide services can be provided in the workplace for CAP/DA beneficiaries who meet the specified qualifications. A beneficiary approved for In-home aide can receive services at any of the task levels as described below. Level I tasks consists of home management tasks such as housekeeping, cooking, shopping, and bill paying. Level II tasks are assistance with basic activities of daily living (e.g., eating, dressing, bathing, etc.) and home management tasks. Higher-level tasks are Level III tasks, and they are 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. Level III tasks are substantial and involves extensive "hands on" care and assistance with a wide range of health-related conditions. Other Level I tasks include paying bills as directed by the 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 beneficiary; providing companionship and emotional support; preparing simple meals; and shopping for food, clothes, and other essential items.

Personal care under the waiver differs in scope, nature, supervision arrangements, and provider type (including provider training and qualifications) from personal care services in the State plan.

The In-Home aide needs must fall within the NA I scope of nursing practice or greater.

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

Short-term intensive services may be used under this service. Short-term intensive services are used for a change in the status of the CAP/DA beneficiary where the duration of care needs is less than three weeks. Short-term intensive services are contained in the service plan.

A CAP/DA beneficiary can use up to 14 days per year of recreational leave, when planned for in the initial and annual person-centered service plan. The exact dates of the leave do not have to be included in the service plan when the initial or annual plan is completed.

Assistance from this service when traveling out of state is allowed when the provision of this service complies with BON- licensure and certification rules.

An assigned worker may accompany a CAP/DA 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/DA beneficiary.

ADL care for adults under the Medicaid Infrastructure Grant (MIG) with Vocational Rehabilitation can be provided in the workplace for a CAP/DA beneficiary who qualifies.

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

Individuals with the following criminal records are excluded from hire:

a. Felonies related to manufacture, distribution, prescription, or dispensing of a controlled substance;
b. More than one felony conviction related to healthcare fraud;
c. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
d. Felony or misdemeanor patient abuse;

e. Felony or misdemeanor involving cruelty or torture;
f. Misdemeanor healthcare fraud;
g. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
h. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
i. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC.

Note: Individuals with criminal offenses occurring more than 10 years previous may qualify for an exemption. The exemption approval must be agreed upon by the CAP/DA beneficiary and documented in the case files.

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

CAP In-Home Aide service is 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 that the paid live-in caregiver assigned to the CAP/DA 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.

Limits, Amount And Frequency

The number of hours of this CAP/DA service is authorized based on medical necessity, caregiver availability, composite score analysis, and other contributing factors identified in the comprehensive assessment and contact monitoring.

A spouse, parent, step-parent, child, sibling, or other relatives can be hired as the employee. The relative must:

a. Be at least 18 years of age; and
b. Meets the qualifications based on need-based assessment and hiring agency or employer.

To comply with Fair Labor Standards Act, a relative, unpaid staff and when approved, a legal guardian, may be paid overtime for hours worked greater than 40-hour week.

A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide personal care services to CAP beneficiaries unless an exemption is granted.

The assigned provider's external employment or other obligations cannot interfere with or negatively affect the provision of services; nor supersede the identified care needs of the CAP/DA beneficiary.

CAP/DA funding cannot 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/time as CAP/DA Nursing Services. Nurse Aide Services may not be provided if it duplicates other Medicaid or non-Medicaid services.

When an individual meets the special circumstances or extraordinary conditions described below, the maximum approved 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. Payment to a legal guardian Power of Attorney, Health Power of Attorney to provide in-home aide services to a CAP/DA beneficiary may be made when any **one** of the following extraordinary circumstances is met:

a. There are no available certified nursing assistants (CNAs) in the CAP/DA 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/DA beneficiary needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
b. The CAP/DA beneficiary requires short-term isolation, 90-days or less, due to experiencing an acute medical condition or health care issue requiring extensive to maximal assistance with bathing, dressing, toileting and eating, and the CAP/DA beneficiary chooses to receive care in their home instead of an institution.
c. The CAP/DA 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 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/DA beneficiary; regular interruption at work to assist with the management of the CAP/DA beneficiary's monitoring or supervision needs; or an employment termination.
d. The CAP/DA 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 beneficiary and avoid institutionalization.
e. Other documented extraordinary circumstances not previously mentioned that places the CAP/DA beneficiary's health, safety and well-being in jeopardy resulting in an institutional placement.

Note: A provider's note that is not an official medical record and does not meet criteria 2-5 cannot be used or considered for determining eligibility for extraordinary circumstances. Not meeting the extraordinary circumstances is not an appealable event.

Approving extraordinary circumstances
The CAP/DA case manager is responsible for reviewing supporting documentation to determine the eligibility of a legally responsible person to become the paid caregiver. The CAP/DA case manager uses supporting documentation to make decisions that align with one of the five extraordinary circumstances. Required supporting documentation are listed below.

- Physician's orders
- Personnel actions forms (PAF)
- Rejection correspondence from In-home care agencies
- Medical documentation outlining the beneficiary's need for short term isolation, physician ordered 24-hour direct observation, and special health needs.

The payment for instrumental 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/DA beneficiary is enrolled in the coordinated caregiving waiver service. Enrollment in this service shall provide quality assurance of the health, safety and well-being of the CAP/DA beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.

The assigned Case Management Entity (CME) shall monitor the CAP/DA beneficiary closely to ensure the services are provided according to the service plan and the waiver participation business requirements.

A legal guardian shall 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 shall not be approved to provide personal care services and receive payment if there are other providers available to render personal care services when the waiver participant has been discharged from a Home Health Agency/In-Home Aide Agency due to non-complaint or violent behavior exhibited by the waiver participant or the legal guardian.

A legal guardian who is currently approved to receive payment for performing personal care services to a CAP/DA 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/DA 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/DA 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 orders and service plans, and critical incident report conclusions did not implicate the legally responsible individual to be negligent. In addition, the physical health of the legally responsible individual is a contributing component to ensure the ongoing health and safety of the CAP/DA beneficiary.

Qualified Provider(s)
Home Care Agency Licensed by the State of North Carolina

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.

CAP IN-HOME AIDE II SERVICE

This is a service for a CAP/DA 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 limited to extensive hands-on assistance (not merely set-up or cueing) with or monitoring of at least two ADLs (bathing, dressing, eating, toileting, hygiene, mobility and transferring). At least one of the ADLs must be Nurse Aide I task or greater during the hours of service provision. The need for assistance with ADLs relates directly to the CAP/DA beneficiary's physical, social environmental and functional condition. Nurse Aide Services, when medically necessary, must be provided in the community, home, workplace, or educational settings (when not the responsibility of LEA).

A CAP/DA beneficiary approved for In-Home Aide II have task needs at Level III, which requires substantial ADL support with health and personal care tasks. Involves extensive "hands on" care and assistance with 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. Level III tasks are considered higher-level tasks for CAP/DA. Lower level tasks are Level I tasks, home management such as housekeeping, cooking, shopping, and bill

paying; and Level II tasks, assistance with basic activities of daily living (e.g., eating, dressing, bathing, etc.) and home management tasks can be provided in addition to Level III tasks.

