

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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Request Information

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

B. Program Title:

Community Alternatives Program for Children

C. Waiver Number: NC.4141

Original Base Waiver Number: NC.4141.

D. Amendment Number: NC.4141.R06.02

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

05/01/20

Approved Effective Date: 05/01/20

Approved Effective Date of Waiver being Amended: 03/01/17

2. Purpose(s) of Amendment

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

The purpose of this amendment includes the following:

1. To update Appendix A and D to describe the roles and responsibilities of a newly acquired contracted vendor, an independent assessment entity to assist the SMA to determine initial eligibility for waiver enrollment. The contracted vendor's responsibilities will be implemented by July 2020.

Appendix A was also updated to reflect name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid.

2 To update Appendix B to describe the new criteria for the target population, medical fragility. Appendix B including QIS was updated to identify responsible party for data collection, frequency of data collection and sampling approach as result of name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid.

3. To update Appendix C to expanded service definitions for: home accessibility and adaptation, participant goods and services, vehicle modification, respite, In-home aide services and Pediatric Nurse Aide. This Appendix including QIS was also updated to reflect responsible party for data collection, frequency of data collection and sampling approach as result of name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid.

4. To update Appendix D to clearly describe the service plan development requirements subject to the implementation of an independent assessment entity. This Appendix including QIS was also updated to reflect responsible party for data collection, frequency of data collection and sampling approach as result of name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid. The Independent Assessment Entity will fully implement by July 2020.

5. To update Appendix E to show budget and employer authority for the new goods and services added to Appendix C. This Appendix along with QIS was also updated to reflect responsible party for data collection, frequency of data collection and sampling approach as result of name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid.

6. To update Appendix F to reflect responsible party for data collection, frequency of data collection and sampling approach as result of name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid.

7. To update Appendix G to clearly describe the new requirements for critical reporting management. This Appendix along with QIS was also updated to reflect responsible party for data collection, frequency of data collection and sampling approach as result of name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid.

8. To update Appendix H to reflect responsible party for data collection, frequency of data collection and sampling approach as result of name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid.

9. To update Appendix I to clearly describe the financial integrity and accountability requirements and the management of rates, billing and claims. This Appendix along QIS was updated to reflect responsible party for data collection, frequency of data collection and sampling approach as result of name changes of the fiscal contracted vendor (MMIS), CAP IT system (CAP Business system) and the State Medicaid Unit, NC Medicaid.

10. To update Appendix J in cost neutrality demonstration tables to show the reimbursement methodology for case management services and financial management services for waiver years 3-5 and to include the new goods and services as listed in #11 below.

11. To separate participant goods and services into five distinct goods and services types, participant goods and services, individual-directed goods and services, non-medical transportation, nutritional services and pest eradication.

3. Nature of the Amendment

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

concurrently (*check each that applies*):

Component of the Approved Waiver	Subsection(s)
<input type="checkbox"/> Waiver Application	
<input checked="" type="checkbox"/> Appendix A Waiver Administration and Operation	A-3, A-4, A-7
<input checked="" type="checkbox"/> Appendix B Participant Access and Eligibility	B-1-b/c; B-6-b/c; B-6-I/J and QIS
<input checked="" type="checkbox"/> Appendix C Participant Services	C1-C3 & QIS
<input checked="" type="checkbox"/> Appendix D Participant Centered Service Planning and Delivery	All sections
<input checked="" type="checkbox"/> Appendix E Participant Direction of Services	E-1,g and E-1 iii & QIS
<input checked="" type="checkbox"/> Appendix F Participant Rights	F-3
<input checked="" type="checkbox"/> Appendix G Participant Safeguards	QIS
<input checked="" type="checkbox"/> Appendix H	H-1a
<input checked="" type="checkbox"/> Appendix I Financial Accountability	I-1 & QIS
<input checked="" type="checkbox"/> Appendix J Cost-Neutrality Demonstration	J-1; J-2ci and J2-d

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

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

Updated the criteria to meet the target group eligibility, but did not modify the target group.

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

1. Request Information (1 of 3)

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

B. Program Title (optional - this title will be used to locate this waiver in the finder):

Community Alternatives Program for Children

C. Type of Request: amendment

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

☐ 3 years ☒ 5 years

Original Base Waiver Number: NC.4141

Waiver Number: NC.4141.R06.02

Draft ID: NC.019.06.02

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date of Waiver being Amended: 03/01/17

Approved Effective Date of Waiver being Amended: 03/01/17

1. Request Information (2 of 3)

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

☒ **Hospital**

Select applicable level of care

☒ **Hospital as defined in 42 CFR §440.10**

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

☒ **Not applicable**

☐ **Applicable**

Check the applicable authority or authorities:

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

☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

☐ **§1915(b)(1) (mandated enrollment to managed care)**

☐ **§1915(b)(2) (central broker)**

☐ **§1915(b)(3) (employ cost savings to furnish additional services)**

☐ **§1915(b)(4) (selective contracting/limit number of providers)**

☐ **A program operated under §1932(a) of the Act.**

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

☐ **A program authorized under §1915(i) of the Act.**

☐ **A program authorized under §1915(j) of the Act.**

☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

Purpose: This waiver program provides an alternative to institutionalization for individual between the ages of 0-20. These services allow the targeted individuals to remain in or return to an HCB setting. This waiver serves a limited number of medically-complex children who are medically fragile and are at imminent risk due to caregiver network unraveling because of the severity and intensity of the care needs. The array of services of this waiver will lead to a reduction in unplanned institutionalization thus promoting continuous community living.

Goals: Improve/maintain beneficiary capacities for self-performance of ADL and IADLs; improve beneficiary compliance with accepted health and wellness prevention, screening/monitoring standards; reduce beneficiary health and safety risks; implement strategies to avoid unplanned hospitalizations; avoid ER visits as a means for receiving primary care; enhance beneficiary socialization and reduce social isolation; reduce risks of caregiver burnout; increase caregiver capacities; enhance beneficiary awareness self-management of chronic conditions; foster a more engaged beneficiary; promote a positive beneficiary personal outlook; improve informal caregiver(s) outlook and confidence in their caregiving role.

Objectives: QI is responsibility of SMA and jointly shared with appointed agencies. The case management entities and providers cooperate with all quality management activities by submitting all requested documents, including self-audits, within defined timeframes and by providing evidence of follow-up and corrective action when review activities reveal their necessity.

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

Organization Structure: NC Medicaid is the administrative authority and outlines the policies/procedures governing the waiver. SMA appoints local entities to provide the day-to-day operation of the waiver to ensure the primary six waiver assurances are met. Medicaid approved entities are appointed by SMA and attest to this appointment by signing the clinical coverage policy specific to the waiver that explicitly outlines responsibilities, required benchmarks and monthly waiver compliance areas. This agreement will also outline remediation methods when non-compliance is identified as well as corrective action steps to include penalties and sanctions. **Service Delivery methods:** 1. The case management entity shall submit to DHHS contractor the following for waiver entrance and service delivery: a. HCBS SRF along with the Physician Attestation in Appendix A, to determine basis eligibility for participation in the CAP program. The SRF establishes initial eligibility and is the first basic component of determining whether a beneficiary is appropriate for CAP services. b. All sections and required fields on Service Request Form must be completed in its entirety to establish eligibility determination for CAP participation. The sections and fields on the form include: 1. Service request; 2. Beneficiary demographics; 3. Beneficiary conditions and related support needs; 4. Informal caregiver availability; 5. Attestation by Physician.

2. The case management entity designated assessors shall complete an initial and annual multidisciplinary comprehensive needs assessment on each beneficiary to determine medical, functional and social acuity level to plan for all the beneficiary's assessed needs. a. Date of LOC request and determination; c. The multidisciplinary comprehensive assessment that identified assessed needs and level of acuity functioning. d. The completed and signed person-centered service plan that identifies the CAP and regular State Plan services in the amount, frequency, duration and scope. 3. The medical, functional and social information collected through the multidisciplinary comprehensive needs assessment are documented in a POC. The POC specifies the person-centered goals, objectives and formal and informal services to address the identified medical and functional care needs of an approved CAP beneficiary. The services documented on the POC effectively meet the needs identified in the assessment. 4. If the CAP beneficiary or legal representative accepts the person-centered service plan by an approved signature, CAP participation is approved. The case management entity shall authorize selected providers according to the approved service plan through service authorizations.

e-CAP will carry out the following: 1. Quality Framework for level of care, administrative authority, service plan, qualified providers, health and welfare, and financial accountability. 2. Critical Incident Reporting System for the waiver programs. The e-CAP system will provide the platform for the State's Critical Incident Reporting System. 3. HCBS assurance of health and welfare through case management functions of assessing, planning, monitoring, linking and follow-up that are organized and easily tracked for continuous quality improvement strategies.

3. Components of the Waiver Request

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

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

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

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

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

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

- ☒ **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ☐ **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

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

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

H. Quality Improvement Strategy. **Appendix H** contains the Quality Improvement Strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ☐ Not Applicable
- ☐ No
- ☒ Yes

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

- ☒ No
- ☐ Yes

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

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

- ☐ **Limited Implementation of Participant-Direction.** A waiver of statewide requirements is requested in order to make

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

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

5. Assurances

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

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on

the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are inpatients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and

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

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

Public Input for 2019 amendment: Stakeholder workgroups convened in the months of July-December 2018 to review the clinical coverage policy that guides the administration of this waiver. The workgroups reviewed the policy to assess the areas for clarity, ease of access and barriers to care. The recommendations from those workgroups were made to clarify the criteria for the target population, to clarify waiver terms and to expand the service definitions to address social determinants of health and undue stress on the caregiver. An Advisory Group reviewed and discussed the changes. The amended waiver was posted for a 30-day public comment period on August 23, 2019 along with the revision made to the clinical coverage policy. Because of the timeframe of the public posting, an engagement meeting was held on 2/11/2020 to restate amendments.

A number of comments were received pertaining to the requirement that Home Health providers when providing a skilled intervention such as tube feeding must have a nursing license. Because the requirement for a nurse license is regulated by the Division of Health Service Regulation, the waiver guideline must be in compliance.

Comments chain-letters were received that described discrepancies in the policy and the waiver and a request to make the language consistent in both documents. Because the waiver application is a technical document and the policy is a guidance document used by waiver participants and providers, requirements in terms of the descriptive words were different. Action by the SMA, the waiver application and the clinical coverage policy were updated for consistency. Other clarifying changes were made.

Below are the comments received, also refer to Additional Information section

Comment 1:

Pediatric Nurse Aide Home Health providers shall comply with 10A NCAC Chapter 13 Subchapter J; and be approved under the nurse taxonomy code of 251J00000X) -

the reason i feel this should not take effect is because as a company that has served many PNA cases throughout the years, Not only will the new change in policy create higher debt for small home-health businesses, it also takes away the opportunity to make a difference in a child's life. I speak on this change because as a company that has a current PNA case that we have held for many years, not being able to afford the annual fees for the new policy changes means we cannot keep the current PNA case / cna that we have had for over 5 years and it also means that we can no longer service PNA cases that are not able to be served by other home health agencies due to the lack of staff or whatever the situation may be which hinders the care for that child. If for some reason this policy should take effect, current PNA cases that are serviced by non-accredited agencies, like Angel Hands, should be grandfathered in; not only for the child's well being and comfort but also for the family / caregiver involved after so many years with one company that has done great things for the case.

Not only would accreditation affect the current PNA case in having to obtain a different agency that is accredited, but it limits us to not being able to give the safe, quality ,effective care to future PNA cases. Perhaps the accreditation can be substituted by a certification that is cheaper annually than the accreditation? There must be another way to audit an agency and require certain policies be in effect than having to become accredited with the taxonomy code. I do know that as an agency that currently services PNA cases, we do require paperwork and training that could be used as evidence to safe practice or perhaps even used as a credited source to keep PNA requirements to the needed level. I would also suggest that instead of pushing agencies to gain one of the accreditation, it would be much more cost effective to the companies and less harmful to the current / future cases to perhaps have an annually or bi-annually audit by the PNA case manager / state representative. They both would serve the same purpose however one would not cause such hardship with the change of policy.

Comment # 2:

It is a policy error to require that Nursing Care be on the license of any Home Care agency providing Pediatric Nurse Aides to patients with feeding tubes. And your subsequent requirement that NCTracks add taxonomy code 251J00000X. Remove this from the policy.

First of all Nursing Care on a Home Care agency's license refers to Private Duty Nursing, it has nothing whatsoever to do with PNA level care. That care is provided by Certified Nursing Assistants who either have CNA1 plus 4 training or who are CNA2s. RNs don't provide the care.

Secondly, if it is your intent is that Home Care agencies RNs provide proper oversight of PNA cases with tube feeding, adding this will not accomplish your goal. It's completely unrelated. RN oversight is already required now, so if a few agencies aren't doing what they are supposed to do now, adding a completely unrelated requirement certainly isn't going to fix that problem now is it? No it isn't.

As you know, no agency provides PNA level Home Care without a service authorization from the State that specifies what care is required. As you know, the regulations already require PNA training, and training in tube feeding. The RN

for an agency is already required to do a task competency check off as well as an aide receiving Board of Nursing course approved training before doing tube feeding. All of these requirements already exist now. If an agency isn't doing them, what you propose won't change that now will it? No.

As you know, the DME company is who gets the doctor's order for tube feeding and who provides the equipment and instruction to the family on what to do. The Home Care agency's RN comes into the home and reviews those instructions as well as the family's tube feeding schedule so that she can instruct the aide in what to do and when to do it on the care plan.

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

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

7. Contact Person(s)

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

Last Name:

Staton

First Name:

Betty v

Title:

Administrative Service Manager

Agency:

NC Medicaid

Address:

2501 Mail Service Center

Address 2:

1985 Umstead Drive

City:

Raleigh

State:

North Carolina

Zip:

27699-2501

Phone:

(919) 527-7093

Ext:

☐

TTY

Fax:

(919) 733-6608

E-mail:

betty.j.staton@dhhs.nc.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State:

North Carolina

Zip:

Phone:

Ext:

☐

TTY

Fax:

E-mail:

8. Authorizing Signature

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

Signature:

Betty Staton

State Medicaid Director or Designee

Submission Date:

Apr 21, 2020

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

Last Name:

Richard

05/06/2020

First Name:

Dave

Title:

Deputy Secretary, NC Medicaid

Agency:

NC Department of Health and Human Services - Division of Health Benefits

Address:

1985 Umstead Drive, Kirby

Address 2:

2501 Mail Service Center

City:

Raleigh

State:

North Carolina

Zip:

27699-2501

Phone:

(919) 855-4101

Ext:

☐

TTY

Fax:

(919) 733-6608

E-mail:

Attachments

Dave.Richard@dhhs.nc.gov

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

05/06/2020

milestones.

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

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

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

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

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

All you are going to do is cause problems for the hundreds of agencies who do it correctly. Those who don't already have nursing care on their license will now have to try and get it. And NCTracks will have to be willing to add that taxonomy code without generating a crisis, something that it does every single time you add a taxonomy code. That's all that will be accomplished by this additional unnecessary requirement. The only solution to your problem is to work with agencies who aren't following proper procedures to get them on track.

This is adding a regulation for the sake of adding a regulation. It serves no purpose and solves no problem. It just creates a headache for those doing their jobs correctly.

Response: DHSR is mandating the requirement for a nurse license for Home Health or In-Home Aide organization when providing care to CAP/C beneficiaries approved to receive Pediatric Nurse Aide Services for tube feeding administration.

Comment: Since "pest eradication" has been added, please consider adding "mold remediation" as well
p. 38 Qualifications for case manager (CM) or care advisor a. Add "and/or Master's degree" so that it reads, "Bachelor's and/or Master's degree in social

work from an accredited school of social work, and one year of directly related experience of community experience...." Many MSWs have bachelor's degrees in other fields so could technically be required to fulfill the 2 years of direct experience required of those with non-BSW bachelor degrees unless this is changed.

Response: stakeholder involvement will be held to discuss needs in community and waiver services that may mitigate health, safety and well-being concerns; engagement is, approximately 18 months in the future.

Comment: p. 61 Conflict of Interest Protection

Does this still allow a child to receive CM services through an agency that his/her primary caregiver (PCG) works for as long as that PCG is not the child's CM? The

regulations in 42 CFR mentioned only prohibit CMEs from also providing in-home nursing, PNA, or in-home aide services. If the intent is to prohibit a child from receiving CM services through a CME that his/her PCG works for, that prevents freedom of choice. In order to allow freedom of choice in such situations, there could be additional protections built in such as putting in writing that the PCG cannot be the CM for his/her own child, etc. Please clarify in the policy.

Response: The conflict of interest protection policy is a federal mandate and is specific to each case management entity.

Comment: p. 96 Limits, Amounts and Frequency

If legal guardians are allowed to be paid caregivers for their child (when over age 18) in extenuating circumstances, this should extend to children under 18 in similar situations because there would no longer be the requirement that the paid caregiver not be making medical or legal decisions for the beneficiary.

Response: NC Medicaid has opted not to allow parents/guardians of minor children to be paid to provide services to the child for whom they are legally responsible which is consistent with federal guidelines.

Appendix A: Waiver Administration and Operation

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

- ☒ **The waiver is operated by the state Medicaid agency.**

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

- ☒ **The Medical Assistance Unit.**

Specify the unit name:

NC Medicaid

(Do not complete item A-2)

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

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

(Complete item A-2-a).

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

Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

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

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

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Appendix A: Waiver Administration and Operation

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

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

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

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

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

Critical incident and grievance management

The contracted entity will also be responsible for the following:

- Real-time Dashboards: These dashboards provide real-time data concerning the waiver population, allowing the state to monitor performance measures.
- Service Request Form: This digital form requires that all the necessary information required to make a proper evaluation of an applicant's level of care is present. This includes a signed consent form from the waiver participant indicating his or her election to pursue waiver services as opposed to services in an institution.
- Level of Care Assessment (LOC): This electronic assessment takes the information provided in the Service Request Form (SRF) and assesses the applicant's ability to meet the level of care required for the CAP Waiver. Assessments where the applicant does not meet the required level of care are reviewed by Registered Nurses (RN) at the SMA for any mitigating factors that indicate potential errors in information entered in the SRF.
- Assessment of Service Needs: This electronic assessment tool provides a platform for a comprehensive, person-centered assessment of the needs of each individual waiver participant. Additionally, as this assessment tool is hosted digitally, the state retains full access to both the results of the assessment and the assessment tool.
- Electronic Service Plan: The results of the assessment provide direct input into the waiver participant's service plan, assuring that the waiver participant's service plan addresses the waiver participant's assessed needs.
- Automated Tracking of Assessment Dates: The CAP Business system automatically triggers a notice when each waiver participant approaches the anniversary of his or her previous assessment, assuring that each waiver participant is reassessed both for service needs and for LOC on an annual basis.
- Monthly and Quarterly Reporting: The CAP Business system vendor provides both monthly and quarterly reports in addition to the reports provided via the system dashboards. This provides the state with additional information to track program participation and identify issues.
- Critical Incident Report System and Complaint and Grievance Management: The CAP Business system provide access to critical incident form and workflow management to process the investigative steps.

Level of Care Assessment (LOC): This electronic assessment takes the information provided in the Service Request Form (SRF) and assesses the applicant's ability to meet the level of care required for the CAP Waiver. Assessments where the applicant does not meet the required level of care are reviewed by Registered Nurses (RN) at the SMA for any mitigating factors that indicate potential errors in information entered in the SRF.

The SMA is solely responsible for the determination of eligibility for all waiver participants; however, a contracted entity and local agencies assist the SMA with these administrative tasks. The contracted entity is an Independent Assessment Entity (IAE). By July 2020, The independent assessment entity will be responsible for gathering the health care information and coordinating with other health care professional to assist SMA to render a decision for level of care with the sole decision of LOC being made by the SMA. By July 2020, The IAE will also be responsible for validation of participant service plans completed by case management entity; slot utilization management; participant waiver enrollment; and waiver expenditures managed against approved limits.

Independent Assessment Entity (IAE)- When the independent assessment entity is implemented that entity will be responsible for level of care evaluations which includes the service request and assessment; validation of participant service plans completed by case management entity; slot utilization management; participant waiver enrollment; and waiver expenditures managed against approved limits. The IAE shall: a. conduct the comprehensive assessment activities to: 1. Address all aspects of the participant's risk factor pertaining to medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational and other areas; 2. Identify conditions and needs for risk mitigation; 3. Identify informal and paid supports such as family members, medical and behavioral health providers, and community resources to assess whole person care needs; 4. Analyze in a multidisciplinary format the current assessment, previous assessment and other pertinent information to determine risk indicators, health and safety concerns and potential services to mitigate risk factors; and 5. Validate annual and change in status assessments completed by the case management entity to ensure ongoing risk factors and current complexity of need functioning level are being adequately met.

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

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

Appendix A: Waiver Administration and Operation

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

- ☐ **Not applicable**
- ☒ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

To ensure compliance with regulations, SMA utilizes agencies with HCBS experience, proven in the community and have resources to provide specific administrative functions in assessment and case management, and insight on how to ensure the six waiver assurances. The appointed CME accepts their administrative roles and agrees to work collaboratively with SMA in the execution of the waiver by signing the governing Clinical Coverage policy. The appointed CME's primary responsibilities are to ensure waiver practices and that there is continuous quality improvement. The CME is prohibited from providing other Medicaid services when providing case management to a waiver beneficiary; one of the assurances of conflict-free case management.

A Request for Provider is announced on the NC Medicaid website upon a need for a CME. Any agency that has experience in HCBS can submit a proposal to become a CME. Each CME must meet a provider qualification threshold that includes:

currently enrolled as a Medicaid provider and approved to provide services under In-Home Services and Supports. Capable of providing case management by both nursing and social work staff. Demonstrated experience with:

Medically-complex children; HCB case management; web-based automation; qualified staff to ensure case mix and caseload management; fiscal soundness, and reserve resources.

The selected agency shall be able to: 1. Refer a service request to determine basic eligibility for LOC to the CME and the IAE after July 2020. 2. Complete annual comprehensive assessments to ascertain medical, psychosocial, and functional needs for waiver participation. 3. Coordinate and collaborate in a multidisciplinary team approach for the provision of waiver services that prevent institutionalization. 4. Develop a person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration, and frequency. The SMA approves the SP. 5. Conduct monthly monitoring of the service plan with beneficiary and quarterly monitoring with all approved service providers.

CME are prohibited to providing other Medicaid services to a waiver beneficiary who is also providing case management.

The CME is responsible for day-to-day case management functions:

- Provide written authorization for approval/participation in the waiver.
- Provide each waiver beneficiary/primary caregiver freedom of choice among waiver services/providers.
- Provide monthly monitoring of the service plan with waiver beneficiary to ensure safe community living.
- Provide direct observation of hands-on personal care services performed with the waiver beneficiary to include personal care quarterly. A child with a high-risk indicator score as identified in a completed assessment must have a face-to-face visit based on the risk-indicator scores and monthly multidisciplinary team meeting.
- Initiate Due Process tasks when an adverse decision is made and coordinate with waiver beneficiary, providers and due process management vendor.
- Provide assistance, when requested, in verifying whether medical documentation supports nursing facility level of care.
- Mitigate risk when a referral to Children Protective Services is made.
- Provide monthly and quarterly Case Management/Care Advisement to the waiver beneficiary. A child with a high-risk indicator score as identified in a completed assessment must have a face-to-face visit every two months and monthly multidisciplinary team meeting.
- Review all initial and revised service plans to provide written authorization for approval and participation in the waiver.

A home visit must be conducted at least quarterly. However, a child with moderate to high risk indicator scores as identified in a completed assessment must have a face-to-face visit as indicated per risk and monthly multidisciplinary team meeting. This visit is conducted in waiver beneficiary's primary residence to ensure health and well-being. The CME will observe the home environment for the provision of services by paid caregiver(s). Annually, a home visit must be conducted to perform the annual reassessment.

•Make a monthly or as needed visit, based on risk indicators with the beneficiary/responsible party to review the health and care needs, satisfaction with services, and assess the provision of all services/supplies to confirm their continued appropriateness.

•Hold a quarterly multidisciplinary treatment team meeting with providers receiving a service authorization/participation notice to review the provision of and continued appropriateness of service plan. A child with a high-risk indicator score as identified in a completed assessment must have a face-to-face visit in accordance with his or her risk-indicator score with the MDT.

•Document changes in medical, functional and psychosocial status.

•Review quality assurances reports monthly to remedy any identified issues.

•Contact the waiver beneficiary/responsible party following the construction/installation of home modifications

to confirm that the modifications safely meet the waiver beneficiary's needs.

- Contact the waiver beneficiary/responsible party within 48 hours of learned discharge from a hospital/rehabilitation facility to assess health status and changes in needs.
- Ensure that services offered to a waiver beneficiary do not duplicate other services.
- Locate and coordinate sources of assistance from informal sources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal supports.
- Ensure that the policies/procedures of the waiver are upheld to maintain the health/well-being of the waiver beneficiary.
- Authorize services in the amount/duration/frequency as identified on the service plan along with a description of the tasks. Ensure that waiver beneficiaries are aware of their right to select from among enrolled service providers and choose waiver services of their choice.

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

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

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

The appointed Independent Assessment Entity (IAE) accepts their administrative roles and agrees to work collaboratively with SMA in the execution of the waiver by complying to the scope of work in their contract and abiding by the governing Clinical Coverage policy. The appointed IAE's primary responsibilities are to perform initial eligibility decisions for waiver participation and annual quality assurance of the service plan. The IAE will be selected through a rigorous RFP process. The selected entity will be required to:

1. Process a service request to determine basic eligibility criteria for LOC.
2. Complete comprehensive assessments to ascertain medical, psychosocial, and functional needs for waiver participation.
3. Coordinate and collaborate in a multidisciplinary team approach to decide of a reasonable indication for at least one waiver service that may prevent an institutional placement, maintain community placement or community integration.
4. Provide quality overview of the completed person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration, and frequency.

The State Medicaid Agency has a contract with an IT vendor to provide an electronic case management and business process system for the daily management of waiver administrative activities. This Business system provides case managers, beneficiaries and providers the means by which continuous quality improvement strategies are organized, tracked and made more effective. The system also provides access to waiver beneficiary eligibility, assessed needs, care planning, monitoring, due process and critical incidences. The IT system's real time access also provides accuracy in care planning and monitoring. The IT system will assist the State Medicaid Agency in ensuring that all policies and procedures are followed per waiver guidelines; processes referrals; ensures waiver beneficiary freedom of choice; ensures quality services; and cooperates with monitoring and reporting activities. The Business system provides for:

1. A coordinated and consistent process to assess, plan, monitor and link beneficiaries who are participating in the waiver;
2. A coordinated and consistent quality improvement strategy framework that continuously improves waiver performance; and
3. A coordinated and consistent methodology to provide quality assurance for the six mandated waiver assurances (Level of Care; Service plan; Qualified Providers; Administrative Authority; Financial Accountability; and Health and Welfare).

The CAP Business system also performs the following:

- Applies prior authorization limits to all waiver services.
- Monitors utilization of waiver services.
- Provides real time data analysis of the performance of the waiver for continuous quality improvement strategies.
- Randomly selects, for the purpose of auditing, case files from appointed case management entities to ensure compliance with the six federal waiver according to all applicable state and federal laws, state and federal rules and regulations, and agency policy.
- Provides alerts and checkpoints to ensure the assessments and service plans are completed per the waiver policy
- Tracks mediation and appeal for Due Process.

The CAP Business system will act as the State's quality assurance system by providing real time reports and data for:

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

The CAP Business system will:

- Perform on-line workflow management processes and tools for the various administrative authority responsibilities related to waiver enrollment, monitoring waiver limits, level of care evaluations, review of service plans, prior authorization of waiver services, utilization management, and quality assurance/quality improvement.
- Process on-line request process for service/level of care determination that is standardized and computerized

for both waiver programs and other HCBS services, as appropriate.

- Generate module for electronically-generated prior approvals for the waiver program, including an interface to MMIS to transmit prior approvals for use in MMIS claims processing.
- Generate quality assurance reporting system for the waiver programs that meets CMS reporting guidelines that can be implemented using a service provider interface, case management interface and administrative authority interface.
- Refine reporting model for a continuous quality improvement program that allows NC Medicaid to analysis quality data state-wide and direct targeted, time-limited quality improvement initiatives state-wide in response to identified quality problems or best practices.
- Implement Web based model for continuing education designed to support NC Medicaid implementation of a continuous quality improvement program.

Appendix A: Waiver Administration and Operation

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

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

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

Each appointed case management entity is required to maintain a compliance rate of 90% at each quarterly assessment. Each month, a compliance score will be generated to inform each case management entity of areas of noncompliance to allow for improvement in noncompliant performance areas. Technical assistance will be provided to the case management entity during each month of non-compliance and at each quarter, if the score is below 90%. The case management entity will be allowed to perform, under a corrective action plan, at less than 90% for a total of 2 consecutive quarters before a decision is made to rescind their case management appointment. During this time span, NC Medicaid will provide technical assistance to assist with quality improvement of noncompliant performances. If after the 2 quarters of technical support (corrective action plan), the score remains below the 90% threshold, NC Medicaid will notify the case management entity that within 60 days their case management entity appointment will be rescinded. A Medicaid Bulletin will be posted to solicit a new provider for that catchment area with a transition timeframe of 60 days. During the solicitation and transition timeline, NC Medicaid will provide close oversight and technical assistance to the relinquishing case management entity to ensure the health and safety of each impacted waiver beneficiary.

If multiple qualified providers submit the required documentation, a selection committee is convened to evaluate the credentials and capacity of the organization given the needs of the service area. An established scale will be used for this evaluation. The organization with the highest score from the scale will be awarded the appointment as case management entity.

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

NC Medicaid will monitor the performance and usability of e-CAP (CAP waiver case management Business system) on a monthly basis. A monthly assessment will be conducted to determine if the case management business system in the areas of waiver entrance, eligibility, assessed needs, utilization limits and health and welfare are functioning per the scope of work and established timelines. Noncompliance area(s) will be remediated quickly through corrective action plans. If noncompliance areas cannot be remediated within a three-month time span, fines and penalties will be imposed. If the non-compliance area(s) span over six months and cannot be remediated, a recommendation will be made to terminate the contract.

Appendix A: Waiver Administration and Operation

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

The State Medicaid Agency will assess performances of all appointed entities through monthly data analysis, quarterly desk-top audits and yearly accountability audits.

The monitoring of those entities is achieved through the objectives and benchmarks outlined through the clinical coverage policy. The State Medicaid Agency will conduct a quarterly evaluation of the performance of each entity through data analysis, complaints and satisfaction surveys. The data analysis will inform if each entity is meeting its established benchmarks and objectives and the quality assurance of the waiver. Each entity must maintain at least a 90% compliance rate of waiver processes such as waiver eligibility, waiver utilization limits and claim reimbursement.

The State Medicaid Agency will monitor, quarterly, the accessibility and usability of the State's MMIS system, NCTracks to ensure claims are processing per waiver business rules. When noncompliance issue(s) are identified, a corrective action plan will be implemented. A root cause analysis will be performed to identify causes and future preventive measures.

The e-CAP system for the case management business processes will be monitored on a monthly basis to ensure accessibility and ease of use for the case manager to perform required waiver functions. The CAP Business system will also be evaluated to ensure compliance of waiver policies and procedures in the areas of waiver entrance, eligibility, assessed needs, utilization limits and health and welfare. A root cause analysis will be performed to identify causes and future preventive measures.

The case management entities are monitored on a monthly basis to ensure compliance to the six waiver assurances and its associated performance measures. Each case management entity is required to maintain a 90% compliance rate of waiver practices to maintain status as the local entry point in the community. The CAP Business system will provide the State Medicaid Agency monthly data analytic reports in the timeliness and accuracy to policy in the areas of level of care, service plan, qualified provider, financial accountability, health and welfare and administrative authority.

The appointed case management entities' primary responsibilities are to ensure waiver practices and that there is continuous quality improvement of the waiver. Public local agencies such as the departments of social services, public health agencies, hospitals, case management agencies and home health organizations that have experience in serving this target population are able to act in the capacity of an appointed case management entity by NC Medicaid. A public Medicaid Bulletin is placed on the NC Medicaid website as well as the State's MMIS website announcing an available service area. A description of the waiver program is provided along with the location of the service area and the demographic of waiver participants. The announcement also lists the required credentials to be an appointed case management entity. Each organization must meet a threshold in order to be appointed. The required threshold consists of:

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

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

The selected agency shall be able to:

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

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

Medicaid providers of waiver services will be monitored on an annual basis through waiver claims and an attestation of waiver compliance.

Appendix A: Waiver Administration and Operation

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

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

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

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

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

Where possible, include numerator/denominator.