This service type is substantial. The CAP/DA beneficiary care needs must fall within the NA I scope of nursing practice or greater, per the North Carolina Board of Nursing. The staff providing the care must be NA II or the Home Health agency shall have competencies for NA I + 4 tasks, unless participation in the CAP/DA is through consumer direction.

Other Level I tasks include paying bills as directed by the CAP/DA 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/DA beneficiary; providing companionship and emotional support; preparing simple meals; and shopping for food, clothes, and other essential items.

Nurse Aide services shall not be provided by personal care aides or home health aides not registered with DHSR, unless participation in the CAP/DA is through consumer direction.

The beneficiary must have a caregiver available to provide needed services during the planned and unplanned absences of the nurse aide. If the regular informal caregiver is not available; there must be a back-up informal caregiver designated 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:

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/DA service occurrence requests are eligible to be used with this service. Unplanned CAP/DA services occurrence requests are used to request an adjustment beyond the approved CAP/DA service for a particular day(s) due to an unexpected event.

A CAP/DA beneficiary can use up to 14 days per year of recreational leave, 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 2A-3, *Out-of-State Services*.

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.

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 that the paid live-in caregiver assigned to the CAP/DA 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) months after the initial attestation.

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

Waiver beneficiaries receiving PDN from State Plan who have not been able to recruit a nurse as evidence by written documentation from the Home Care agency, CNA II services can be temporarily authorized, when all qualifying condition are met, to offer support and assistance with IADLs and monitoring of ADLs when approved the supervising nurse of the Home Care agency

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. More than one felony conviction related to healthcare fraud;

c. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;

d. Felony or misdemeanor patient abuse;

e. Felony or misdemeanor involving cruelty or torture;

f. Misdemeanor healthcare fraud;

g. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;

h. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or

i. 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/DA beneficiary when a prospective employee is within the 10-year rule, and the CAP/DA 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/DA service are authorized by the CME, based on medical necessity of the CAP/DA beneficiary, caregiver availability, budget limits and other available resources.

A spouse, parent, step-parent, or grandparent is eligible for hire as the employee when a CAP/DA beneficiary is 18 years of age or older. A spouse, parent, or grandparent, of the CAP/DA beneficiary may provide this service only when:

a. CAP/DA 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/DA assessment.

To comply with Fair Labor Standards Act, a relative, paid staff, and when approved, a legal guardian of a CAP/DA 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. There are special rules under the Department of Labor for companion care and consumer direction. The hiring agency or the financial management entity shall know those rules and apply them accordingly.

A legal guardian, Power of Attorney, Health Power of Attorney of a CAP/DA beneficiary age 17 and under cannot be hired to provide personal care services to CAP/DA 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/DA beneficiary.

CAP/DA 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/DA In-Home Aide services or private duty nursing. In-home Aide II 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 parent, legal guardian or a legally responsible party (an individual who acts on behalf of the wavier beneficiary) to provide in-home aide services to a CAP/DA beneficiary may be made when any one of the following extraordinary circumstances is met:

a. There are no available CNAs in the CAP/DA 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/DA beneficiary needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.

b. The CAP/DA 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/DA beneficiary chooses to receive care in their home instead of an institution.

c. The CAP/DA 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/DA 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/DA beneficiary; regular interruption at work to assist with the

management of the CAP/DA beneficiary's monitoring or supervision needs; or an employment termination.

d. The CAP/DA 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/DA beneficiary and avoid institutionalization.

e. Other documented extraordinary circumstances not previously mentioned which places the CAP/DA beneficiary's health, safety and well-being in jeopardy resulting in an institutional placement.

Note: A provider's note that is not an official medical record and does not meet criteria 2-5 cannot be used or considered for determining eligibility for extraordinary circumstances. Not meeting the extraordinary circumstances is not an appealable event.

Approving extraordinary circumstances
The CAP/DA case manager is responsible for reviewing supporting documentation to determine the eligibility of a legally responsible person to become the paid caregiver. The CAP/DA case manager uses supporting documentation to make decisions that align with one of the five extraordinary circumstances. Required supporting documentation are listed below.

- Physician's orders
- Personnel actions forms (PAF)
- Rejection correspondence from In-home care agencies
  Medical documentation outlining the beneficiary's need for short term isolation, physician ordered 24-hour direct observation, and special health needs

When an individual meets the extraordinary circumstances described above, the maximum number of hours that can be 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 instrumental 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/DA beneficiary monitored closely by the case management entity (CME) to ensure quality assurance of the health, safety and well-being of the CAP/DA 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) monitoring visits, one in-person and the second telephonically, to ensure the services are provided according to the service plan and the CAP/DA participation business requirements.

A legally responsible person shall not be approved to provide personal care services and receive payment because of an unjustified unwillingness to work with Home Care Agencies/In-Home Aide Agencies. A legally responsible person shall 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/DA beneficiary has been discharged from a Home Care Agency or In-Home Aide Agency due to non-complaint or violent behavior exhibited by the CAP/DA beneficiary or the legal guardian.

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

When a determination is made in the best interest of the CAP/DA beneficiary to have a legally responsible person to provide personal care services, a physician's recommendation must be provided to the case manager outlining the specific care needs of the CAP/DA beneficiary and how those needs can only be provided by the legally responsible person. In collaboration with the physician's recommendation, an analysis of the case record is performed to evaluate the legally responsible person's compliance with treatment and service plans and to ensure critical incident reports did not implicate the legally responsible person to be negligent. The physical health of the legally responsible person is considered and evaluated to ensure the health and well-being of the beneficiary. No more than 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 support 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 by state law).

Qualified Provider

Home Care Agency Licensed by the State of North Carolina.

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 NA II to a CAP/DA beneficiary requiring specialized or skilled nursing care. Home Health agency shall obtain a physician's order to render the authorized 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/DA 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.

PERSONAL ASSISTANCE SERVICES

Personal assistance service is a range of assistance to enable a CAP/DA beneficiary to accomplish tasks that they would normally do for themself if they did not have a disability. This assistance may take the form of hands-on assistance (performing a task for the person) or cueing to prompt the beneficiary to perform a task. Personal assistance services may be provided on an episodic or on a continuing basis. Personal assistance services provide hands-on assistance with Activities of Daily Living (ADLs) and basic home management tasks. The need for assistance is identified through a comprehensive assessment that evaluates physical, social, environmental, and functional conditions. Hands-on assistance is provided for seven keys ADLs: bathing, dressing, eating, toileting, hygiene, mobility and transfer, and key Instrumental Activities of Daily Living (IADLs) to include: light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication, and money management). Such assistance also may include the supervision of the beneficiary as provided in the service plan.

Personal assistance services may be provided in the community, home, workplace, or educational settings (when the service does not replace or duplicate the service required to be provided in the school under the provisions of Individual with Disabilities Education Improvement Act of 2004 {IDEA}) at the discretion of the beneficiary or designated representative.

Consumer-Directed Providers

Consumer-directed providers must:

a. undergo a criminal background and registry check prior to hire and payment of payroll; and
b. demonstrate competencies and skill sets to care for the CAP/DA beneficiary as documented by the consumer-directed beneficiary or responsible party.

The competency documentation is uploaded in the case file using the CAP Business System to inform the financial management agency of the readiness to hire and pay the selected employee (personal assistant).

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

Personal assistance service is 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 that the paid live-in caregiver assigned to the CAP/DA 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.

Limits, Amount And Frequency

The number of hours of this CAP/CD service is authorized based on medical necessity, caregiver availability, composite score analysis, and other contributing factors identified in the comprehensive assessment and contact monitoring.

A spouse, parent, step-parent, child, sibling, or other relatives can be hired as the employee. The relative must:

a. Be at least 18 years of age; and
b. Meets the qualifications based on needs assessment and hiring agency or employer.

To comply with the Fair Labor Standards Act, a relative, unpaid staff and when approved, a legal guardian, may be paid overtime for hours worked greater than 40-hour week.

A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide personal care services to CAP beneficiaries unless an exemption is granted.

The assigned provider's external employment or other obligations cannot interfere with or negatively affect the provision of services; nor supersede the identified care needs of the CAP/DA beneficiary.

CAP/DA funding cannot 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).

Payment to a parent, legal guardian or a legally responsible party (an individual who acts on behalf of the wavier beneficiary) to provide in-home aide services to a CAP/DA beneficiary may be made when any one of the following extraordinary circumstances is met:

f. There are no available CNAs in the CAP/DA 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/DA beneficiary needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.

g. The CAP/DA 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/DA beneficiary chooses to receive care in their home instead of an institution.

h. The CAP/DA 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/DA 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/DA beneficiary; regular interruption at work to assist with the management of the CAP/DA beneficiary's monitoring or supervision needs; or an employment termination.

i. The CAP/DA 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/DA beneficiary and avoid institutionalization.

j. Other documented extraordinary circumstances not previously mentioned which places the CAP/DA beneficiary's health, safety and well-being in jeopardy resulting in an institutional placement.

Note: A provider's note that is not an official medical record and does not meet criteria 2-5 cannot be used or considered for determining eligibility for extraordinary circumstances. Not meeting the extraordinary circumstances is not an appealable event.

Approving extraordinary circumstances
The CAP/DA case manager is responsible for reviewing supporting documentation to determine the eligibility of a legally responsible person to become the paid caregiver. The CAP/DA case manager uses supporting documentation to make decisions that align with one of the five extraordinary circumstances. Required supporting documentation are listed below.

- Physician's orders
- Personnel actions forms (PAF)
- Rejection correspondence from In-home care agencies
  Medical documentation outlining the beneficiary's need for short term isolation, physician ordered 24-hour direct observation, and special health needs

When an individual meets the extraordinary circumstances described above, the maximum number of hours that can be 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 instrumental 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/DA beneficiary monitored closely by the case management entity (CME) to ensure quality assurance of the health, safety and well-being of the CAP/DA 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) monitoring visits, one in-person and the second telephonically, to ensure the services are provided according to the service plan and the CAP/DA participation business requirements.

A legally responsible person shall not be approved to provide personal care services and receive payment because of an unjustified unwillingness to work with Home Care Agencies/In-Home Aide Agencies. A legally responsible person shall 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/DA beneficiary has been discharged from a Home Care Agency or In-Home Aide Agency due to non-complaint or violent behavior exhibited by the CAP/DA beneficiary or the legal guardian.

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

COORDINATED CAREGIVING

Coordinated Caregiving consists of supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community, which provides for such support as adaptive skill development, assistance with activities of daily living (ADLs), and instrumental activities of daily living (IADLs), linkage to health care providers and local resources, social and leisure skill development, protective oversight, and supervision. This service provides learning opportunities, developing and maintaining skills in the areas of social and recreational activities and personal enrichment. The setting for this service is in the waiver participant's primary private residence or waiver participant's relative or related family and friend's primary private residence.

This service is intended to promote the waiver participant's independence and provides supportive services for personal care and basic home management tasks due to the waiver participant's inability to perform these tasks independently due to a disabling condition. Coordinated Caregiving integrates the waiver participant into the usual activities of family and community life.

Coordinated Caregiving is provided by a caregiver who resides in the home of the waiver participant or the caregiver's home. Coordinated Caregiving is provided in a private residence. It affords all the rights, dignity, and qualities of living in a private residence, including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.

A CAP/DA beneficiary assessed at any one of the listed acuity levels may receive coordinated caregiving.

The acuity levels are listed below.

i. Low
ii. High

The Community Environment Requirements:

The home shall provide living arrangements to meet the individual needs of the CAP/DA beneficiary, and other live-in caregiver(s).
The home must have a living room, kitchen, dining area and bathroom. The home must have operable windows, two exterior doors with locks, fire alarms, fire extinguisher and an emergency first aid kit.
The Coordinated Caregiver Provider agency shall assure a care plan is developed for each CAP/DA beneficiary in conjunction with the CAP/DA beneficiary assessment to be completed within 30 calendar days following the referral but no later than the 30 calendar days of the approved service plan. The care plan shall be individualized.
The coordinated caregiving care plan must be revised as needed based on further assessments of the CAP/DA beneficiary and live-in caregiver.

The coordinated caregiving care plan must document the following:

a. A statement of the daily care or service to be provided to the live-in caregiver of the CAP/DA beneficiary based on the assessment or reassessment;
b. A statement of the education and coaching to be provided to the live-in caregiver. The developer of the plan, the CAP/DA case manager, live-in caregiver, and the CAP beneficiary when applicable, shall sign the care plan upon its completion.

Home and Community-Based Characteristic Compliance

Mail – a CAP/DA beneficiary shall receive their mail promptly and it must be unopened unless there is a written statement that the supportive caregiver is authorized to open and read the CAP/DA beneficiary's mail.

Laundry -Laundry services must be provided to a CAP/DA beneficiary without any additional fee.

Telephone - A telephone must be available in a location providing privacy for a CAP/DA beneficiary to make and receive a reasonable number of calls of a reasonable length.

Personal Space -Personal space must be provided for the CAP/DA beneficiary to secure their personal valuables.

Management of CAP/DA beneficiary's funds - CAP/DA beneficiary shall manage their own funds unless there is a written agreement designating a Power of Attorney (POA) or legal guardian, legal representative or payee.

Limits, Amount And Frequency

The live-in caregiver is paid a stipend to provide the oversight and supervision needed to maintain community placement. An individual serving as the CAP/DA beneficiary's power of attorney, guardian, or representative may be approved to be the live-in caregiver. The coordinated caregiving Medicaid reimbursement rate does not include room and board.

The coordinated caregiver provider must provide the live-in caregiver with up to 50 percent of the Medicaid established rate as a stipend to compensate caregiving tasks as described in the care plan.

A CAP/DA beneficiary receiving coordinated caregiving services shall use that service as their primary service option. However, under extenuating circumstances, combining other hands-on services and supportive services can be approved when determined necessary and when coordinated to mitigate risk. Services that are approved cannot duplicate other service coverage and tasks.

Qualified Provider(s)
Live-in Caregiver Qualifications:

a. Must be at least 18 years of age, in good health and able to follow written and verbal instruction; and
b. Must pass criminal and registry checks.