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

Performance Measure:

AA-1 Number and percent of case management entities who completed waiver participant's annual recertification of need within the specified timeframe. Numerator: number of case management entities who completed waiver participant's annual recertification of need within the specified timeframe Denominator: number of case management entities

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business management system, case management entities' files and NC Medicaid MMIS

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">CAP Business system case management system, case management entities' files and NC Medicaid MMIS</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

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

Performance Measure:

AA-2 Number and percent of case management entities that submitted a service authorization for waiver services within five days of the approved service plan date.

Numerator: number of case management entities that submitted a service authorization for waiver services **Denominator:** number of case management entities reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entities' files.

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

		95% 5% margin of error
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business System case management system and case management entities' files</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

AA-3 Number and percent of case management entities that processed 95% of the applicants requesting a waiver slot within specified timeline. Numerator: number of case management entities that processed 95% of the applicants requesting a waiver slot within specified timeline Denominator: number of case management entities reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entities' files.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 5px; margin-top: 5px;">CAP Business System case management system and case management entities' files</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

AA-4 Number and percent of case management entities with a core case management responsibility compliance score of 90% or better. Numerator: number of case management entities with a core case management responsibility compliance score of 90% or better. Denominator: number of case management entities

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entities' files.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: CAP Business System case management system and case management entities' files		Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

AA-5 Number/percent of CME experience survey respondent who report overall waiver assistance/guidance was provided by the SMA when required within a timely manner.
Numerator: number of CME experience survey respondent who report overall waiver assistance/guidance was provided by the SMA within a timely manner
Denominator: number of experience surveys

Data Source (Select one):

Participant/family observation/opinion

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business System case management system</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
CAP Business system	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div data-bbox="833 449 1227 525" style="border: 1px solid black; height: 36px; margin-top: 5px;"></div>

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

The appointed CMEs' primary responsibilities are to ensure waiver practices and that there is continuous quality improvement of the waiver. The appointed CMEs are the organizations NC Medicaid have assigned to be the local lead

for waiver management. An organization that seeks designation as the CME must meet the criteria NC Medicaid sets

forth as a qualified provider of home and community based services. When appointed as the CME, these entities are responsible for gathering the information to assist in determining the basic eligibility criteria for waiver participation and completing the assessment to assist in determining level of acuity and need for services to support inclusion into the community. The waiver beneficiary has the freedom to choose a CME at any time. Upon approval for waiver participation, participant rights and freedom of choice are explained. A list of CMEs in their catchment area is offered to each waiver beneficiary for his or her selection.

NC Medicaid uses a case management business system to evaluate all waiver beneficiaries/provider agencies in the

processing/performance of waiver activities. To validate the efficiency and capacity of the CAP Business system programmed to support NC Medicaid administrative operations, the sampling methodology will be a 100% for waiver

year one.

Appointed case management entities that provide the day-to-day oversight of the waiver program are required to meet additional thresholds that validate readiness and ability to provide oversight of the waiver program at the local level.

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

- Program participation –tracks the waiver enrollment date to ensure annual reassessments are performed in a timely manner, by sending alerts to the assigned case manager two months prior to the due date. The system also checks for a level of care determination, a consent form and freedom of choice notice, prior to the approval of waiver participation.

- Waiver entrance- validates medical and functional status are consistent with nursing facility of care, through the approval of a service request form (SRF). When the level of care is met and a waiver slot is available, the CAP Business

system places the SRF in the assignment assessment queue, to prepare for the next phase of waiver entrance (comprehensive assessment) process. Information from the SRF is auto-populated through a method of prompted questions to ensure all medical, functional, behavioral and social needs were holistically assessed. Key risk factors from the assessment auto-populate to the service plan to plan for all identified needs.

- Utilization management- stores all service plans and its associated budget limits to ensure the waiver is cost neutral and does not exceed the established average per capita cost. The CAP Business system places service utilization

limits on all waiver services authorized by the CME to prevent over utilization. The placement of utilization limits ensures a 100% compliance rate of claim reimbursement. Thus allowing waiver services to be paid in the amount, frequency and duration as planned in the service plan. These limits ensure services do not exceed the service plan and to ensure services are not reimbursed prior to the effective date. The Business system has the capacity to run real

time data analytic reports daily for the purpose of claims analysis that allows for quick remediation, if needed.

- Quality Improvement System- has a robust QIS through data analytic that is real time. The data report allows real time discovery and quick remediation, when required. Desktop audits can be performed immediately to evaluate the rate of compliance to waiver practices.

As a safeguard to ensure compliance to waiver policies and practices, and to ensure established benchmarks are met monthly, on a quarterly basis, an analysis of the case management entity's performance will be conducted. All case management entities will be evaluated quarterly against waiver QIS. A score card will be generated through Business system that will be reviewed monthly by the State Medicaid Agency to ensure compliance of waiver

assurances and its associated performance measures. Each quarter, the cumulative results will inform waiver compliance and the need for remediation that could possibly include sanctions until Continuous Quality Improvement (CQI). Continuous failure to comply with waiver assurances will result in case management provider termination.

- A score of 90 and better, the case management entity will be rated an A organization.

- A score of 89 or less, the case management entity will be rated a B organization.

- A score less than 89, the case management entity is in jeopardy of termination.

Each case management entity must maintain a 90% compliance rate on a quarterly basis. The score of each case management entity will be shared with waiver beneficiaries through the Introductory or Annual Letter and freedom of choice documents and other stakeholders through the NC Medicaid website.

The core case management responsibilities include the following:

- assessing, care planning, monitoring, follow-up and linkage. Responsibilities also include waiver enrollment, waiver enrollment managed against approved limits, waiver expenditures managed against approved levels, level of care evaluation, review of participant service plans, prior authorization of waiver services and utilization management.

b. Methods for Remediation/Fixing Individual Problems

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

The State Medicaid Agency has a number of safeguards in place to discover/identify problems/issues within the waiver program when an appointed entity is performing administrative functions. The State Medicaid Agency has appointed a State fiscal contractor and case management entities to perform tasks of participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved limits level of care evaluation; review of waiver beneficiary service plan; prior authorization of waiver services; utilization management; Quality assurance and quality improvement activities.

Upon discovery of non-compliance for an appointed case management entity, the State Medicaid Agency notifies the case management entity of the non-compliant area and requests a corrective action plan to correct the noncompliant

area. Technical assistance and/or training on policies and procedures are provided. State Medicaid Agency approves the corrective action plan and follows-up with the case management entity to ensure the corrective action plan (remediation plan) is completed. If warranted by persistent non-compliance (more than 2 occurrences of the same areas), sanctions are enforced to include enrollment restrictions for 60-days or until the remediation is reached, if remediation efforts cannot be achieved within 60 days. Individuals requesting or waiting for services and active waiver beneficiaries will be notified of the sanction to allow informed choice and selection of another case management entity, if desired. If remediation efforts are not reached, actions will be made to dissolve that entity as an appointed case management entity. Individuals requesting or waiting for services and active waiver beneficiaries will be notified of the inability of the case management entity to remediate noncompliant area(s) to allow selection of another case management entity. In after three months of unsuccessful remediation to include technical assistance, training and suspension of new enrollment, the State Medicaid Agency will initiate termination of the case management entity. A transition plan will be implemented to reduce an access to care concern.

Upon discovery of non-compliance for the CAP IT vendor, the State Medicaid Agency notifies the IT vendor of the non-compliant area(s), requests a corrective action plan to correct the non-compliant area(s) and provide technical assistance and/or training on policies and procedures. The State Medicaid Agency approves the corrective action plan (remediation plan) and follows-up with the IT vendor to ensure the corrective action plan is completed. If warranted by persistent non-compliance, civil financial penalties are enforced. If consistent noncompliant

performance exists, a recommendation will be made to terminate the contract. A transitional plan would be developed prior to the termination of the contract to ensure the health and safety of waiver participants. Upon discovery of non-compliant area(s) exhibited by waiver Medicaid providers, the State Medicaid Agency Program Integrity Unit will investigate and imposed sanction, if necessary, based on the severity of the incident. A recommendation may be made for an action of closure or civil fines.

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

ii. Remediation Data Aggregation

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

Responsible Party(check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 250px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 250px; margin-top: 5px;"></div>

c. Timelines

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

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged		<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)		<input type="checkbox"/>	
	<input type="checkbox"/>	Disabled (Other)		<input type="checkbox"/>	
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury		<input type="checkbox"/>	<input type="checkbox"/>

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Medically Fragile	0	20	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			<input type="checkbox"/>
	<input type="checkbox"/>	Serious Emotional Disturbance			

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

Condition for waiver entrance/enrollment:

1. Meets the Medically Fragile Level of Care (LOC criteria;
2. Meet the eligibility criteria for Long-Term Care (LTC) Medicaid and be assigned to one of the defined Medicaid categories;
3. Have reasonable indication that HCBS would be needed within 30 calendar days of a comprehensive assessment;
4. Requires 1 or more coordinated waiver services to maintain health, safety and well-being in the community; and
5. Requires the management of waiver services and other services to promote community inclusion and integration.

Each waiver beneficiary must meet an established nursing facility LOC to meet the basic waiver entrance criteria. When LOC is determined, the results of the comprehensive assessment identifies the functional level of acuity of either skilled or hospital. The individual cost limit is based on a combination of both nursing facility level of care and hospital level of care.

The definition for medical fragility include the following:

1. A medically fragile individual has a primary chronic medical condition or diagnosis (physical rather than psychological, behavioral, cognitive or developmental) that has lasted, or is anticipated to last, more than 12 months.
2. The individual's chronic medical condition:
 - a. Requires medically necessary ongoing specialized treatments or interventions (treatments or interventions that are supervised or delegated by a physician or registered nurse) without which will likely result in a hospitalization; or
 - b. Resulted in at least four (4) exacerbations of the chronic medical condition requiring urgent/emergent physician-provided care within the previous 12 months; or
 - c. Required at least one inpatient hospitalization of more than 10 calendar-days within the previous 12 months; or
 - d. Required at least three inpatient hospitalizations with the previous 12 months; and
3. The individual chronic medical condition:
 - a. Requires the use of life-sustaining device(s); or
 - b. Requires life-sustaining hands-on assistance to compensate for the loss of bodily function; or
 - c. Requires non-age-appropriate hands-on assistance to prevent deterioration of the chronic medical condition that may result in the likelihood of an inpatient hospitalization.

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

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

- ☐ Not applicable. There is no maximum age limit
- ☒ The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.

Specify:

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

The (CME) shall assist a waiver participant at age 20 to develop an adult transition plan in anticipation of the aging out of this waiver at 12:01 am of the 21st birthday.

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

1. The CME designee shall implement a transition, transfer plan 12 calendar months prior to the birth month.

These coordination activities are:

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

Appendix B: Participant Access and Eligibility

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

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

- ☐ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ☐ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

- ☐ A level higher than 100% of the institutional average.

Specify the percentage:

- ☐ Other

Specify:

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

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

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

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

- ☐ **The following dollar amount:**

Specify dollar amount:

The dollar amount (select one)

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

Specify the formula:

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

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

Specify percent:

- ☐ **Other:**

Specify:

Appendix B: Participant Access and Eligibility

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

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

The data elements retrieved from the service request form and the comprehensive assessment provide assurances of ability to meet waiver participant's needs within the average cost limits of the waiver.

Beneficiary's medical, functional, behavioral, mental and social information will be assessed utilizing a screening tool (Service Request Form). This screening tool will establish initial basic eligibility determination of nursing LOC. This screening tool provides for a comprehensive medical overview and information to help determine intensity of support needs as well as risk factors that may impede health, safety and well-being. This screening tool has a built-in smart logic mechanism that auto-fills the assessment to reduce data entry errors.

An multidisciplinary comprehensive needs assessment is conducted by Lead Agency's social worker and registered nurse initially and annually on each beneficiary to determine medical, functional and social acuity level to plan for all the beneficiary's assessed needs to assure health safety and well-being. The multidisciplinary comprehensive assessment addresses the following areas to assure health, safety and well-being can be maintained within the cost limit:

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

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

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

If program admission is denied due to needs cannot be safely met under the waiver, when all resources are explored and exhausted, referrals to other services are made and the waiver beneficiary is offered due process rights. After admission to the waiver, QA activities related to health, safety and well-being beneficiary's outcomes are performed by the case management entity and NC Medicaid.

Program growth will be closely monitored by the Medicaid agency to determine need for a waitlist or amendment to the waiver to

increase number of unduplicated recipient to be served based on State budgetary limits.

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

- ☐ The participant is referred to another waiver that can accommodate the individual's needs.
- ☒ Additional services in excess of the individual cost limit may be authorized.

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

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

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

On a monthly basis, the assigned case manager or care advisor will assess the beneficiary's needs and service provision to assure health, safety and well-being are maintained within the waiver average cost limit. Every three months, the case manager or care advisors is required to conduct a home visit to observe hand-on assistance of service to ensure amount, frequency and duration are sufficient to needs and health, safety and well-being is maintained in the average cost limits.

Upon discovery or by request, adjustments are made to the POC or level of care. The case manager or care advisor must review supporting documentations to determine the need for a reassessment to determine a change in the beneficiary's level of acuity. A reassessment is performed within 30 days of the request or discovery to review personal health information; caregiver information; medical diagnoses; medication and precautions; skin; neurological; sensory and communication; pain; musculoskeletal; cardio-respiratory; nutritional; elimination; mental health; informal support; and housing and finances to identify medical, functional and social needs. The new assessment is scored through the scoring algorithm that determines the level of acuity. The beneficiary's POC is planned based on the identified LOC identified in the reassessment. If beneficiary is not in agreement with the results of the reassessment, an appeal can be requested by the beneficiary/responsible care giver

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

The case manager or care advisor corresponds with the beneficiary and service providers within 30-days of the change in the participant's condition to identify an alternative care plan to meet the beneficiary's current needs. A reassessment of needs is performed through a comprehensive multidisciplinary assessment conducted by both the social worker and nurse. Adjustments are made to the POC or level of care based upon the summary of findings. An assessment will be conducted on a quarterly basis to assess average cost of care needs. When average cost of care

needs are 75% of the average at two consecutive quarters, NC Medicaid will work with the family and the case manager to assess the appropriateness of waiver services, to identify alternative resources to augment expenditures. When cost of care needs are 100% of the average cost, arrangements must be made to access appropriateness of waiver participation to assure cost neutrality of service provision. If an adverse decision is made, the waiver beneficiary is granted an appeal.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4000
Year 2	4000
Year 3	4000
Year 4	4000
Year 5	4000

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	3950
Year 2	3950
Year 3	3950
Year 4	

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
	3950
Year 5	3950

Appendix B: Participant Access and Eligibility

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

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

- ☐ Not applicable. The state does not reserve capacity.
- ☒ The state reserves capacity for the following purpose(s).

Purpose(s) the state reserves capacity for:

Purposes	
Emergency	
Money Follows the Person	
Military	

Appendix B: Participant Access and Eligibility

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

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

Emergency

Purpose (*describe*):

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

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Money Follows the Person

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

Military

Purpose (describe):

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

Describe how the amount of reserved capacity was determined:

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

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

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

Appendix B: Participant Access and Eligibility

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

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

- ☒ The waiver is not subject to a phase-in or a phase-out schedule.
- ☐ The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity.

Select one:

- ☒ Waiver capacity is allocated/managed on a statewide basis.
- ☐ Waiver capacity is allocated to local/regional non-state entities.

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

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

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

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

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

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

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

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

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

Transfer Policy:

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

The following steps must be completed prior to the transition:

The following steps must be completed prior to the transfer:

1. The identification of the waiver beneficiary's anticipated start date of service;
2. A completed coordinated transition plan between provider agencies;
3. A written narrative of how to plan for the health, safety and well-being of the beneficiary;
4. A transfer request to e-CAP to have record electronically transferred to the receiving county;
5. A confirmed appointment for a home visit by the receiving entity to assess the home environment identifying any health and welfare concerns and planning for mitigation and safety; and
6. An update service plan that informs of the start on the first date of service provisions.

If the beneficiary is aging out of CAP/C

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

- The development of a comprehensive adult transition plan.

Coordination activities shall include:

- A. conference between both entities to derive a comprehensive transition plan that outlines timelines and case management needs;
- B. the transferring entity to provide a breakdown of case management utilization activities to ensure appropriate case management time to manage the beneficiary's need by the new entity;

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

The State Medicaid agency will assessment the remaining case management hours and the utilization of the case management hours by the referring case management agency before An assessment of case final approval of the transfer is granted. This process is necessary to ensure the health, safety and well-being of the waiver beneficiary in terms of access to ongoing case management services.