FINANCIAL MANAGEMENT SERVICES

Financial management services are provided for a CAP/DA beneficiary who is directing their own care to ensure that consumer-directed funds outlined in the service plan are managed and distributed as intended. An approved financial manager shall perform financial intermediary (FI) services to reimburse the personal assistant(s) and designated providers.

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

a. Serving as the CAP/DA 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:

a. Deduct all required federal, state taxes, including insurance, prior to issuing payment;
b. Administers benefits to the personal assistant(s) as directed by the CAP/DA beneficiary;
c. Files claims for self-directed services and supports;
d. Maintains separate accounts on each beneficiary's services, and producing expenditure reports as required by the state Medicaid agency;
e. Tracks and monitors individual budget expenditures;
f. Completes necessary background checks (criminal and health care registry) and age verification on personal assistant(s); and
g. Provides payroll statements on at least a monthly basis to the personal assistant(s).

Limits, Amount and Frequency

FMS are billed in one (1) unit as per the established and approved Fee Schedule.

A consumer-directed enrollment fee must be included in the service plan for the month of enrollment and must not exceed one (1) unit. Monthly management fees must be assessed each month and must not exceed (1) one unit per month.

Note: A consumer-directed transition fee must be assessed for a CAP/DA beneficiary transferring from one fiscal intermediary to another and must not exceed one (1) unit. A consumer-directed transition fee must be assessed for CAP/DA beneficiary transferring back to a previous fiscal intermediary. The transition fiscal intermediary fee is one-half (.5) of the approved monthly management fee.

Qualified Provider(s)

A qualified provider of this service is Accountants, financial advisors, financial managers, attorneys, other individuals meeting qualifications of financial management. The FMS shall have a minimum of three (3) years of experience in developing, implementing and maintaining a record management process that includes written policies and procedures. The FMS shall maintain current and archived beneficiaries, attendants, 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 Financial Management Services (FMS) shall also:

a. have the capacity to provide FMS through both 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 North Carolina Medicaid Provider for FMS (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.

COMMUNITY TRANSITION SERVICES

A service for a prospective CAP/DA beneficiary for transitioning from an institutional setting to a community setting. This service may be used for a duration of one year of the transition to the community to pay for necessary and documented expenses for a CAP/DA beneficiary to establish a basic living arrangement.

These expenditures are for initial set-up expenses who make the transition from an institution to their own primary private residence in the community.

Community Transition Services may cover:

a. Essential furnishings, and household products including furniture for the bedroom or living room, window coverings, food preparation items, and bed or bath linens;
b. One-time credit repair consultation visits to assist with creating a credit repair plan;
c. Residential application fees
d. Security deposits or other such payments (such as first month's rent) required to obtain a lease on an apartment or home;
e. Set-up fees or deposits for utility or service access (such as telephone, electricity, heating); and
f. Linkage to health-related legal support, when qualifying conditions are met.

Items and services (including rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary. A receipt shall be provided for each purchase or invoice for each payment. 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 items listed above, not to exceed $2,500 over lifetime of the CAP/DA waiver approval period.

This service must be utilized within one year from the date of the beneficiary's discharge from an institution.

This service does not include rent or back rent payments.

COMMUNITY INTEGRATION SERVICES

This service is for an active waiver participant in jeopardy of losing their community placement due to tenancy-related issues. This service may be used in any duration or type, up to the maximum allotted amount through the duration of the waiver approval cycle, to pay for necessary and documented tenancy-related expenses for the waiver participant. The following are allowable activities for Community Integration:

The assistance in Community Integration service enables waiver participants to maintain their housing as outlined in the participant's approved plan of care (POC).
Services must be provided in the home or in a community setting. The service consists of the following components:

1. Authorizing a community-based organization, housing authority agency, or a legal aid representative to assist the waiver participant in developing a housing plan that identifies preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and the associated support needed to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).
2. Authorizing a community-based organization or a legal aid representative to assist the waiver participant in developing an individualized community integration plan that includes securing supporting documents or records, completing/submitting applications, arranging to identify resources to assist with securing deposits, and locating furnishings for the home.
3. Authorizing a community-based organization or a legal aid representative to assist with crisis intervention by engaging property housing managers and landlords for eviction risk mitigation efforts related to a waiver participant's disability.

Items and services must be of sufficient quality and appropriate to the needs of the waiver participant. To seek reimbursement, the service vendor shall provide an invoice for each service intervention as described in the service definition, and linkage to health-related legal support, when qualifying conditions are met.

Items and services (including rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary. A receipt shall be provided for each purchase or invoice for each payment. 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 Integration Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the CAP/DA beneficiary is unable to meet such expense or when the services cannot be obtained from other resources. Community Integration services are available to cover expenses, not to exceed $2,500 over lifetime of the CAP/DA waiver approval period in combination with Community Transitions services.

This service does not include back payment for rent.

Community Integration Services do not include monthly rental or mortgage expense; food, regular utility charges; and household appliances or items that are intended for purely diversional and recreational purposes.

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.

EQUIPMENT, MODIFICAITON AND TECHNOLOGY

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

An assessment of need must be recommended by a multidisciplinary team that includes 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 . A physician's signed order may be needed to certify that the requested equipment, technology, adaptation or technology is necessary, when applicable. When feasible there must be up to two competitive quotes for home or vehicle 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 CME shall file a claim to Medicaid for this service to reimburse the contractor. 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/DA beneficiary resides that is owned by the beneficiary, or their family;
b. A rented residence when the modifications are portable; or
c. A rented residence, when portal modifications are allowed by the owner.

Vehicle modifications can be provided only in the following settings:

a. A primary vehicle of the CAP/DA beneficiary; or
b. A primary vehicle of the documented legal guardian or primary caregiver.

Approval for floor coverings, air filtration, and generators must be based on Registered Nurse (RN) assessment and Medical Doctor (MD) certification.

This service may cover:

a. Installation, maintenance, and repairs of ramps; grab bars; safety rails and handrails;
b. Widening of doorways or passages for wheelchair or walker accessibility;
c. An emergency egress when determined to be medically necessary due to physical limitations of the responsible party;