To coordinate the transition of children's Medicaid to adult Medicaid at age 17.75, the case manager or care advisor will assist the family to file a Medicaid application 90 days prior to the 18th birthday to ensure appropriate Medicaid eligibility prior to the 18th birthday.

For CAP beneficiaries transferring to a different county:

- A. conference between both counties to derive a comprehensive transfer plan that outlines timelines and case management needs;
- B. The case manager or care advisor of the transferring county shall coordinate the transfer with the case manager or the care advisor of the receiving county at least 30 calendar days prior to the anticipated transfer.
- C. The case managers or care advisors of the transferring and receiving counties shall discuss and plan for the health, safety and well-being of the waiver beneficiary.
- D. The electronic health record is transferred to the receiving county at least 10 business days prior to the transfer.
- E. The case manager or care advisor of the receiving county shall arrange for a home visit to assess the home environment to identify any health and welfare concerns to plan for mitigation and safety.
- F. The case manager or care advisor shall coordinate the provision of services to start on the first date of the transfer into the receiving county.

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

Waiver beneficiary requesting to transfer from one case management entity to another and the case management utilization rate is near the maximum allowable or the newly requested case management entity has a waiver compliance a score of 89% or less, the waiver beneficiary will be provided education and consultation of what this means and how these issues may cause concern with health, safety and well-being. Education will also be provided about the possibility that the transfer may not be to grant as a result current performance issues or over the maximum utilization limits. Close monitoring of utilization of case management hours will be carefully analyzed to ensure appropriate use. When data from the CAP Business system identifies inappropriate use of case management time, a root cause analysis will be conducted to validate misappropriation. If evidence warrants misappropriate a corrective action plan will be implement to request Medicaid reimbursement for the miss use of management hours.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- ☒ §1634 State
- ☐ SSI Criteria State
- ☐ 209(b) State

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

- ☒ No
☐ Yes

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

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- ☐ Low income families with children as provided in §1931 of the Act
☒ SSI recipients
☐ Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
☒ Optional state supplement recipients
☒ Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- ☒ 100% of the Federal poverty level (FPL)
☐ % of FPL, which is lower than 100% of FPL.

Specify percentage:

- ☐ Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
☒ Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
☒ Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
☐ Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
☐ Medically needy in 209(b) States (42 CFR §435.330)
☒ Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)
☒ Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)

Specify:

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

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

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

Select one and complete Appendix B-5.

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

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

Check each that applies:

- ☐ **A special income level equal to:**

Select one:

- ☐ **300% of the SSI Federal Benefit Rate (FBR)**
☐ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- ☐ **A dollar amount which is lower than 300%.**

Specify dollar amount:

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

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

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

- ☐ **Aged and disabled individuals who have income at:**

Select one:

- ☐ **100% of FPL**
☐ **% of FPL, which is lower than 100%.**

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

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

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

- ☒ **The provision of waiver services at least monthly**
☐ **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

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

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

- ☐ **Directly by the Medicaid agency**
☐ **By the operating agency specified in Appendix A**
☐ **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- ☒ **Other**
Specify:

The SMA is solely responsible for the determination of the initial and annual LOC for all waiver participants; however, a contracted entity will assist the SMA with this administrative task. By May 2020, an Independent Assessment Entity will be responsible for evaluating initial level of care and reasonable indication of need for waiver services through the oversight of the SMA, refer to Appendix A-3 and D for specific details. An independent assessment entity is an independent organization that does not perform case management services, and is not directly or indirectly affiliated with the prospective or enrolled waiver participant. The independent assessment entity makes initial and ongoing level of care decisions about waiver participation by completing the SRF and needs-based comprehensive assessment eligibility enrollment paperwork. The State Medicaid agency will provide second-level reviews known as registered nurse (RN) exception reviews when the independent assessment entity is not able to definitively decide on level of care. A SMA-employed RN will conduct a second-level review known as registered nurse (RN) exception review when the independent assessment entity identifies that LOC may not be met based of the SMA algorithms of determining LOC and the health information entered in the CAP Business system. During the interim of the procurement of the Independent Assessment Entity, the SMA will continue to work collaborative with case management entities to gather and provide the necessary health information to yield a LOC decision.

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

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

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

The HCBS LOC is comparable to the Nursing Facility LOC clinical coverage with the following exclusions:

This waiver uses the following LOC criteria to evaluate and reevaluate LOC. HCBS Nursing Facility Level of Care Criteria must require a need for any one of the following:

1. Need for services, by physician judgment, requiring:
 - A. supervision of a registered nurse (RN) or licensed practical nurse (LPN); and
 - B. other personnel working under the direct supervision of a registered nurse or licensed practical nurse.
2. Observation and assessment of beneficiary needs by a registered nurse or licensed practical nurse. The nursing services must be intensive and directed to an acute episode or a change in the treatment plan that requires such concentrated monitoring.
3. Restorative nursing measures once a beneficiary's medical condition becomes stable as noted in the treatment plan. Restorative nursing measures are used to maintain or restore maximum function or to prevent advancement of progressive disability as much as possible. Restorative nursing measures are:
 - A. A coordinated plan that assist a participant to achieve independence in activities of daily living (bathing, eating, toileting, dressing, transfer and ambulation);
 - B. Use of preventive measures or devices to prevent or delay the development of contractures, such as positioning, alignment, range of motion, and use of pillows;
 - C. Ambulation and gait training with or without assistive devices; or
 - D. Assistance with or supervision of transfer so, the participant would not necessarily require skilled nursing care.
4. Dialysis (hemodialysis or peritoneal dialysis) as part of a maintenance treatment plan.
5. Treatment for a specialized therapeutic diet (physician prescribed). Documentation must address the specific plan of treatment such as the use of dietary supplements, therapeutic diets, and frequent recording of the participant's nutritional status.
6. Administration or control of medication as required by state law to be the exclusive responsibility of licensed nurses:
 - A. Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration;
 - B. Drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgment on a continuous basis; or
 - C. Frequent injections requiring nursing skills or professional judgment.
7. Nasogastric or gastrostomy feedings requiring supervision and observation by an RN or LPN:
 - A. Primary source of nutrition by daily bolus or continuous feedings;
 - B. Medications per tube when beneficiary on dysphagia diet, pureed diet or soft diet with thickening liquids; and
 - C. Per tube with flushes.
8. Respiratory therapy: oxygen as a temporary or intermittent therapy or for a beneficiary who receives oxygen continuously as a component to a stable treatment plan:
 - A. Nebulizer usage;
 - B. Nasopharyngeal or tracheal suctioning;
 - C. Oral suctioning; and
 - D. Pulse oximetry.
9. Isolation: when medically necessary as a limited measure because of a contagious or infectious disease.
10. Wound care of decubitus ulcers or open areas.
11. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan; or
12. HCBS Nursing Facility LOC may be established by having two (2) or more conditions in Category I OR one (1) or more conditions from both Category I and II below.
 - b. Conditions that must be present in combination as listed above may justify HCBS nursing facility level of care:
 1. Category I: (Two or more, or at least one in combination with one from Category II)
 - A. Ancillary therapies: supervision of participant's performance of procedures taught by a physical, occupational, or speech therapist, consisting of care of braces or prostheses and general care of plaster casts.
 - B. Chronic recurrent medical problems that require daily observation by licensed personnel or other personnel for prevention and treatment.
 - C. Blindness
 - D. Injections: requiring administration or professional judgment by an RN or LPN or a trained personal assistance.
 - E. Diabetes: when daily observation of dietary intake or medication administration is required for proper physiological control:
 - i. Vision, dexterity and cognitive deficiencies; or
 - ii. Frequent hypoglycemic and diabetic ketoacidosis (DKA) (high blood sugar) episodes with documentation requiring intravenous or intramuscular (IV or IM) or oral intervention.
 - F. Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction as prescribed by a primary care physician;

G. Frequent falls due to physical disability or medical diagnosis;

H. Behavioral problems symptoms due to cognitive impairment and depressive disorders such as:

- i. Wandering or exit seeking behavior due to cognitive impairments
- ii. Verbal disruptiveness;
- iii. Physical aggression;
- iv. Verbal aggression or physical abusiveness; or
- v. Inappropriate behavior (when it can be properly managed in the community setting)

2. Category II: (One or more conditions from both Category I and II)

- A. Need for teaching and counseling related to a disease process, disability, diet, or medication.
- B. Adaptive programs: re-training the beneficiary to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the beneficiary's participation in the program and document the beneficiary's progress.
- C. Factors to consider along with the beneficiary's medical needs are psychosocial determinants of health such as:
 - i. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders and progress notes or by nursing or therapy notes);
 - ii. Age;
 - iii. Length of stay in current placement;
 - iv. Location and condition of spouse or primary caregiver;
 - v. Proximity and availability of social support; or
 - vi. Effect of transfer on individual, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning helps alleviate the fear and worry of transfer).

A LOC determination using the SRF must be completed at initial enrollment. Annual reevaluation of LOC is performed through a needs assessment that determines ongoing nursing facility equivalent LOC and acuity level. A favorable change to a waiver beneficiary's condition that improves functionality and mobility to the point waiver services are no longer needed to support community inclusion may result in a dis-enrollment from waiver participation. The functional acuity levels of skilled and hospital are established through a comprehensive assessment that covers the following areas:

The multidisciplinary assessment includes the following functioning areas to ensure waiver beneficiary access and eligibility:

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

When the LOC is determined, an assessment is completed to identify the functioning acuity level. The information obtained from the LOC instrument informs of the nursing facility LOC. The CAP Business system has acuity functionality programmed to identify the identified acuity levels of skilled and hospital.

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

- ☐ The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.
- ☒ A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.

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

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

The Service Request Form is the first eligibility consideration for participation in the waiver. The SRF establishes the basic eligibility criteria for nursing or hospital facility level of care for all waiver beneficiaries.

The SRF must be completed to its entirety and signed by a designated clinician and must have clear indication of nursing facility level of care needs in order to initiate the scoring algorithm to determine nursing or hospital facility level of care. The following required fields on the form include:

- o Program request.
- o Waiver beneficiary demographics.
- o Waiver beneficiary conditions and related support needs.
- o Informal caregiver availability.
- o Physician Attestation.
- o Date of LOC request and determination.

When nursing or hospital facility LOC is established through the SRF, the CAP IT system electronically transmits to the Medicaid's Fiscal Agent the level of care decision to enter the prior approval eligibility in the Medicaid Management System. A prior approved LOC is one of two components required in the State's MMIS in order to adjudicate waiver claims. The second component is the assignment of a waiver special coverage code.

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

Upon an initial referral for waiver participation, a Service Request Form (SRF) is completed to determine eligibility. The SRF evaluates the participant's medical, functional, psychosocial and behavioral needs and evaluate those needs against an established level of care that is equivalent to nursing facility or hospital level of care. The data gathered on the SRF is aggregated and scored through a LOC algorithm to yield an approval or denial of LOC. If the SRF is approved for LOC, the potential waiver participant is placed in an assessment queue. Activities that must be conducted prior to waiver entrance include a needs assessment and a service plan. The needs assessment will confirm the need for waiver intervention. The needs assessment includes the following which validates LOC:

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

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

An annual SRF is not completed. The ongoing and continuous LOC is established through an assessment of need. The assessment has logic to evaluate one's ongoing level of care through entries of medical, functional, behavioral, and psychosocial characteristics.

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

- ☐ Every three months
- ☐ Every six months
- ☒ Every twelve months
- ☐ Other schedule

Specify the other schedule:

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

- ☒ The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
- ☐ The qualifications are different.

Specify the qualifications:

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

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

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

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

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

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:

LOC-A1 Number and percent of waiver beneficiaries who had a level of care indicating need for institutional level of care prior to waiver participation.

Numerator: number of waiver beneficiaries who had a level of care indicating need for institutional LOC prior to waiver participation **Denominator:** number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;"> 95% 5% margin of error </div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;"> CAP Business system case management system and NC Medicaid MMIS </div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: 150px;">CAP Business system</div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 150px;"></div>

Performance Measure:

LOC A-2: Number and percent of LOC decisions made by the IAE that were processed in accordance with waiver guidelines and procedures for each waiver participation year N: LOC decision completed in accordance with waiver requirements D: Total Number of LOC decisions

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100px;"></div>
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

CAP Business system		
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

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

Performance Measures

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

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the

method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

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

Performance Measures

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

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

Performance Measure:

LOC-C1 Number and percent of new enrollees who received a level of care determination using the Service Request Form (SRF). Numerator: number of new enrollees who received a LOC determination using SRF Denominator: number of new enrollees

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

CAP Business system case management system and NC Medicaid MMIS		
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

LOC C2: PM: Number and percent of comprehensive assessments performed by the IAE that were completed in accordance with waiver guidelines and procedures for each waiver participation year
N: Number of comprehensive assessments performed by the IAE that were completed in accordance with waiver guidelines and procedures
D: Total Number of comprehensive assessments

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business system</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

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

The CAP Business system is a business system employed by the State Medicaid Agency to manage the LOC determination decisions for all interested individuals and active waiver participants on an initial and annual basis. This system assists in the discover of non-compliant LOC practices through aggregating and analyzing LOC workflow.

The CAP Business system performs the following tasks to ensure compliance to LOC policies and procedures which

allows the State Medicaid Agency to quickly discovery areas of noncompliance:

- No-wrong door referral
- Service request forms workflow- referral, consent forms, physician attestation and mandatory fields
- RN exception reviews to reassess health care information, when applicable
- Notification letters to providers and waiver participants
- Comprehensive assessment of needs
- Prior approval segments
- Workflow timelines and alerts

b. Methods for Remediation/Fixing Individual Problems

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

Upon the discovery of non-compliant waiver workflow activities in the area of LOC, the State Medicaid Agency notifies the non-compliant entity within 30-days of the discovery; requests a corrective action plan to remediate the concerns and a summary of the root cause. The State Medicaid Agency provides technical assistance and training on policies and procedures in the noncompliant area(s). The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant entity to ensure the corrective action plan is being followed through the duration of the action plan. If the non-compliant issue continues, a freeze on performing LOC activities for waiver participants is imposed on that entity until continuous quality is achieved. If, after 3 months of assistance and remediation strategies have not promoted quality improvement, the entity assigned that LOC responsibility will be terminated indefinitely.

ii. Remediation Data Aggregation

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

Responsible Party (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

☒ No

☐ Yes

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Individuals seeking Medicaid services and have an indication to meet the basic eligibility criteria of the waiver, a service provider, a case management entity and the county department of social services or Tribal Nation may provide general information about the waiver and a referral is made by the individual upon an agreement of a selected case management entity in their service area.

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

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

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

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

To ensure conflict free case management, NC Medicaid will appoint case management agencies to be solely responsible to complete independent assessment.

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

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

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

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

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

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Coordination of Care- case management and care advisement		
Statutory Service	In-Home Care Aide Service		
Statutory Service	Respite-Institutional and In-Home		
Supports for Participant Direction	Financial Management		
Supports for Participant Direction	Individual-Directed goods and services		
Other Service	Assistive Technology		
Other Service	Community Transition		
Other Service	Home Accessibility and Adaptation		
Other Service	Non-Medical Transportation		
Other Service	Nutritional Services		
Other Service	Participant Goods and Services		
Other Service	Pediatric Nurse Aide Services		
Other Service	Pest Eradication		

Service Type	Service		
Other Service	Specialized Medical Equipment		
Other Service	Training, Education, and Consultative Services		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Coordination of Care- case management and care advisement

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

01 Case Management

Sub-Category 2:

01010 case management

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

A service that directs and manages the special health care, social, environmental, financial, and emotional needs of a waiver participant to maintain the waiver participant's health, safety, and well-being and for continual community integration. Case management services are available to assist waiver participants in gaining access to needed medical, social, educational, and other services. Case management includes the following principal components: assessing, care planning, referral or linkage and monitoring and follow-up.

Individuals transitioning out of an institutional setting may receive pre-transition case management activities to assist with the

transition to a home setting. The pre-transition activities are limited to 30-days or 60-days (for MFP) prior to the waiver participation approval date. These services are not billable until after the applicant has transitioned home and meet all remaining eligibility requirements to participate in the waiver.

The case manager performs the following:

- assesses well-being of beneficiary monthly to identify if services plan continues to meet need.
- Assists with the development and approval of the person-centered service plan.
- Links and refers to community resources.
- Monitors formal and informal services to ensure health, safety and well-being
- Follows-up to ensure services are meeting assessed needs

Assessing includes the following:

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

Care Planning include the following:

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

Care Planning Knowledge include the following:

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

Referral/Linkage includes the following:

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

Referral/Linkage knowledge includes:

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

Skills and Abilities to:

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

Monitoring and follow-up include:

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

Monitoring and follow-up knowledge:

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

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

Case management services shall not exceed \$377/month (\$56.56/hr. X 80 hours) per calendar year (January 1-December 31) per waiver participant for combined use of both case management and care advisor services. The SMA has a process in place for a case management entity to request additional case management units/hours per calendar year when the original allocation is exhausted for the following reasons:

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

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

Case Management entities are prohibited from providing case management services in conjunction with other waiver and non-waiver services.

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

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

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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Entities

Appendix C: Participant Services

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

Service Type: Statutory Service

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

Provider Category:

Agency

Provider Type:

Case Management Entities

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

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

Qualifications:

- a. A direct connection to the service area to provide continuity and appropriateness of care;
- b. Experience with 0-17 children and adults 18 years and older with medical-complexities or physical disabilities;
- c. Policies and procedures that align with the CAP/C policies and procedures;
- d. Three (3) years of progressive and consistent home and community based services experience; a provisional status may be granted to new agency without required experience- over-the-shoulder monitoring by State Medicaid Agency for 12 consecutive months; if no deficiencies after the 12th month, only quarterly monitoring and QA will be required for the next 24 months. If performance requirements are met, no intensive supervision will be required
- e. Ability to provide case management services through approved qualified professionals;
- f. Architectural requirement to support the requirement of current and future automated programs;
- g. Adequate staff to participant ratio based on acuity of need for each case manager's caseload (appropriate case mix); best-practice is 40 participants for one FTE; and
- h. Ability to collaborate with network of providers, to ensure services can be rendered within five (5) days of submission of the service authorization;
- i. Ability to make home visits as required and requested. Provider enrollment and recertification and claim submission training provided by NCTracks (GDIT)

Participate in initial and annual refresher trainings to include:

- a. Person-centered training;
- b. Abuse, neglect, exploitation;
- c. Program integrity (PI);
- d. Conflict resolution;
- e. Mental Health First Aid;
- f. Critical incident reporting;
- g. Health, Safety and Well-being and Individual Risk Agreement;
- h. Medicaid Due Process Appeal Rights and EPSDT;
- i. Consumer-Direction;
- j. Quality Assurance and Performance Outcomes
- k. Cultural Awareness; and
- l. Motivation interviewing or a similar training

In addition, the case manager or care advisor shall complete other required trainings sponsored by their organization annually:

- a. Bloodborne Pathogens and Infection Control;
- b. Health Insurance Portability Accountability Act (HIPAA)
- c. End of Life planning;

Verification of Provider Qualifications

Entity Responsible for Verification:

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

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

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

In-Home Care Aide Service

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

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

Personal care aide services must fall within the Nurse Aide I scope of nursing practice. Personal care aide services may be provided in the community, home, workplace, or educational settings at the discretion of the Home Care Agency. Personal care aide services can be provided in the workplace for waiver participants who meet the specified qualifications. Level I tasks, which consists entirely of home management tasks, are covered only when provided in conjunction with Level II Personal Care tasks. Typical Level II tasks will include oxygen therapy, break-up and removal of fecal impaction, sterile dressing change, wound irrigation, I.V. fluid assistive activities, nutrition activities, suctioning, tracheostomy care, elimination procedures and urinary catheters. Typical Level I tasks include paying bills as directed by the participant; essential shopping, cleaning and caring for clothing; performing basic housekeeping tasks such as sweeping, vacuuming, dusting, mopping and washing dishes; identifying medications for the participant; providing companionship and emotional support; preparing simple meals; and shopping for food, clothes, and other essential items.

Assurance: The services under the waiver's personal care aide are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Tasks, amount, frequency, and duration must be clearly outlined in job duties developed by the waiver participant or responsible party or representative participating in consumer-directed care.

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

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

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

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

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

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

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

A spouse, parent, step-parent, or grandparent can be hired as the employee when a waiver participant is 18 years of age or older.

The employment of a spouse, parent, or grandparent of the waiver participant shall provide this service only if:

- a. Waiver participant and provider are 18 years of age or older; and

b. The person meets the qualifications to perform the level of personal care determined by the waiver assessment.

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

Individuals with any one of the following criminal records are excluded from hire:

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

Individuals with criminal offenses (listed above) occurring more than 10 years before the date of the criminal report may qualify for an exemption when the exemption does not violate Medicaid guidelines. The financial manager shall inform the waiver participant when a prospective employee is within the 10-year rule and the waiver participant shall have the autonomy to approve the exemption.

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

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

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

Parents, step-parents, loco parentis, legal guardian, or significant others to a parent shall not be hired to provide personal care services to CAP beneficiaries under the age of 18. This applies for both traditional and consumer-directed services.

A spouse, parent, step-parent, child, sibling, or other relatives is eligible for hire as the employee when a CAP beneficiary is 18 years of age or older. The employment of a spouse, parent, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if:

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

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

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

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

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

Consumer-directed providers shall:

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

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

Individuals with the following criminal records are excluded from hire:

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

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

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

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

Service Delivery Method (check each that applies):

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

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

☐ Legally Responsible Person

☒ Relative

☐ Legal Guardian

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: In-Home Care Aide Service

Provider Category:

Individual

Provider Type:

Direct Staff

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

initially and annually

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: In-Home Care Aide Service

Provider Category:

Agency

Provider Type:

In-Home Aide Providers

Provider Qualifications

License (specify):

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

Medicare certified home health agency.

Certificate (specify):

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

Other Standard (specify):

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

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

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Frequency of Verification:

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

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

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

Service Type:**Service:****Alternate Service Title (if any):****HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

A service for a waiver participant that provides temporary relief to the primary unpaid caregiver(s) by taking over the care needs of the participant for a limited time. This service may be used to meet a wide variety of needs, including family emergencies; planned special circumstances when the primary unpaid caregiver needs to be away for an extended period (such as vacations, hospitalizations, or business trips); relief from the daily responsibility of caring for an individual with a disability, or the provision of time for the primary unpaid caregiver to complete essential personal tasks.

It can be used as day, evening, or overnight care to meet a range of beneficiary needs such as caregiver relief. Respite care may be provided either in the beneficiary's residence or in a facility licensed to provide the LOC required by the beneficiary (such as a nursing facility or hospital).

Institutional Respite is a service for CAP beneficiaries that provides temporary support to the primary caregiver(s) by taking-over the care needs for a limited time. The provision of this service takes place in a Medicaid-certified nursing facility or a hospital with swing beds. Institutional respite is computed on a daily capitation rate per the current Medicaid Fee Schedule.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite-Institutional and In-Home

Provider Category:

Agency

Provider Type:

Home Care Providers

Provider Qualifications

License (specify):

TITLE 10: CH22, 0.0100

10 NCAC 06B .0101

Meet Medicare requirements for Tribal Governments

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

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

Service Type: Statutory Service

Service Name: Respite-Institutional and In-Home

Provider Category:

Individual

Provider Type:

Hired workers under participant directed services

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The following findings are on their background check:

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

Verification of Provider Qualifications

Entity Responsible for Verification:**Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite-Institutional and In-Home****Provider Category:****Provider Type:****Provider Qualifications****License (specify):**

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

Certificate (specify):**Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services****C-1/C-3: Provider Specifications for Service****Service Type: Statutory Service****Service Name: Respite-Institutional and In-Home****Provider Category:**

Agency

Provider Type:

Institutional providers

Provider Qualifications

License (*specify*):

TITLE 10: CH22, 0.0100

10 NCAC 06B .0101

Meet Medicare requirements for Tribal Governments

Certificate (*specify*):

Other Standard (*specify*):

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation

DHHS fiscal agent (GDIT/NCTracks)

Tribal Governments

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-directio

05/06/2020

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

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

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

\$93.00 per month is the maximum limit for financial management services. When financial management services are being shared due to a waiver participant transferring from one FM provider to another in one planning month, \$46.50 is the maximum limit per each FM provider for that planning month.

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

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

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

Service Delivery Method (check each that applies):

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Management Agency

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Financial Management

Provider Category:

Agency

Provider Type:

Fiscal Management Agency

Provider Qualifications

License (specify):

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

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Individual-Directed goods and services

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

Individual Directed Goods and Services must be documented in the service plan and the goods and services that are purchased under this coverage must be clearly linked to an assessed waiver participant need established in the service plan.

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

Types of coverable goods and services:

The following items are also coverable using this service in addition to other coverable items:

Items to assist with personal hygiene and bathing; Items to assist with dressing; Items to assist with accessibility in the home; Items to assist with eating; Items to assist with toileting and Items to assist with mobility.

The listed items are coverable:

Long handle sponges, Long handle brushes, Elastic shoelaces, Bath tap turners, Button aids, Zipper pulls, Socks aids, Door knob grippers, Wheelchair or walker baskets/bags/caddy, Writing aids, No spill cups straw holder, two-handle mug, Scooper bowls and plates, Plate guards, Bibs, Bottom wipers, Bedside commode cushion, Incontinence disposal system, Protectants for a mattress, chair or car seat to protect against incontinence accidents, and wheelchair canopy.

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

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

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

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

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

Service Delivery Method (check each that applies):

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

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

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

Provider Specifications:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Individual-Directed goods and services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications**License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:**

Appendix C: Participant Services

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

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

Provider Category:**Provider Type:****Provider Qualifications****License** (*specify*):**Certificate** (*specify*):**Other Standard** (*specify*):**Verification of Provider Qualifications****Entity Responsible for Verification:**

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction

Service Name: Individual-Directed goods and services

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

This service shall be used for:

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

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

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

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

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

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

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

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

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

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

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

Entry in the waiver when a home or vehicle modification or assistive technology is requested to return to or remain in the primary private residence that prevents risk of institutionalization (the installation of equipment or modification must be completed within three (3) months of approval.

The installation of a home or vehicle modification or assistive technology is completed through evidence of an invoice and a prior approval claims submitted to NCTracks.

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

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

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

Service Delivery Method (check each that applies):

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Specialized Therapist
Agency	Business/Commercial

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Specialized Therapist

Provider Qualifications

License (specify):

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

Certificate (specify):

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

Other Standard (specify):

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

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

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

Frequency of Verification:

At time of waiver service provision

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

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications**License (specify):**

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

Certificate (specify):

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

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.
 NC Medicaid MMIS for provider enrollment

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:**Category 1:**

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Community Transition service can be used for individuals transitioning from an institution or provider owned/controlled residence to a private residence for which the individual is responsible for his/her own rent/utilities. This service may be used in any duration or type, up to the maximum allotted amount, at the start of a community transition and up to 1 year after the original transition date to pay for necessary and documented one-time expenses for the waiver participant to establish or maintain a basic living arrangement within one year

of the transition to community.

Services for prospective waiver participants transitioning from an institutional setting to a community setting. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

Community transition services may cover the following:

- Essential furnishings, and household products including furniture for the bedroom or living room, window coverings, food preparation items, and bed/bath linens
- Residential application fees
- Security deposits required to obtain a lease on an apartment or home
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating)
- Environmental health and safety assurances, such as pest eradication; allergen control; one-time cleaning prior to occupancy

Items and services (including rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary. The vendor of the service shall provide a receipt for each purchase or invoice to seek reimbursement. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service definition.

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

Room and board fees are excluded

Payment for rent is excluded

Not to exceed \$2500 per waiver participant for the life of the waiver cycle

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

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

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

Service Delivery Method (check each that applies):

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Property Management Agencies
Agency	Retail suppliers
Individual	Independent Contractors

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Property Management Agencies

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provide or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Retail suppliers

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (*specify*):

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provide or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Individual

Provider Type:

Independent Contractors

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

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

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

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

An assessment of need must be reviewed by a multidisciplinary team in conjunction with a Physical Therapist (PT), Occupational Therapist (OT), Rehabilitation Engineer, or Assistive Technology Professional (for ECUs/EADLs) certifying necessity. A copy of the assessment must be submitted with the request for Home Modifications (with the exception of floor coverings, air filters, and generators). A physician's signed order may be requested to certify that the requested adaptation is necessary. The physician's order and the assessment completed by a PT, OT, Rehabilitation Engineer or Assistive Technology professional must be on file in the waiver participant's record. When feasible, there must be at least one competitive quote for home modifications to determine the most efficient method to complete the request. An appropriate professional shall provide the modifications or adaptations to the primary private residence.

Assurance: The service under the waiver's Home accessibility and adaptation is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Construction and installation must be completed according to state and local licensure regulations and building codes when applicable. All items must meet applicable standards of manufacture, design and installation.

Home modifications can be provided only in the following settings:

- a. A primary private residence where the waiver participant resides that is owned by the waiver participant or his or her family;
- b. A rented residence when the modifications are portable;

Approval for floor coverings, air filtration, and generators must be based on RN assessment and MD certification. The following are the only covered home accessibility and adaptation modifications:

- a. Wheelchair ramps, stationary or portable, and wheelchair ramps with landing pads;
- b. Threshold ramps, used to allow wheelchairs to move over small rises such as doorways or raised landings;
- c. Grab bars or safety rails mounted to wall, floor or ceiling;
- d. Modification of an existing bathroom to improve accessibility for a disabled beneficiary, such as : installation of roll in shower, low threshold showers, sink modifications (raised, lowered, pedestal, pedal specific for beneficiary), water faucet controls, tub modifications, toilet modifications (such as raised seat or rails), floor urinal adaptations, turnaround space modifications for wheelchair and stretcher bed access, and required plumbing modifications that are necessary for the modifications listed above;
- e. Widening of doorways for wheelchair access, turnaround space modifications for wheelchair access;
- f. An emergency egress door when determined to be medically necessary due to physical limitations of the responsible party;
- g. Bedroom modifications to widen turnaround space to accommodate hospital beds, larger or bulky equipment and wheelchairs (ex. removing a closet to add space for the bed or wheelchair);
- h. Lift systems and elevators that are used inside a beneficiary's private primary residence and are not otherwise covered under DME;
- i. Porch stair lifts;
- j. Floor coverings, when existing floor coverings contributed to documented falls, resulting in injury as evidenced by hospital and emergency room visits, or when those floor coverings are contributing to asthma exacerbations, documented in the health record, requiring repeated emergency room or hospital treatment;
- k. Driving surfaces, when existing driving surfaces leading to the primary private residence pose an access to care issue to the beneficiary with documented gaps in service provision or documented inability to render emergency services contributing to impassable path;
- l. Portable or whole house air filtration system and filters under the following circumstances:
 1. For a beneficiary with severe allergies or asthma, when all other preventive measures such as removal of the allergen or irritant, removal of carpeting and drapes have been attempted, and the beneficiary's asthma remains classified as moderate persistent or severe persistent, and a physician has certified that air filtration is of benefit. Ozone generators and electronic or electrostatic or other air filters which produce ozone.
 2. For a beneficiary susceptible to infection, when adequate infection control measures are already in place, yet the beneficiary continues to acquire airborne infections, and when a physician has certified that air filtration is of benefit in preventing infection, a germicidal air filter (with UV light) may be provided.
 3. The smallest unit that meets the beneficiary's needs is covered; , if a beneficiary spends most of his or her time confined to a specific area of the house, then a whole-house system is not covered.

- m. Replacement filters for items covered under the home accessibility and adaptation service;
- n. Portable back-up generator for a ventilator, when the beneficiary uses the ventilator more than eight hours per day, and in the event of a power outage, the beneficiary requires hospitalization, if not for the presence of the portable generator. The coverage of a 220-volt line from a circuit breaker panel in the home to a receptacle installed outside is covered in that instance.

The replacement of a fixture (sink or toilet) and, or a mirror over the vanity may be replaced using funding through the home accessibility and adaptation service when during demolition the fixture or mirror cannot be preserved as described in the specification document.

Home accessibility and adaptation items that require a physician's order:

- a. Tub replacement; and
- b. A portable generator.

The home accessibility and adaptation service consists of the following:

- a. Technical assistance in device selection;
- b. Training in device use by a qualified assistive technology professional;
- c. Purchase, necessary permits and inspections, taxes, and delivery charges;
- d. Installation;
- e. Assessment of modification by the case manager and by any applicable inspectors to verify safety and ability to meet waiver participant's needs;
- f. Repair of equipment, as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment, and only when not covered by warranty. The waiver participant or his or her family shall own any equipment that is repaired; and
- g. The move of modification or adaptation from one primary private residence to another. An evaluation of the cost for labor and costs of moving modification or adaptation must be approved prior to the move.