d. Modification of bathroom facilities to improve accessibility for a disabled individual, including toilet; shower and tub (including hand-held showers), and sink fixtures or modifications; water faucet controls; floor urinal adaptations; plumbing modifications; and modification for turnaround space
e. Bedroom modifications to accommodate hospital beds and wheelchairs;
f. Kitchen Modifications to improve accessibility for an individual with a disability including cabinets, sink fixtures or modifications, water faucet controls, related plumbing modifications, and modification for turnaround;
g. Floor coverings for ease of ambulation for the home;
h. Hypoallergenic filters for the home, when qualifying conditions are met;
i. Replacement filters for items covered under the equipment, modification and technology;
j. Hydraulic, manual, or electronic lifts, including portable lifts or lift systems that can be removed and taken to a new location and are used primarily inside the beneficiary's home;
k. Non-skid surfaces for the car or home;
l. Lift chairs when prescribed by a physician and confirmed by a Physical or Occupational Therapist;
m. Door handle replacements for the home;
n. Door modifications for the car or home;
o. Installation of raised roof or related alterations to existing raised roof system to approve head clearance;
p. Lifting devices for the car or home;
q. Devices for securing wheelchairs or scooter for the car;
r. Adapted steering, acceleration, signaling and breaking devices only when recommended by a physician and a certified for the car;
s. Driving evaluator for people with disabilities, and when training on the installed device is provided by certified personnel;
t. Handrails and grab bars for the home;
u. Seating modifications for the car;
v. Lowering the floor of the vehicle when the vehicle is not pre-manufactured with a lowered floor;
w. Transfer assistance for the car;
x. 4-point wheelchair tie-down for the car;
y. Wheelchair or scooter hoist for the car;
z. Cushions for the car or home when not covered by State Plan;
aa. Wheelchair or scooter lift for the car or home;
bb. Ramp for the car or home;
cc. Devices for securing oxygen tank for car;
dd. Other modifications outside of these general categories approved by the State Medicaid Agency;
ee. Smart home devices such as smart bulb, controllers for televisions, switches and entryways, clocks and thermostatic when the CAP/DA beneficiary lives alone and addresses a need identified in the assessment and listed in the person-centered service plan;
ff. Portable or whole house air filtration system and filters under the following circumstances:

    1. For a CAP/DA 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 or less than or equal to 50 parts per billion ozone by-products is not covered.
    2. For a CAP/DA 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 their time confined to a specific area of the house, then a whole-house system is not approved.

gg. Portable back-up generator for a ventilator, when the CAP/DA beneficiary uses the ventilator more than eight hours per day and in the event of a power outage the beneficiary would require hospitalization if not for the presence of the generator. The coverage of a 220-volt line from a circuit breaker panel in the home to a receptacle installed outside. The coverage of a carbon monoxide monitor;

hh. 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, HVAC, TV, telephone, hospital bed, computer, small appliances). All Environmental Control Units perform most of the same functions but vary by the method of control that best suits the beneficiary. An ECU or EADL can range from a single function device up to a whole house computer-based system; and

ii. Replacement of fixtures, mirrors and storage space when removed, dismantled or damaged during an approved modification.

The Equipment, modification and technology service consists of the following:

a. Technical assistance in device selection;
b. Training in device use by a qualified assistive technology professional;
c. Purchase, necessary permits and inspections, taxes, and delivery charges;
d. Installation;
e. Assessment of modification by the case manager and by any applicable inspectors to verify safety and ability to meet beneficiary's needs; and
f. Repair of equipment, as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment, and only when not covered by warranty. The CAP/DA beneficiary or their family shall own any equipment that is repaired.

The Case Management Entity (CME) approves the services through a service authorization.

Note: Medicaid assumes no liability related to use or maintenance of the equipment, modification or technology and assumes no responsibility for returning the private residence to its pre-modified condition. Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of CAP/DA services, unless the modification is to the provider's own home for the exclusive use of that CAP/DA beneficiary.

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, technology, 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 CAP/DA 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 CAP/DA 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 CAP/DA 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 services of Equipment, Modification, and Technology are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with CAP/DA objectives of avoiding institutionalization.

Limits, Amount And Frequency

$28,000 over the 5-year cycle of the waiver.

The case management entity shall track the cost of equipment, modification and technology billed and paid during the plan year, to avoid exceeding the $28,000 limit over the lifetime of the waiver (five years).

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

Items that are covered through DME, orthotics and prosthetics, home health supplies, and EPSDT are obtained through the respective programs prior to requesting CAP/DA services. CAP/DA shall not cover items that are covered by one of these programs but were denied for a particular beneficiary for lack of evidence of declaration of need.

Note: The replacement of a fixture (sink or toilet) and, or a mirror over the vanity may be replaced using funding through the equipment, modification and technology when during demolition the fixture or mirror cannot be preserved as described in the specification document.

Equipment, modification and technology items that require a physician's order:
a. Tub replacement; and
b. A portable generator.

Equipment, modification and technology exclude the following:

a. Addition of square footage to the home;
b. Home renovations;
c. A dwelling where the owner refuses portal modification;
d. The modification in a rented residence that is not portable;
e. Purchase of locks;
f. Modification during new construction;
g. Roof repair or replacement;
h. Central air conditioning;
i. Swimming pools, hot tubs, spas, saunas;
j. Items that meet the definition exclusions for general utility to a non-disabled beneficiary;
k. Replacement of equipment that has not been properly used, has been lost or purposely damaged as verified by written documentation or through observation;
l. Computer desks or other furniture; and
m. Items that meet the definition exclusions for recreational in nature.

Medicaid is the payer of last resort; if the beneficiary has private insurance that covers the item, this insurance is billed.

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

The total funding budget for equipment, modification and technology services is planned per CAP/DA beneficiary and the total budget shall be shared between the two primary caregivers when shared responsibilities are established.

A CAP/DA beneficiary who resides in foster care is eligible to receive equipment, modification and technology when equipment, modification and technology are portable.

A CAP/DA beneficiary who is receiving coordinated caregiving and resides in the home of a caregiver is eligible to receive equipment, modification and technology when the equipment, modification and technology are portable.

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.

MEAL PREPARATION AND DELIVERY

A service for a CAP/DA beneficiary who requires special assistance with nutritional planning per an assessment of needs. This service is often referred to as "Meals on Wheels" and provides for the preparation and delivery to the CAP/DA beneficiary's home of one nutritious meal per day. Special diets may be allowed.

This service can cover one home meal such as Uber Eats, DoorDash, Grub Hub, nutritionally balanced frozen meal, or a similar service.

Limits, Amount And Frequency

One (1) meal per day

Oral nutritional supplements are not covered.

Qualified Providers(s)
Agencies or organizations that meet Division of Aging and Adult Services requirements for home delivered meals and comply with 10A NCAC Chapter 06 Subchapter K.

Federally Recognized Tribes

GOODS AND SERVICES

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

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

Participant goods and services are items that are intended to:

a. increase the CAP/DA beneficiary's ability to perform activities of daily living (ADLs) or instrumental activities of daily living (IADLs); 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 brushes Long handle shoehorns Elastic shoelaces Bath tap turners	Button aids Zipper pulls Socks aids	Reacher and grasping aids Door knob 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	Arthritic 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	Standing aid Bed raisers Orthopedic pillows Wheelchair canopy Repair to broken eyeglasses frames

Goods and services may also include the coverage of waiver-specific protective equipment (wipes, hand sanitizer, disinfectant wipes and spray, thermometer, facial tissue and bio-hazard waste bags) when qualifying conditions are met.

Coverage of medication dispensing boxes, hypoallergenic pillows, blinds and housing safety and quality inspection are coverable, when qualifying conditions are met.

Non-medical transportation services are intended to allow CAP/DA 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/DA beneficiary cannot exceed $800.00/fiscal year in combination with other approved goods and services.

a. Mile reimbursement - .67 per mile with a maximum radius of 35 miles from the CAP/DA beneficiary's residence. The maximum allowable per trip is $25. 00. 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 $25. 00. The maximum allowable trips per month is three (3).

d. Gas Vouchers - .67 per mile with a maximum radius of 35 miles from the CAP/DA beneficiary's residence. The maximum allowable for one gas voucher per trip is $25. 00. The maximum allowable gas vouchers per month is three (3).

Chore-Declutter and garbage disposal services are intended to cover the following services:
a. One-time home cleaning prior to obtaining occupancy in a new residence;
b. Yard maintenance fee to ensure safe entry in the home, when the pathway into the home poses a hazard as result of storm or weather event;
c. Removal of excessive amounts of garbage in the home or yard that poses a health hazard for the CAP/DA beneficiary; and
d. Service to declutter the home to clear pathways, sitting and sleeping surfaces.

Maximum of $60.00/hour with a maximum of 13 hours per fiscal year or $800.00 in combination with other approved goods and services.

Individual Directed Goods and Services

Services for the CAP/DA beneficiary directing care that provides services, equipment, or supplies not otherwise provided through this program or through the Medicaid State Plan, and the CAP/DA 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/DA beneficiary or responsible party does not have resources to obtain the necessary item or service that shall aid in the prevention or diversion of institutional placement. Individual goods and services are items that are intended to: increase the CAP/DA beneficiary's ability to perform ADLs or IADLs 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/DA beneficiary need 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/DA 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	Button aids Zipper pulls Socks aids	Reacher and grasping aids Door knob grippers Key turners	Arthritic utensils and adaptive utensils	Bottom wipers Bedside commode cushion	Standing aid Bed raisers Orthopedic pillows

Long handle brushes Long handle shoehorns Elastic shoelaces Bath tap 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	No spill cups straw holder two-handle mug Scooper bowls and plates one pull can opener Plate guards Jar openers Bibs	Incontinence disposal system Protectants for a mattress, chair or car seat to protect against incontinence accidents	Wheelchair canopy Repair to broken eyeglasses frames

Goods and services may also include the coverage of waiver-specific protective equipment (wipes, hand sanitizer, disinfectant wipes and spray, thermometer, facial tissue and bio-hazard waste bags) when qualifying conditions are met.

Coverage of medication dispensing boxes, hypoallergenic pillows, blinds and housing safety and quality inspection are coverable, when qualifying conditions are met.

Nutritional Services are services for a CAP/DA beneficiary that provides coverage for physician-ordered health supplements, vitamin or mineral supplements, herbal preparations and over-the-counter medications (OTC) 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/DA 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/DA objectives of avoiding institutionalization.

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

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

Pest Eradication

A service for CAP/DA beneficiary that provides a one-time pest eradication treatment. This service is coverable when the CAP/DA beneficiary is living in their 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 cost of this service shall not exceed $1600.00 per CAP/DA beneficiary over the course of two State fiscal years (July-June); $800.00 maximum for each fiscal year. Participant 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/DA funding;
c. Transportations services provided by CAP/DA must not duplicate or replace the transportation services offered by the Medicaid State Plan;
d. Items that are not of direct medical or remedial benefit to the CAP/DA 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 of 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/DA 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 cameras 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/DA 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.

PERSONAL EMERGENCY RESPONSE SYSTEM

Personal emergency response system is an electronic device that enables CAP/DA beneficiary to secure help in an emergency. The CAP/DA beneficiary may also wear a portable "help" button to allow for mobility. The system is connected to the CAP/DA beneficiary's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

The approved provider must have capability to provide a 24-hour monitoring system.

Limits, Amount And Frequency

One (1) per month

Installation and maintenance are not covered.

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 SUPPLIES

Specialized medical supplies are:

a. Oral Nutritional Supplements: Provided to promote the health and well-being by increasing the ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). These supplies and equipment are necessary to avoid institutionalization and promote continuous community integration. A signed physician's order certifying medical necessity for the supply is required.
b. Incontinence Supplies: provided to assist with bowel and bladder management and skin integrity are necessary to avoid institutionalization and promote continuous community integration. A signed physician's order certifying medical necessity for the incontinence supply is required.

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

a. comprehensive Multidisciplinary declaration of needs assessment completed by the case manager identifying equipment, supply, adaptation, or modification needs; and
b. copy of the physician's order, when determined to be applicable.

Limits, Amount And Frequency

Incontinence Supplies and Oral Nutritional Supplements: Based on comprehensive needs assessment

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/DA beneficiary that provides for training, orientation, and treatment regimens, regarding the nature of the illness or disability and its impact on the CAP/DA beneficiary and family for the individuals who provide unpaid care, support, training, companionship, or supervision which may include family members, neighbors, friends and companions. The purpose of this training is to enhance

the decision-making ability of the beneficiary, the ability of the beneficiary to independently care for themselves, or the ability of the family member in caring for the CAP/DA beneficiary.

Training and education consists of information and techniques for the use of specialized equipment and supplies and updates as necessary to maintain health and safety and well-being. All training and education services are documented in the service plan as a goal with the expected outcomes. This service covers conference registration and enrollment fees for classes.

Service is provided by community colleges, universities, or an organization with a training or class curriculum approved by NC Medicaid.

This service can cover violence intervention services, when qualifying conditions are met.
To ensure the direct care worker who is not hired through a provider agency is trained in core areas, specific training courses may be authorized for payment when qualifying conditions are met.

Limits, Amount And Frequency

Service is limited to $500 per fiscal year (July 1- June 30).

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

Individuals who are paid service providers are excluded from this service.

Personnel hired through a Home Care Agency, Home Health Agency, Hospice Agency 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 Case Management Entity (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/DA. CAP/DA services shall not cover items that are covered by one of these programs but were denied for a particular CAP/DA 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 beneficiary;
c. reimbursement for registration fees when participation occurred prior to the service request; or
d. reimbursement for licensing, certification, or credentialing.

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; 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 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.

Appendix C: 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 shall identify areas that you are knowledgeable and areas that you may need additional help. These tools shall also assist you in identifying your personal care needs and the required skills your hired employee must assure your health, safety, and well-being. Once you complete the self-assessment questionnaire; you shall 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 shall also be used to identify your training needs and confirm the ability of your employee(s). This tool shall 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: an individual has health/personal care work experience*
  - *Training provided: employer shall provide training to employee on selected tasks*

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 they provide?
   ☐ 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, stepparent, 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 must 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.