The CME authorizes the services through a service authorization and verifies training, technical assistance, permits, inspections, safety and ability to meet waiver participant's needs.

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

Home accessibility and adaptation provides a combined vehicle modification and assistive technology waiver cycle benefit of \$28,000 per waiver participant. When the maximum utilization limit is reached, requests for home modification are reviewed separately to determine extreme need.

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

Home modification excludes the following:

- a. home modifications that add to the total square footage of the home;
- b. home improvements, renovations, or repairs;
- c. homes under construction;
- d. a dwelling where the owner refuses the modification;
- e. the modification in a rented residence when the requested modification is not portable;
- f. purchase of locks;
- g. service agreements, maintenance contracts, insurance, and extended warranties;
- h. roof repair, central air conditioning;
- i. swimming pools, hot tubs; spas, saunas, or any equipment, modification or supply related to swimming pools, hot tubs, spas, or saunas;
- j. items that have general utility to a non-disabled waiver participant;
- k. replacement of equipment that has not been properly used, has been lost or purposely damaged;
- l. computer desk and other furniture;
- m. plumbing, other than the plumbing described under the covered items in letter(d);
- n. approved vendor shall not be the spouse, parent, primary caregiver or legal guardian of the waiver participant; and
- o. Air filtration that is less than or equal to 50 parts per billion ozone by-products.

A generator with a wattage capacity power of 3kW to 10kW, used only during an emergency to maintain a life-sustaining device. The portable generator is not intended for stand-by power (permanent installed generator with an automatic turn-on). A portable generator through CAP/C services is primarily used on a short-term, temporarily basis, during an emergency, to ensure the continuous operation of a ventilator, and when applicable, other small medical devices that safe-keep medication and other essential health care items operating.

Funding for home accessibility and adaptation available through the waiver must be shared to meet the needs of the household. Equipment, technology and modification are shared when the disabilities of two or more waiver participants living in the same household are similar.

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

A waiver participant who resides in foster care is eligible to receive a home modification when the modification is portable.

A waiver participant who is in a permanent foster care placement, ordered by the court and the placement is intended to last more than three (3) years, is eligible to receive a permanent home modification.

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

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Home Accessibility and Adaptation

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License (specify):

Local business licensure requirement specific to business entity

Certificate (specify):

Other Standard (specify):

Case Management Entity must approve and authorize the service and the provider.

The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license. Licensed contractors are preferred.

Enrolled Medicaid providers who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer's specifications and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Service Definition (Scope):

Category 4:

Sub-Category 4:

Transportation covered by this waiver is intended to allow waiver participants to gain access the community to obtain medication, food, attend activities and access resources, to meet goals as specified in person-centered service plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized. This service has maximum utilization limits and does not duplicate NEMT.

The services under the waiver's non-medical transportation are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization

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

Transportation of a waiver participant to receive medical care that is provided under the State plan must be billed as a State plan transportation service.

Mile reimbursement - .58 per mile with a maximum radius of 35 miles from the waiver participant's residence.

The maximum allowable per trip is \$21.80. The maximum allowable trips per month is three (3).

• Bus tokens- \$2.50 maximum for a day pass or \$45.00 maximum for a month's pass. The maximum allowable per year is \$540.00.

• Taxi rides or share rides - The maximum allowable per trip is \$21.80. The maximum allowable trips per month is three (3).

• Gas Vouchers - .58 per mile with a maximum radius of 35 miles from the waiver participant's residence. The maximum allowable for one gas voucher per trip is \$21.80. The maximum allowable gas vouchers per month is three (3).

The maximum approved amounts for participants goods and services, individual-directed goods and services, pest eradication, non-medical transportation and nutritional services cannot exceed \$800.00 total per each fiscal year.

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

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

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

Service Delivery Method (check each that applies):

☐ Participant-directed as specified in Appendix E

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individuals
Agency	Retail Vendor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Individual

Provider Type:

Individuals

Provider Qualifications

License (*specify*):

Must have a Valid Driver's license

Certificate (*specify*):

Other Standard (*specify*):

An individual provider of transportation shall have a valid drivers' license, car insurance that covers liability and his or her own.

The individual must demonstration capacity to furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Non-Medical Transportation

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License (*specify*):

Employees must have a valid driver's license

Certificate (*specify*):

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Nutritional Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

A service for a waiver participant that provides coverage for physician ordered health supplements, vitamin or mineral supplements, herbal preparations and nutritional supplements such as vitamins that are directly related to the primary physical medical condition and are determined medically necessary but are not available under the State Plan. These nutritional supplements such as vitamins are necessary to assist the waiver participant to maintain community placement and for the management of health and safety as identified in the person-centered service plan. Assurance: The services under the waiver's nutritional supplements such as vitamins are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

This service is not intended to cover prescription drugs or prescriptions with a rebate.
 The cost of this service shall not exceed \$800.00 per waiver participant in a fiscal year (July 1-June 30). Participants goods and services and individual goods and services are excluded when this service is approved and reimbursed to it maximum limits during each qualifying fiscal year.
 This service is not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase health supplements, vitamin or mineral supplements, herbal preparations and nutritional supplements such as vitamins and these nutritional services are not available through another source.

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

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

Service Delivery Method (check each that applies):

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Vendor
Agency	DME

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Services

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Nutritional Services

Provider Category:

Agency

Provider Type:

DME

Provider Qualifications

License (*specify*):

meet all applicable licensure requirements per NC Medicaid Provider Enrollment requirements

Certificate (*specify*):

Other Standard (*specify*):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Participant Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3:**Sub-Category 3:**

Service Definition (Scope):**Category 4:****Sub-Category 4:**

A service for the waiver participant who is not directing their own care that provides services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase the item or service or the item or service is not available through another source. This service helps assure health, safety, and well-being when the waiver participant or responsible party does not have resources to obtain the necessary item or service that will aid in the prevention or diversion of institutional placement. Participant goods and services are items that are intended to: increase the waiver participant's ability to perform ADL's or IADL's and decrease dependence on personal assistant services or other Medicaid-funded services.

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

Types of coverable goods and services are specific to items to assist with personal hygiene and bathing, Items to assist with dressing; Items to assist with accessibility in the home; Items to assist with eating; Items to assist with toileting and Items to assist with mobility. The following specific items are approvable using this service: Long handle sponges, Long handle brushes, Elastic shoelaces, Bath tap turners, Button aids, Zipper pulls, Door knob grippers, wheelchair or walker baskets/bags/caddy, writing aids, no spill cups straw holder, two-handle mug,

Scooper bowls and plates, Plate guards, Bibs, Bottom wipers, Incontinence disposal system, Protectants for a mattress, chair or car seat to protect against incontinence accidents, wheelchair canopy, specialized mixer/blenders.

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

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

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

Service Delivery Method (check each that applies):

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

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

- ☐ Legally Responsible Person
☐ Relative
☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME
Individual	Individual
Agency	Business/Commercial

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Participant Goods and Services

Provider Category:

Agency

Provider Type:

DME

Provider Qualifications

License (specify):

meet all applicable licensure requirements per NC Medicaid Provider Enrollment requirements

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service**Service Name: Participant Goods and Services**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):****Other Standard (specify):****Verification of Provider Qualifications****Entity Responsible for Verification:****Frequency of Verification:****Appendix C: Participant Services**

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

Service Type: Other Service**Service Name: Participant Goods and Services**

Provider Category:**Provider Type:****Provider Qualifications****License (specify):****Certificate (specify):**

Other Standard (specify):

The Case Management entity must approve and authorize the service.
 The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license. Licensed contractors are preferred.
 Enrolled Medicaid providers who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer's specifications and requirements.

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

DHHS fiscal agent – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years
 NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

Initially and at time of service provision

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Pediatric Nurse Aide Services

HCBS Taxonomy:**Category 1:**

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:**

Service Definition (*Scope*):

Category 4:

Sub-Category 4:

A service for a waiver participant who is unable to perform any two the seven key Activities of Daily Living (ADLs) tasks independently due to a medical condition identified and documented on a validated assessment. This service provides extensive hands-on (not merely set-up or cueing) assistance with at least two ADLs (bathing, dressing, eating, toileting, hygiene, mobility and transfer) in which at least one of the ADLs must be Nurse Aide II (NA II) tasks during the hours of service provision. The need for assistance with ADLs relates directly to the waiver participant's physical, social environmental and functional condition. Pediatric Nurse Aide Services, when medically necessary, must be provided in the community, home, workplace, or educational settings (when not the responsibility of LEA). The personal care needs must fall within the NA II scope of nursing practice. This service type is substantial. This means that the waiver participant's needs can only be met by certified professional such as an NA I or II. Nurse Aide services could not and shall not be provided by home health aides not registered with DHSR, unless participation in the waiver is through the consumer-directed model of care.

The staff providing the care must be an NAI or the Home Health agency shall have competencies for NA I + 4 tasks. Typical Level II tasks will include oxygen therapy, break-up and removal of fecal impaction, sterile dressing change, wound irrigation, I.V. fluid assistive activities, nutrition activities, suctioning, tracheostomy care, elimination procedures and urinary catheters. Typical Level I tasks include paying bills as directed by the participant; essential shopping, cleaning and caring for clothing; performing basic housekeeping tasks such as sweeping, vacuuming, dusting, mopping and washing dishes; identifying medications for the participant; providing companionship and emotional support; preparing simple meals; and shopping for food, clothes, and other essential items. Level I tasks, which consists entirely of home management tasks, are covered only when provided in conjunction with Level II Personal Care tasks.

ADL care for a waiver participant under the age of three (3) years is considered age appropriate and the responsibility of the parent or responsible representative.

Personal care under the waiver differs in scope, nature, supervision arrangements, and/or provider type (including provider training and qualifications) from personal care services in the State plan. Because this service is different than state plan services in the scope, nature, and supervision requirements, waiver participants between the ages of 18-20 years old are included to receive this service.

Assurance: The service under the waiver's Pediatric Nurse Aide is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Pediatric nurse aide services can be provided in the workplace for waiver participants who meet the specified qualifications. Level I tasks, which consists entirely of home management tasks, are covered only when provided in conjunction with Level II Personal Care tasks.

The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the nurse aide. If the regular informal caregiver (parent) is not available, there must be a back-up informal caregiver designated by the parent who can be physically present with the beneficiary and make judgments on the caregiver's behalf regarding the care of the beneficiary.

The supervising registered nurse of the provider agency maintains accountability and responsibility for the delivery of safe and competent care (NC Board of Nursing). Decisions regarding the delegation of any nurse aide tasks are made by the licensed nurse on a beneficiary-by-beneficiary basis.

The criteria stated below must be met in order for a task to be delegated to unlicensed personnel. The task:

- a. is performed frequently in the daily care of a beneficiary or group of beneficiaries;
- b. is performed according to an established sequence of steps;
- c. involves little or no modification from one beneficiary situation to another;
- d. may be performed with a predictable outcome;
- e. does not involve ongoing assessment, interpretation, or decision-making that cannot be logically separated from the task itself; and
- f. does not endanger the beneficiary's life or well-being.

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

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

medical needs or a caregiver crisis (significant illness or death in the family).

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

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

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

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

Individuals with any one of the following criminal records are excluded from hire:

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

Individuals with criminal offenses occurring more than 10 years previous to the date of the criminal report may qualify for an exemption when the exemption does not violate Medicaid guidelines. The financial manager shall inform the Waiver participant when a prospective employee is within the 10-year rule and the Waiver participant shall have the autonomy to approve the exemption.

The services under the waiver's pediatric nurse aide are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

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

A spouse, parent, step-parent, or grandparent, is eligible for hire as the employee when a Waiver participant is 18 years of age or older. The employment of a spouse, parent, or grandparent, of the Waiver participant may provide this service only if:

- a. Waiver participant and provider are 18 years of age or older; and
- b. Meets the qualifications to perform the level of personal care determined by the WAIVER assessment.

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

Waiver funding must not be used to pay for services provided in public schools.

Nurse Aide services must not be provided at the same day or time as Waiver In-Home Aide services or private duty nursing. Pediatric Nurse Aide Services may not be provided if it duplicates other Medicaid or non-Medicaid services.

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

Nurse Aide services shall not be provided at the same day or time as other personal care-type services. Pediatric Nurse Aide Services may not be provided if it duplicates other Medicaid or non-Medicaid services.

An employee submitting an application for hire under the consumer-directed care must comply with all policies and procedures of the consumer-direction program and successfully pass a background check.

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

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

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

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

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

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

- ☐ Legally Responsible Person
- ☒ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Direct Staff
Agency	Home Care Agencies

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Pediatric Nurse Aide Services

Provider Category:

Individual

Provider Type:

Direct Staff

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and educational services are needed and documentation is available to support training needs were met. Must be CPR certified.
Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

initially and annually

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Pediatric Nurse Aide Services

Provider Category:

Agency

Provider Type:

Home Care Agencies

Provider Qualifications

License (*specify*):

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

Medicare certified home health agency.

Certificate (specify):

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

Other Standard (specify):

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

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

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

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

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

Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Frequency of Verification:

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

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

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

Service Type:

Other Service

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

Service Title:

Pest Eradication

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

A service for waiver participants that provides a one-time pest eradication treatment. This service is coverable when the waiver participant is living in his or her own home, when not already included in a lease, and when the eradication is for the management of health and safety as identified in the person-centered service plan. The eradication procedure is limited to one time per year.

Assurance: The service under the waiver's Pest Eradication is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

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

The cost of this service shall not exceed \$1600.00 per waiver participant (July-June); \$800.00 maximum for each fiscal year.

This service is not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase the pest eradication and the treatment is not available through another source.

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

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

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

Service Delivery Method (check each that applies):

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Vendor

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Pest Eradication

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17990 other

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Supplies that are necessary to avoid institutionalization and promote continuous community integration often prescribed by a physician.

- a. Adaptive Tricycles: A durable medical equipment used for the development of gross motor skills, range of motion, improved endurance, improved circulation, trunk stabilization and balance, or as an adjunct to gait training.
- b. Vehicular transport vest: A durable medical equipment for safe transport.
- c. Adaptive car seats: a durable medical equipment for appropriate positioning and safe transport.

Specialized medical equipment and supplies consists of the following:

1. The performance of assessments to identify the type of equipment needed by the participant.
2. Training the participant or caregivers in the operation and/or maintenance of the equipment or use of the supply.
3. Repair of the equipment is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment.

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

Service only covers items not available through EPSDT

Adaptive tricycles for individuals: - \$ 3,000 over the cycle of the waiver

Adaptive car seats or vehicular transport for individuals between the ages of 0-20 children weighing over 30 pounds or with a seat to crown height that is longer than the back height of the largest safety car seat if the child weighs less than the upper weight limit of the current car seat. As priced per plan year.

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

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

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

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

Service Delivery Method (check each that applies):

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

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

☐ Legally Responsible Person

☐ Relative

☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME Supplier

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

DME Supplier

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled as a Medicaid provider as a DME provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years,
NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

Initially and every five years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Training, Education, and Consultative Services

HCBS Taxonomy:**Category 1:**

13 Participant Training

Sub-Category 1:

13010 participant training

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

A service that provides supportive services to the waiver participant, the waiver participant's unpaid primary caregiver, or unpaid support system. The purpose of the supportive service is to enhance the decision-making ability of the waiver participant, enhance the ability of the waiver participant to independently care for him or herself, or enhance the ability of the primary caregiver in caring for the waiver participant. These service activities which include training and counseling services for individuals who provide unpaid support, training, companionship or supervision to waiver participants. All training and education services must be documented in the participant's person-centered care plan as a goal with the expected outcomes. This service may cover conference registration and enrollment fees for classes.

The services under the waiver's training/education and consultative services are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. This service may not be used to provide training to a paid caregiver.

Each waiver beneficiary will be assessed using person-centered planning methodology. If a waiver beneficiary's status changes, and requires service units over the average limit, an assessment of needs will be evaluated on an individual basis. Service requests that meet eligibility criteria will be approved at the assessed need, NC Medicaid will closely monitor the individual and wavier average per capita cost to maintain cost neutrality of the waiver.

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

This service is limited to \$500 per fiscal year. Individuals who are paid service providers cannot be trained or educated using this service.

An organization with a training or class curriculum approved by the SMA including Universities, Colleges and Community Colleges shall provide training and education services.

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

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

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

Service Delivery Method (check each that applies):

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial/Educational Settings

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Training, Education, and Consultative Services

Provider Category:

Agency

Provider Type:

Business/Commercial/Educational Settings

Provider Qualifications

License (specify):

- 1) Universities, Colleges, and Community Colleges
- 2) An organization with a training/class curriculum approved by the Division of Medical Assistance.

Certificate (specify):

- 1) Universities, Colleges, and Community Colleges
- 2) An organization with a training/class curriculum approved by the Division of Medical Assistance.

Other Standard (specify):

The case management entity must approve and authorize the service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management Entity

Frequency of Verification:

prior to service provision

Appendix C: Participant Services

C-1/C-3: Service Specification

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

05/06/2020

the Medicaid agency or the operating agency (if applicable).

Service Type:

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

Service Title:**HCBS Taxonomy:****Category 1:****Sub-Category 1:****Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Service Definition (Scope):****Category 4:****Sub-Category 4:**

Vehicle modification is a service for a waiver participant that enables increased independence and physical safety through transport. The intent of a vehicle modification is to adapt, alter, or install controls or services to an unmodified motor vehicle such as an automobile or van that is a waiver participant's primary means of transportation. The vehicle must be owned by the waiver participant or the primary caregiver prior to the initiation of the modification. Vehicle modifications are specified by the service plan as necessary to accommodate the special needs of the beneficiary to enable the beneficiary to integrate more fully into the community and to ensure the health, safety, and well-being. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the modification in the event of an accident. Modifications do not include the cost of the vehicle or lease.

Assurance: The service under the waiver's Vehicle modification is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

The following modifications are covered for an unmodified vehicle:

- a. Door handle replacements;
- b. Door modifications;
- c. Installation of raised roof or related alterations to existing raised roof system to approve head clearance;
- d. Lifting devices;
- e. Devices for securing wheelchairs or scooters;
- f. Adapted steering, acceleration, signaling and breaking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel;
- g. Handrails and grab bars;
- h. Seating modifications;
- i. Lowering of the floor of the vehicle;
- j. Transfer assistances;
- k. 4-point wheelchair tie-down;
- l. Wheelchair or scooter hoist;
- m. Cushions;
- n. Wheelchair or scooter transporting mobility devices;
- o. Ramps; and
- p. Devices for securing oxygen tanks.

Vehicle modifications may be approved for a previously modified vehicle when the modification is intended to meet the waiver participant's care needs and allows for physical safety through transport. The service does not cover the purchase or lease of the vehicle itself, but the actual cost of the installed modifications. When a vehicle is a manufactured modification or has been previously modified, the above exhaustive list of items are covered when the items listed in the assessment are specific to the disability. An assessment must be completed by a Physical Therapist or Occupational Therapist specializing in vehicle modifications, or a Rehabilitation Engineer or Vehicle Adaptation Specialist certifying necessity. All vehicles must be evaluated with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications. A copy of the assessment must be submitted with the request for Vehicle Modifications. Upon a determination analysis of a request, a physician's signed order may be required to certify that the requested adaptation is necessary. Obtained physician's signed order must be on file in the waiver participant's record. When feasible, there must be at least one competitive quotes with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications to determine the most efficient method to complete the request.

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

Vehicle modification is included in a combined home modification and assistive technology budget of \$28,000 per beneficiary per the cycle of the CAP/C waiver, which is renewed every five years. When the maximum utilization limit is reached, requests for vehicle modification is denied. The CME shall track all costs of vehicle modifications billed and paid, to avoid exceeding the \$28,000 limit over the cycle of CAP/C waiver.

The cost of renting or leasing a vehicle with adaptations, service and maintenance contracts and extended warranties and adaptations purchased for exclusive use at the school or home school are not covered. Items that are not of direct or remedial benefit to the CAP/C beneficiary are excluded from this service. The CME shall authorize vehicle modification through service authorization prior to the initiation of the modification.

A vehicle modification may be considered for an older vehicle or a vehicle with over 80,000 miles when the recommendation from the vehicle modification specification guarantees the vehicle's ability to withstand the modification and the vehicle has a life expectancy of five (5) or more years.

The service reimburses the cost of the depreciated value of a previously modified vehicle, see above, when as assessment of the previously modified vehicle is in good condition. The assessment reports

- a. The age of the previous modifications;
- b. The original price of the modifications;
- c. The current value of the modifications;
- d. The age of the vehicle; and
- e. The current appraised condition and value of the vehicle.

Those items that are not of direct medical or remedial benefit to the beneficiary or are considered recreational in nature are excluded and not authorized by the case management entity. Approval for vehicle modifications is based upon medical need; there is no entitlement of services up to the program limit (\$28,000).

Vehicle modifications are provided and must be installed according to applicable standards and safety codes such as manufacturer's installation instructions, National Mobility Equipment Dealer's Association guidelines, Society of Automotive Engineers guidelines, and National Highway and Traffic Safety Administration guidelines.

Exclusions:

Vehicle modification excludes the following:

- a. Items that are not of direct or remedial benefit to the CAP/C beneficiary;
- b. purchase price or lease of the vehicle itself;
- c. Regularly scheduled upkeep and maintenance;
- d. The cost of renting a vehicle with adaptations;
- e. Service and maintenance contracts and extended warranties;
- f. Adaptations purchased for exclusive use at school; or
- g. Replacement of a vehicle adaptation if the beneficiary or family fails to keep their automobile insurance policy current when the repair would have been covered by the insurance.

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

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

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

Service Delivery Method (check each that applies):

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

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

- ☐ Legally Responsible Person
- ☐ Relative
- ☐ Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Meets applicable state and local requirements for type of device that the vendor is providing.
All vehicles must be evaluated by an adapted vehicle supplier.
Motor vehicle modifications are provided and installed in accordance with applicable standards and safety codes including manufacturer's installation instructions, National Mobility Equipment Dealer's Association guidelines, Society of Automotive Engineers guidelines, and National Highway and Traffic Safety Administration guidelines.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management Entity, if the case management agency bills for the modifications on behalf of the vehicle adapter.

Frequency of Verification:

Prior to service delivery.

Appendix C: Participant Services

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

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- ☐ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ☒ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☐ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ☐ **No. Criminal history and/or background investigations are not required.**
- ☒ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal Background checks are conducted in accordance with GS 131 E255 and NCAC 27G.0202.

Criminal background checks and registry checks are conducted on all personnel providing waiver services. For case management staff, the appointed case management entity is required to perform a state background check and a national background check if lived outside of North Carolina within five years. The record of this background check is kept on file at the provider agency and uploaded in the CAP Business system.

For all personal care assistants who are providing hands-on waiver services, the In-Home Aide Agency or the Home Health Agency is required to perform a criminal background and registry check on all hired employees prior to assignment to a waiver beneficiary. The record of this background check is kept on file at the provider agency and must be produced upon demand.

For all Medicaid enrolled providers, the State's contracted vendor, conducts a background check to include an OIG search on all applicants prior to the assignment of a National Provider Number. If the background check is not favorable, the applicant is not granted a Medicaid enrollment status.

For direct hire employees, the financial management entity is mandated to conduct a SBI background check on all employees to include a registry and Registry check. The results of the background check are filed in the waiver beneficiary's file.

The verification of criminal history and background check is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. The financial manager is required to verify criminal history and background check of the provider, hire employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis. This section has been updated.

The case manager verifies that this has been completed before waiver services and participation are approved. NC Medicaid conducts annual audits to ensure compliance of waiver assurances and performance measures in regard to criminal history and background checks. The NC Medicaid Program Integrity Unit conducts post audit reviews, criminal history and background investigation are included in their reviews.

The NC Medicaid Program Integrity Unit conducts post audit reviews, criminal history and background investigation are included in their reviews.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ☐ **No. The state does not conduct abuse registry screening.**
- ☒ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Division of Health Services Regulation (DHSR) is responsible for maintaining the nurse aide registry. DHSR requires direct care staff to be screened through the Nurse Aide Registry at hire and at least annually thereafter. All direct care staff are not nurse's aides, the DHSR conducts a criminal background check on entities monitored by that division. The licensed entities monitored by DHSR are mandated to conduct criminal backgrounds and registry checks on all hired employees to assure health, safety and well-being of all individuals to mitigate risk. A waiver participant using the consumer-direction model of care selected worker (personal assistant) is required to undergo a health care registry check prior to providing supplement and supportive services. The health care registry check is completed by the financial management entity during the employment screening process. Health care registry checks are obtained by the NC Health Care Registry and the Office of Inspector General (OIG) U.S. Department of Health and Human Services Exclusion Database. Any findings related to a substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry and or OIG U.S. Department of Health and Human Services Exclusion Database or a finding that restricts the selected worker (personal assistant) from working in the health care field. This procedure is a mandatory responsibility if the financial management entity. To mitigate risk of abuse, neglect, exploitation to a waiver participant, the State Medicaid Agency has implemented a mandatory requirement of a health care registry check prior to the approval of authorization to the financial management entity to submit Medicaid waiver service claim for reimbursement. The selected worker (personal assistant) must receive clearance to provide HCBS through the CAP Business system, e-CAP from the financial management entity checking a mandatory field. Once the mandatory field is checked, it validates this requirement was met. Random samples are performed quarterly to monitor the performance of the financial management entity

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ☒ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ☐ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- ☐ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ☒ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of **extraordinary care** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

A waiver participant age 18 years old and over may have his or her In-home Aide, Respite In-home, Pediatric Nurse aide Services provided by a relative and/or legally responsible person who is an employee of an In-Home Care Agency or directing care through participant directed services. The CME plays a major role, along with the participant and/or

representative in assessing and determining need for personal care. The CME also assists in monitoring the service plan, tasks and time records to assure appropriate provision and utilization of waiver services. Additional safeguards include post-payment reviews conducted by the State Medicaid Agency. The limit is up to 8 hours maximum a day. On a case-by-case review, hours may exceed 8 hours based on assessed and demonstrated need.

The employment of a spouse, parent, child or sibling of the waiver participant is eligible to provide personal care services only if waiver participant is 18 years old and older and the person providing the care meets the following qualifications:

- a. Is at least 18 years of age;
- b. Meets the aide qualifications; or deemed competent by the appropriate licensed supervisory professional of the In-Home Care agency to provide the personal care task at that level as defined in 10A NCAC 13J.110; and
- c. Does not have other employment that interferes with the needs of the waiver participants regarding time and days.

A legal guardian, Power of Attorney, Health Power of Attorney of an 18-year-old or older waiver participant cannot be hired to provide In-home Aide, Respite In-home, Pediatric Nurse aide services to a waiver participant. Exclusions may apply when (a) there is a staffing shortage in remote areas of the state; or (b) the lack of a qualified provider who can furnish services at unusual times during the day because of the complexity of the waiver participant's care needs.

When it is determined to be in the best interest of the waiver participant who is 18 years old and older to have a legally responsible individual to provide personal care services, a physician's recommendation shall be provided to the case manager outlining the specific care needs of the waiver participant and how those needs can only be provided by the legally responsible individual. In conjunction with the physician's recommendation, an analysis of the case record is performed to evaluate the legally responsible individual's compliance with treatment and service plans and to ensure critical incident reports did not implicate the legally responsible individual to be negligent. In addition, the physical health of the legally responsible individual is heavily considered.

Paid care by a legally responsible person may be authorized when extraordinary conditions apply which include the following circumstances:

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

☒ **Self-directed**

☒ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

- ☐ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ☐ **The state makes payment to relatives/legal guardians under specific circumstances and only when the**

relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

A legally responsible individual can only perform personal care tasks for 40 or less hours per week to ensure compliance with Department of Labor requirements. The approved hours are based primarily on the assessed needs identified in the assessment.

This waiver allows a spouse or legally responsible individual of a waiver participant who is 18 years old and older to perform personal care services and receive payment when any one of the following extraordinary circumstances occur: 1. The waiver participant is experiencing a cognitive or intellectual limitation and the presence of an unfamiliar individual is more disruptive than productive and the waiver participant requires additional assistance with ADLs than ordinary as identified in a service plan.

2. The waiver participant is in an area with limited access to service providers and the assessment of needs identifies that the waiver participant requires five or more hours per day of uninterrupted personal care.

3. The waiver participant has a secondary diagnosis of mental illness or an intellectual disability and the behavior, because of this illness, poses harm to an unfamiliar person or past behaviors have alienated service providers.

The legal guardian will not receive payment for performing instrumental activities of daily living tasks solely such as meal preparation, laundry, money management, home maintenance, shopping, and medication management. The performance of ADLs associated with the IADLs are included in the payment for performing personal care tasks.

When the legal guardian is authorized to receive payment for providing in-home aide or pediatric nurse aide services, the waiver participant will be enrolled in the coordinated caregiving waiver service. The enrollment in this service will provide quality assurance of the health, safety and well-being of the waiver participant and provides the controls to ensure that payments are made only for the services authorized to provide.

The assigned case management entity will perform weekly contacts to include two weekly in-person monitoring visit to ensure the services are provided in accordance with the service plan and the waiver participation business requirements.

A legal guardian will not be approved to provide personal care services and receive payment because of unwarranted biases to a Home Health Agencies/In-Home Aide Agencies without first attempting to work with those agencies. A legal guardian will not be approved to provide personal care services and receive payment if there are other providers Health Agency/In-Home Aide Agency due to non-complaint or violent behavior exhibited by the waiver participant or the legal guardian.

A comprehensive multidisciplinary assessment is conducted to identify medical, functional, social and family support needs. The severity of these needs is identified in the assessment and carried over to the service plan. The CME coordinates with the waiver participant and other care professionals to create a plan of care to meet the needs identified in the assessment. Each month, the CME corresponds with the beneficiary and service providers to assure that the services authorized on the POC are adequate in the amount, frequency and duration. Every three months, the CME is required to conduct a home visit to observe hands-on assistance to assure services approved for the amount, frequency and duration are sufficient for current needs. Adjustments are made upon discovery. Also, the CME is required to review supporting documentations to determine the need for a reassessment when the beneficiary is hospitalized or endures a significant change in status. Another monitoring task the CME performs to assure services are in the best interest of the individual is a quarterly multidisciplinary monitoring team meeting with all services providers.

- **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Enrollment is available to an interested provider at any time. Providers must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once Medicaid enrollment application is approved, and the provider has completed a managed change request to provide waiver services, the provider is authorized to provide services in the approved catchment area. Each approved provider is required to be listed on the freedom of choice provide form in each catchment area to be eligible to render services to waiver participants.

The CME and IAE (after July 2020) will provide each waiver participant a freedom of choice policy in which the waiver participant must sign to acknowledge his or her rights to choose any qualified provider eligible to provide a waiver services.

Case management entities will be approved to serve their NC Medicaid application catchment areas when all qualification requirements are met.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. Sub-Assurance: *The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.*

Performance Measures

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

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

Performance Measure:

QP-A1 Number and percent of waiver providers who met the required provider requirements to provide waiver services. Requirements: active NPI, Medicaid enrollment status annually, complete trainings annually and render services as per service plan. **Numerator:** number of waiver providers who meet requirements to provide waiver services **Denominator:** number of waiver providers reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

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

Performance Measure:**QP-A2 Number and percent of waiver providers passing the OIG registry check****Numerator: number of waiver providers passing the OIG registry check****Denominator: number of waiver providers****Data Source (Select one):****Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

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

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

Specify: CAP Business system case management system and NC Medicaid MMIS		Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

QP-A3 Number and percent of case management entities monitored quarterly through audits (desktop, site, or an analysis of data) that maintained a 90% compliance score. Numerator: number of case management entities with a compliance score of 90% or better Denominator: number of case management

entities monitored during the quarterly auditing period**Data Source** (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

Reports of assessments, SP, level of care determinations, service authorizations, criminal incident reports and monthly and quarterly monitoring documentation uploaded in CAP Business system.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

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

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

Performance Measure:

QP-B1 n/# of waiver beneficiaries who selected consumer direction where all staff had the required criminal/registry checks, prior to the receipt of waiver services

Numerator: number of consumer direction waiver beneficiaries where all staff had the required criminal/registry checks, prior to the receipt of services **Denominator:** number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system and case management system and NC Medicaid MMIS</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

QP-B2: N/# of non-certified hired staff through provider-directed agencies who passed a criminal background and registry check prior to assignment of work N: # of non-certified hired staff through provider-directed agencies who passed a criminal background and registry check prior to assignment to work D: # of non-certified hired staff reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

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

	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

c. Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

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

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

Performance Measure:

QP-C1 Number and percent of waiver providers who received a service authorization that completed the CAP specific waiver overview and orientation training module, initially and annually. Numerator: number of waiver providers who completed CAP training initially and annually Denominator: number of waiver providers reviewed

Data Source (Select one):**Training verification records**

If 'Other' is selected, specify:

Material will be uploaded in the CAP Business system by the case management entity annually and continuously and ongoing.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

QP-C2 Number and percent of consumer-directed waiver beneficiaries whose direct staff completed all required trainings identified during the self-assessment questionnaire
Numerator: number of consumer-directed waiver beneficiaries whose direct staff who completed all required trainings
Denominator: number of consumer-directed waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: CAP Business system case management system and NC Medicaid MMIS		Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

QP-C3 Number and percent of case management entities that completed annual mandatory training requirements
Numerator: number of case management entities that completed annual mandatory training requirements
Denominator: number of case management entities reviewed

Data Source (Select one):**Training verification records**

If 'Other' is selected, specify:

Material will be uploaded in the CAP Business system by the case management entity annually.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system by the case management entity</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

QP-C4 PM: Number and percent of HCBS providers who completed the HCBS training initially prior to rendering waiver services N: Number of HCBS providers who completed the HCBS training initially prior to rendering waiver services D: Total number of HCBS providers reviewed

Data Source (Select one):**Reports to State Medicaid Agency on delegated Administrative functions**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">95%; 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">CAP Business system</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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

The CAP Business system(CBS)evaluates waiver activities. To validate the efficiency and capacity of the IT system,the sampling methodology will be 100% for waiver year one.