No knowledge/experience	I have no knowledge or experience in this area; extensive training is needed.
Minimal knowledge/experience	I have some knowledge and experience in this area; substantial training needed.
Substantial knowledge/experience	I have advanced knowledge and experience in this area; minimal training is needed.
Extensive knowledge/experience	I have expert knowledge and experience in this area, and little training is 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)	☐	☐	☐	☐
Setting job standards/responsibilities for an employee(s)	☐	☐	☐	☐
Completing an employee performance review	☐	☐	☐	☐
Reviewing an employee(s) work tasks and timesheets	☐	☐	☐	☐
Creating a job description	☐	☐	☐	☐
Resolving issues/conflict with an employee	☐	☐	☐	☐

	No knowledge/ experience	Minimal knowledge/ experience	Substantial knowledge/ experience	Extensive knowledge/ experience
Finding other available services/resources in the community	☐	☐	☐	☐
Planning for back-up or emergency care	☐	☐	☐	☐
Medicaid fraud, waste, and abuse	☐	☐	☐	☐
Tracking/monitoring use of Medicaid services	☐	☐	☐	☐

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 shall 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 shall result in my removal from the consumer-direction model of care and I shall 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 they have 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 consultation with NC Medicaid shall 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: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
toileting		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
incontinence care		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
dressing		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
personal hygiene		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
transfers/ambulation positioning		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
fall prevention		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐

		Training provided: ☐Yes No ☐
feeding/meal prep		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
vital signs/ monitoring		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
therapy reinforcement		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
G-tube/J-tube care		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
IV fluids/site check		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
administering/ monitoring medication		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
seizure management		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
apnea monitoring		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
catheter care		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
wound care		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
housekeeping		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
shopping		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
meal preparation		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐

transportation		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
other		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
other		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐
other		Previous caregiver: ☐Yes No ☐ Hlth./pers. care experience: ☐Yes No ☐ Training provided: ☐Yes No ☐

Task List and Employee Competency Validation Signature Page

My signature indicates that I have completed the task list and confirmed the skill set of the employee(s) that I intend to hire. I understand that an employee(s) is not required to be a licensed health care professional to provide my care needs. I have determined that my employee(s) has the competencies to complete the tasks required for my care and I take full responsibility of hiring, training, and supervising the employee(s) I hire and ensuring that they maintain the requirements needed to provide my care.

Individual acting as employer name: Beneficiary name:

Individual acting as employer signature: Date signed:

The care advisor's signature indicates that they have reviewed the completed task list and employee competency validation.

Care advisor name:

Care advisor signature: Date signed:

Appendix E: Created August 2018 Revised: November 2018

Appendix E: 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 their 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 with 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 quality 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 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 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 replace 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 shall 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 0-17 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 17, 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, can be selected and receive payment to provide my care, when 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 shall 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 with 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 shall incur the medical expenses of the established amount before my Medicaid is made available. I must also pay my selected providers the cost of these medical expenses incurred.
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 the consumer-directed option, 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 cannot 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 within 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 participation in the Community Alternatives Program may end.

CAP Beneficiary Name: _____

Legally Responsible Person or Primary Caregiver Name:

_____

_____ _____

CAP Beneficiary Signature Date

_____ _____

Legally Responsible Person or Primary Caregiver Date

Case Manager

Appendix F: Glossary of CAP Terms

Activities of Daily Living (ADLs)

Basic personal care usually performed by an individual during the day, including ambulation, bathing, bed mobility, dressing, eating, personal hygiene, toilet use, and transfers. A CAP/DA beneficiary must require assistance with a minimum of two ADLs that are not age-appropriate personal care needs; and are unable to perform these tasks independently. These activities are directly linked to the beneficiary's medical condition or diagnosis described and documented on a validated assessment. These activities are usually performed by unlicensed paraprofessionals and do not constitute skilled medical or skilled nursing care. However, if a CAP/DA beneficiary requires nursing services, the nurse would be expected to perform or assist the beneficiary with their ADLs.

a. **Bathing** – Ability to take a full-body bath, shower, bed bath or sponge bath, shampooing, and, transferring in and out of the tub or shower and drying off;
b. **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;
c. **Eating** – Ability to feed self-food and drink liquids orally;
d. **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;
e. **Personal hygiene** – Ability to perform grooming activities such as brushing teeth, combing hair, washing face and hands, and skin care;
f. **Toileting** – Ability to use the toilet, commode, bedpan, urinal and ability to transfer on and off the toilet, cleanses, and adjust clothes; and
g. **Transfer** – Ability to move between surfaces, to and from the bed, chair, wheelchair, vehicle and standing position.

Administrative Authority

NC Medicaid shall maintain its authority over rules, regulation and policy that govern how the CAP/DA waiver is operated. The operation of the CAP/DA waiver 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.

Assessment Assignment

An applicant or beneficiary who has met the basic eligibility requirement of level of care and has been assigned a CAP/DA assessment waiver slot. The beneficiary is approved for an assessment to identify clinical need for CAP/DA waiver services.

Assurance

The commitment by a state to operate a Home and Community-based services (HCBS) waiver program according with statutory requirements.

Applicant

An individual seeking to participate in the Community Alternatives Program for disabled adults (CAP/DA).

Beneficiary

An individual receiving Medicaid benefits.

Case Management Entities (CME)

Appointed agencies to act as the lead entities for waiver operations in a county. The appointed entity is the local entry point and approval authority for CAP/DA services. The lead entity is appointed by NC Medicaid to be responsible for the day-to-day case management functions for potential and an eligible CAP/DA beneficiary. These agencies may include county departments of social services, county health departments, county agencies on aging, 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

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

Biologically related

Related by direct genetic lineage rather than by marriage or adoption.

Case Management Services

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. Waiver case management services are defined as services furnished to assist individuals in gaining access to needed medical, social, educational and other services.

The CME shall coordinate the provision of all services and list them in the plan of care.

Community Alternatives Program (CAP)

A Medicaid CAP 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/DA
c. Community Alternatives Program for Disabled Adults choosing consumer-directed services: CAP/CD

Coordinated Caregiving Services

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

a. Supports full access to the greater community;
b. Is selected by the beneficiary from among settings options;
c. Ensures a beneficiary's 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-Directed Care

An alternative option offered under the CAP/DA waiver. Consumer-directed is self-directed care option for a CAP/DA beneficiary and their caregivers who wish to remain at their primary private residence and have increased control over their own services and supports. It offers a CAP/DA 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 Need-Based Assessment

A collaborative process that is used to obtain information about an individual, including their 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/DA services as well as the development of the service plan.

Conflict of interest

A situation in which a person is in a position to derive personal benefit from actions or decisions made in their official capacity.

Disenrollment

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

NC Medicaid

NC Medicaid is designated as the administrative authority over the Waiver. NC Medicaid manages the CAP Waiver. NC Medicaid develops 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 appointed entities. NC Medicaid is also required to provide training and technical assistance to lead entities.

CAP Business System

A Web-based software application developed by an approved Medicaid contractor to support the operations of CAP Waiver under the provision of 1915 (c) Home and Community-based services (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/DA beneficiary is excluded from capturing EVV data.

Emergency plan

A document that identifies important contact and care needs when the CAP/DA beneficiary or primary caregiver is experiencing an emergency. This document also provides 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 plan also contains disaster planning.

Employer Authority

A concept of consumer-directed care that allows a CAP/DA beneficiary to exercise the choice and control over the individuals who furnish CAP/DA 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. This model is not used in the CAP/DA waiver.
b. Common Law Employer- This option designates the CAP/DA 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 fiscal contractor performs employer-related tasks on behalf of the CAP/DA beneficiary but does not serve as the common law employer of the hired direct staff. This option is used in the CAP/DA 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/DA service or supply unless exemptions are granted.

Financial Management Services

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

Freedom of Choice of Provider Form
A form signed by the CAP/DA 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 when 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/DA Waiver, according to 42 CFR 441.302 (a).

Home and Community Based Services

Services, not otherwise furnished under the State's Medicaid plan, are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

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.

Equipment, modification and technology

Equipment and physical adaptations or modification to the CAP/DA 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).

Independent Assessment Entity

An organization procured by NC Medicaid to manage and provide oversight for the assessment for interested applicants seeking participation in the CAP/C or CAP/DA programs. The assessments contain the service request for and the initial comprehensive assessment, and when applicable the annual and change in status assessments

Individual

A person applying for initial participation in the CAP/DA waiver regardless of Medicaid eligibility.

Individual Risk Agreement

An addendum to the service plan 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 their personal choices, through surrogate decision makers, or through planning team consensus.

In-Home Aide

An In-Home Aide is a certified professional provided through a licensed home care agency that provides supportive assistance to individuals receiving personal care under this clinical coverage policy.

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.

In-Home Respite Services

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

Institutional Respite Care

Institutional respite care is the provision of temporary support to the primary caregiver(s) of the CAP/DA beneficiary by taking-over care of the CAP/DA 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 town for some extended period of time.

Instrumental Activities of Daily Living (IADLs)

Normal day-to-day activities are performed by a CAP beneficiary or responsible party. These activities are necessary for maintaining a beneficiary's immediate environment. These activities are 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 Waiver

A disability of medical and physical abnormalities includes a primary medical diagnosis 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 reports Alzheimer's or dementia). 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.

Money Follows the Person (MFP)

A state demonstration project that assists people who live in **inpatient facilities** to move into their own communities with supports. MFP has four objective components:

a. Increase the use of home and community-based services (HCBS) and reduce the use of institutionally based services;
b. Eliminate barriers and mechanisms in state law, state Medicaid plans, or state budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice;
c. strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and,
d. ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

NC Medicaid

NC Medicaid is designated as the administrative authority over the Waiver. NC Medicaid manages the CAP/DA Waiver. NC Medicaid develops 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 delegated entities. NC Medicaid is also required to 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 (DHHS), that allows provider enrollment in the Medicaid program and claim submittal to Medicaid program.

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 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/DA beneficiary has a legal guardian. The case manager is not expected to keep copies of this documentation or submit the documentation to DHHS designated entity.

Parent or legally responsible representative, as defined here, shall not be the paid provider of any CAP/DA service or supply unless an exemption is approved.

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/DA waiver.

Participant Notice

Written notification to the agency or agencies providing regular State Plan services to inform of CAP approval and participation. The notice documents verify the non-CAP home and community care services the beneficiary is receiving (or shall receive pending Medicaid approval) and reminds the provider to coordinate any changes with the case management entity (CME).

Personal Care Assistant

A personal care assistant is a paraprofessional provided through the consumer-directed option who provides hands-on assistance to a CAP/DA beneficiary receiving personal care under this clinical coverage policy. The personal care assistant is hired by the CAP/DA beneficiary or representative to provide help with personal care and home maintenance.

Personal Maintenance Tasks are basic instrumental activities of daily living tasks that must be performed in association with the required assistance with activities of daily living.

Person-Centered Planning

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

Portable Generator

A generator with a wattage capacity power of 3kW to10kW, used only during an emergency to maintain a life-sustaining device when eligibility conditions are met. The portable generator is not intended for stand-by power (permanent installed generator with an automatic turn-on). A portable generator through CAP/DA services is primarily used on a short-term, temporary 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 beneficiary owns or rents in his own right or the primary private residence where a beneficiary resides with other family members, parents, grandparents, or friends. A CAP/DA beneficiary's primary residence can include a foster care type setting when the CAP/DA beneficiary is between the ages of 18-21. 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 unrelated people can live in the primary private residence of an approved CAP beneficiary. Refer to *Adult Medicaid Manual* for a description of living arrangement for Medicaid refer to: https://medicaid.ncdhhs.gov/

Quarterly

Three calendar months.

Reasonable Indication of need

An individual or active CAP/DA 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 CAP/DA services offered in the waiver 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 service, at least monthly; or
b. 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/DA 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/DA beneficiary's home. This service can also be arranged for overnight care in the home or at a facility (such as a nursing facility or hospital).

Responsible Party

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

Service Request Form

An individual being considered for the CAP/DA services shall require the level of care provided by a nursing facility. A service request form replaces the FL-2 form and must be completed to determine the basic eligibility criteria for level of care and CAP/DA participation. This form has a scoring logic that is comparable to the FL-2 that identifies nursing level.

Short-term intensive

A limited service provision beyond the previously approved service provision amounts to address a change in the CAP/DA 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 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 the purpose 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 orientation 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 new medical diagnosis that requires more skilled care or monitoring.

Staff to Participant Ratio

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

Successful completion of training

Successful completion of CAP/DA training is when:

a. The applicant or beneficiary receives a certificate of participation; or
b. The applicant or beneficiary receives a written acknowledgement that the requirements of the training were met.

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 aide or respite.

Willingness and Capability (Consumer-Directed Model of Care)

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 case management entity (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: Emergency Back-Up 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 they are 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/College/University; and My primary teacher/contact staff 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,_____shall help with my Activities of Daily Living.

IMPORTANT TELEPHONE NUMBERS:

Name:_____ Telephone #: _____

Name:_____ Telephone #: _____

Name:_____ Telephone #: _____

Appendix H: Individual Risk Agreement

INDIVIDUAL RISK AGREEMENT

The risk(s) [situation, conditions, circumstances that impact health, safety and well-being] that have been identified below have been determined and the CAP/DA-Choice 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 CAP beneficiary has negotiated an agreement with measurable time frames. Risks that have been identified shall be continuously monitored and re-evaluated throughout the length of the agreement. The beneficiary is aware of the possible consequences of not addressing risks as outlined in their agreement. Individuals under the age of 18, the parent or legally responsible party assume the risk for the CAP beneficiary.

Name –CAP Waiver Beneficiary	**Name** – CAP Case Management Entity

Name(s) – Individuals involved in risk identification and reduction discussion (list all who contributes and supports the agreement)

1. **Describe the risk(s) identified by multidisciplinary team (MDT)** [e.g., exhibited behavior that is deemed to be verbally/physically abusive to others, non-compliance of the Plan of Care; or risk/hazard(s) in the person's environment (pest infestation, lack of sufficient water supply, etc.), unstaffed hours, use of lower acuity services]. Specifically state each area and the responsible person.

2. **Describe the adverse outcome/harm that may result from failure to address the risk(s)** (e.g., decline in physical/emotional health , injury to self or others).

3. **Describe the beneficiary's understanding of identified risk(s) and their plan for addressing it**. (Include the assumed risks, training oversight and emergency procedures)

4. **What alternative measures may be used by the case management entity, the beneficiary, or by their 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 case management entity have been explained to me. I accept the risk(s) associated with my choice, decision or preferred course of action.

SIGNATURE – Beneficiary / Legal Representative	Date Signed

Appendix I: CAP/DA Resources

How to Make a CAP/DA Referral

A referral may also be made by calling 833-522-5429 or faxing the completed referral form to 833-470-0597.

NC LIFTSS Website

Assisting families to direct their care through consumer direction

Consumer Direction National Resource