NC Medicaid verifies all Medicaid providers are licensed or certified, as required, and properly enrolled as a Medicaid provider by the State Medicaid Agency fiscal agent for each type of service furnished. A rigorous process that includes submitting a complete copy of the applicable criminal complaint, consent order, documentation of license, suspension, penalty notice, and/or final disposition. The provider application, has the following questions that must be answered: Have you ever been convicted of any criminal offense, had adjudication withheld on any criminal offense, plead no contest to any criminal offense or entered into a pre-trial agreement for any criminal offense? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had disciplinary action taken against any business or professional license held in this or any other State, including licenses issued by the North Carolina Division of Health Service Regulation and endorsements issued by any Local Management Entity as that term is defined in N.C.G.S. 122C-115.4? Has your license to practice ever been restricted, reduced/revoked in this or any other State or been previously found by a licensing, certifying or professional standards board or agency. Have you or any entity you are or were either an agent, owner, or managing employee of, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any State? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had payments suspended by Medicare or Medicaid in any State? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had civil monetary penalties levied by Medicare, Medicaid or other State or Federal agency or program, including NC DHSR, even if the fine(s) have been paid in full? Have Medicare or Medicaid in any State ever taken recoupment actions against you or any entity you are or were an agent, owner, or managing employee of? Do you or any entity you are or were either an agent, owner, or managing employee of, owe money to Medicare or Medicaid that has not been paid in full? Have you ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services? Have you ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? Have you ever been convicted under federal or state law of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct? Have you or any entity you are or were either an agent, owner, or managing employee of, ever been found to have violated federal or state laws, rules or regulations governing North Carolina's Medicaid program or any other State's Medicaid program or any other publicly funded federal or state health care or health insurance program? Applicants must meet all program requirements and qualifications, for which they are seeking enrollment, before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once participation as a Medicaid provider has been approved, providers are assigned an NPI with an effective date and are notified by mail. Providers may begin submitting claims to Medicaid, upon receipt of their NPI. An active Medicaid Provider must be reassessed, a minimum of every three years to, ensure the provider's credentials and qualifications continue to meet N.C. standards.

Addition to this rigorous state licensure/certification standards, a Medicaid provider must demonstrate competency to perform services. The State Medicaid Agency approves each provider to provide waiver services. After approval to provide the service and before services may be rendered, each approved provider must complete a Provider CAP Training Overview module.

The CME will provide the Medicaid provider a service authorization initially, annually, and as needed, so to initiate approved waiver services.

Waiver beneficiaries have the freedom to choose to receive waiver services from any active credentialed Medicaid provider that serves their county. A waiver participant may switch providers without any restrictions. The only restrictions that will be imposed is a 5-day delay to the switch between case management entities within a county. Because of the appointment of lead entity and the utilization limitation of case management hours annually, when a request is made to switch a case management entity, the case manager will notify the State Medicaid Agency to initiate a root cause analysis to identify reason, current utilization limits and the performance of the previous and newly selected case management entity. The State Medicaid Agency will provide technical guidance for the approval and transfer of the case management entity.

Medicaid providers that provide personal care services and other in-home type services, must ensure the following activities to comply with state laws: 1. background checks are completed on all employees; 2. competency evaluations and trainings are conducted for in-home aide staff; 3. Monitor quality of care; 4. Handle Workers Compensation; 5.Manage the payment of income and Social Security taxes; 6.Ensure that in-home aides work under the supervision of a Registered Nurse, and 7. Abide by the waiver policy of no seclusion and

restraints. FMS will conduct background/registry checks on all direct support staff.

b. Methods for Remediation/Fixing Individual Problems

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

Upon discovery of non-compliance, The State Medicaid Agency appointed fiscal agent notifies the provider via letter and electronically to inform of the return of the provider application. The returned application will highlight the areas of non-compliance along with information in how to re-submit the application. The provider must comply with all required timelines. If the timeline is not met, the provider application will be voided. A provider must document and provide a record of provision of services before seeking Medicaid payment. The record must provide an audit trail for services billed to Medicaid. Submitting a written explanation in lieu of supporting documentation may result in the denial of the application. Each provider must notify the State Medicaid Agency fiscal agent within thirty (30) calendar days of learning of any adverse action initiated against the license, certification, registration, accreditation and/or endorsement of the provider or any of its officers, agents, or employees.

Upon non-compliance of CAP specific guidelines, the CAP Medicaid provider will be notified via written correspondence detailing the non-compliant area(s). The provider will be given a specified period of time to comply. If compliance is not reached, depending on the occurrence, a referral will be made to Program Integrity with a recommendation of termination or pay back.

Upon discovery of non-compliance of the FMS, the State Medicaid Agency notifies the FMS of the noncompliance and gives the FMS 30 calendars days to correct the noncompliance areas. Technical Assistance is provided to the FMS. Persistent non-compliance will result in a sanction of a civil financial penalty. Three incidences of a civil financial penalty will result in the termination of the provider as a fiscal intermediary. Any direct support staff without a criminal background and registry check will not be allowed to provide services until verification is confirmed that the checks were complete.

Upon discovery of non-compliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within 3 business days. Repeated findings of non-compliance by a CAP IT contractor results in in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

The State Medicaid Agency will ensure that provider training is conducted in accordance with state licensure/certification requirements, NC Medicaid clinical policy and waiver requirements. The appointed case management entity staff, are required to have mandatory annual trainings as specified by the waiver. Upon discovery of non-compliance, case management entities will be required to attend an ad-hoc mandatory training session in person or by webinar. Persistent non-compliance will result in suspension of new enrollment until compliance is maintained. Failure to meet annual training requirements for all staff for two consecutive waiver years will result in provider termination as a case management entity.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

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

☒ **No**

☐ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

☒ **Not applicable-** The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

☐ **Applicable -** The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- ☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- ☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2, HCB Settings Waiver Transition Plan, for a description of how the state will achieve compliance with the HCB settings requirements of the final rule for both residential and non-residential settings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person/Family-Centered Plan of Care

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- ☐ **Registered nurse, licensed to practice in the state**
- ☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**
- ☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

☐ **Social Worker**

Specify qualifications:

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ☐ Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.
- ☒ Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

An assessment is conducted to initially assess needs and risk indicators to validate eligibility to receive this level of care and service. Upon the approval of waiver participation, the waiver participant is required to select a case management entity to assist with the development of a person-centered service plan which is based on an individual's assessed needs and is designated to address any risk indicators identified. The CME arranges an appointment with the waiver participant and encourages the waiver participant's support system to attend. Prior to the first appointment, the waiver participant is encouraged to identify goals/objectives to address social/health needs. The CME reviews those goals with the waiver participant and relates them to the identified risk indicators to begin the discussion of the person-centered service plan. The CME is also responsible to provide monthly case management to ensure each waiver participant's health/welfare is maintained. The CME may also be approved by SMA to render other waiver services when there is no other qualified entity available and the CME is the only willing and qualified entity and the other protections could only be used if this first condition is met. To prevent conflict of interest and to promote freedom of choice, the SMA has instituted firewalls to safeguard the waiver participant. Two firewalls: Two firewalls: 1. Clearly defined definition for COI that is discussed with the waiver participant and signed by both the case management entity and the waiver participant and approved by the SMA. This HCBS waiver arranges for conflict free case management in that a CME cannot provide a direct service to the waiver participant and case management by the same person or unit within their organization or make decisions that can potentially benefit or incentivized their organization. 2. Initial Assessments performed by a CME or IAE (after 7/2020) that has no direct or indirect affiliation with the waiver participant. After July 2020, the IAE will be responsible to perform a quality validation of annual eligibility decisions to ensure the service plan is conflict free and the waiver participant could fully exercise freedom of choice. As a means of documenting choice was provided to the waiver participant, the case management entity must review and have the waiver participant to acknowledge and sign an agency disclosure form that provides information about COI, free choice of providers or lack of specific service providers in that service region. Disclosure about freedom of choice and conflict of interest is provided in four written formats-Participant Disclosure Form, Introductory Letter, Welcome Letter and a reassessment anniversary letter. Each of these letters are generated in the CAP Business system and mailed either by the CME or IAE (after 7/2020). Yet another safeguard is Rights and Responsibilities form. This form clearly outlines the responsibilities of the waiver participant, the IAE (after 7/2020), CME and SMA in their responsibilities of assuring freedom of choice and conflict of interest protections. The form must be signed and dated by the waiver participant and uploaded in the CAP Business system prior to the approval of the service plan. The e-CAP Business system performs a quality check of the service plan to validate COI protections were practiced by the CME with all waiver participants. When CME acts in a dual role, safeguards are in place to assure the CME administratively separates the plan development function from the direct service provider functions. Two safeguards in are placed to manage potential conflict of interest in this area. The first safeguard is for the services and approval authority to be provided by two distinct units or personnel within that organization. The second safeguard is for the CME to have an independent reviewer to perform quality checks on a quarterly basis to assess concerns of conflict and needs of the waiver participant is adequately met. In instances of agencies in rural eastern, southern and western communities with limited resources, conflict of interest protections is managed through separation of authority within that agency. The CME/provider agency must administratively separate the plan monitoring function from the direct service provider functions. A safeguard is in place for the monitoring and service rendering staff to be provided by two distinct units/personnel within that organization. A second safeguard is for the CME/provider agency to have an independent reviewer to perform quality checks on a quarterly basis to assess concerns of conflict and needs of the waiver participant is adequately met. The case management entity is also required to assess adequacy of provider network on a quarterly basis from <https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/community-alternatives-program-for-disabled-adults>. The SMA identifies in advance the potential agencies that will fall in this threshold through a network analysis on a quarterly basis. When an agency is approved to function in this dual role, the SMA monitors those agencies closely by the initial service plan, paid claims, revisions to service plans, monitoring of monthly and quarterly visit summary reports, incident reports and annual surveys. The CME is also required to assess provider network in the service region routinely for available providers and discuss free choice of provider (disclosure form) with the waiver participant on a quarterly basis. Entities can only provide both case management services and other waivers services when prior approved by the SMA. The state CAP unit will assist the waiver participant to select another direct service provider when COI is evident. The waiver participant will be offered a dispute resolution process when COI is identified. The waiver participant will be provided a written notice and requested to reply within 10 business days to initiate a dispute.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The waiver participant is supported in the service plan development process. Prior to the official in-home assessment, the waiver participant is provided an Introductory letter or an anniversary letter that informs the waiver participant on how the service plan will be developed and how to access needed waiver services based on risk indicators. Both letters provide detailed information about each waiver service to allow the waiver participant the opportunity to formulate a plan to meet health care needs. The letters also provide information about fair hearing and grievance and complaints. Additionally, while the assessor is in the home conducting the comprehensive assessment, the waiver participant is provided with information about person-centered planning and the need to select a case management entity to initiate the person-centered plan. The assessor informs of risk indicators identified after completion of the comprehensive assessment and provides the waiver participant a list of waiver services that may assist to mitigate those risks. The waiver participant is encouraged to begin identifying person-centered goals and services to meet health care needs in preparation of the service plan development.

Upon the completion of the comprehensive assessment by the assessor, the selected case management entity is provided access to the completed comprehensive assessment along with a summary of findings and recommended waiver services that may aid in mitigating risks for the waiver participant. The case management entity meets with the waiver participant to complete the person-centered plan that includes cultural influences and holistic overview of assessed needs. The waiver participant leads the service plan development process. The waiver participant is granted the authority to include individuals he or she finds to be pertinent to participate in the development of the service plan.

Information provided to the waiver participant to assist with service plan development:

- Waiver benefit package - the names of each waiver service and its definition and how one qualifies for a particular waiver services, the utilization limits and how the services may prevent institutional placement.
- Person-centered planning – information to describe the definition of person-centered planning and how the participant is entitled to determine who should be involved in decision-making and who may attend planning meetings. The participant is also provided information about how to ensure his or her likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity are included in the plan. The participant is also informed about assumed risk when choosing to participate in a home and community-based program.
- Freedom of Choice – information is provided to describe what freedom of choice is and how the participant can exercise his or her freedom of choice when selecting to participate in the waiver, how to select waiver services and providers to provide services which also includes the case management agency for management of the day-to-day oversight during waiver participation. A participant may select a different provider at any time, for any reason.
- Fair hearing- information is provided on how to request an appeal when an adverse decision is made and the timeline granted to file an appeal.
- Complaints and Grievances- information is provided that describes what is a complaint and a grievance and how to voice a complaint and a grievance. The timeline is provided on how the complaint or grievance is to be managed.
- Abuse, Neglect and Exploitation (ANE) - information is provided on what ANE means, ways to identify concerns and how to report suspensions. This information also states the obligation by State Medicaid Agency, case management entities and service provided to report concerns of ANE to the appropriate officials.
- Resources available in the community- a list of resources is provided to the waiver participant that describes Medicaid services and other community resources potentially available to the participant while the participant completes through the eligibility steps.

Fraud, Waste and Abuse - information is provided on what fraud, waste and abuse is and how to report concerns. This information also informs of the obligation of the State Medicaid Agency, case management entity and service providers to report fraud, waste and abuse when it is suspected.

Service plan development will also include planning for individuals wishing to transition from an institution. The safeguards in place to ensure an appropriate assessment of need is conducted and that a person-centered service plan is developed to adequately address needs in the type, frequency, duration and amount are identified by the following:

A. Coordination of at least two transition planning meetings are arranged to begin the building of relationships as well as obtaining information to plan for community living. This information will assist to complete the service request form that is required for participation in this HCBS program. At this meeting, educational information about the transition process is effectively communicated to the interested individual and family.

B. During the second transition planning meeting, the assessor will initiate a dialogue about peer supports and social supports, substance addition, behavior support needs and tenancy support needs for preparation of service planning.

C. The assessment of need and the service plan development will be contingent upon various factors, one, in particular, is the confirmation of housing. When housing is secured the following steps are followed:

1. An assessment is initiated within 2 business days of the arrangement of housing.
2. A service plan is completed within 15 business day or within 5 business days of the arrangement of housing, when a time limit is placed on acquiring the housing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Service Plan Development Process is completed in multiple steps. The first step is to establish the level of care. The LOC is the first determinant of waiver eligibility. The next step is the determination of reasonable indication of need based

on functional needs and psychosocial factors identified in a comprehensive assessment. Individuals determined to have reasonable indication of being institutionalized or have a reasonable indication of meeting a nursing facility level of care (LOC) with assessed complexity of needs ranging from low to high skill levels and who do not have available resources to meet immediate needs- medical, psychosocial and functional. The affirmative results of having reasonable indication of needs leads to the last step of eligibility, the service plan development. Breakdown of each step:

First step is the health information gathering and consultation with the primary physician to decide of level of care (LOC) using a service request form. Upon the approval of the LOC and the assignment of a slot, the CME or IAE(after July 2020) initiates

the second steps of eligibility which is the comprehensive assessment that assesses the following functional areas:

- Contact information
- Diagnosis and history;
- Caregiver information;
- Medication and precautions;
- Skin;
- Neurological;
- Sensory and communication;
- Pain;
- Musculoskeletal;
- Cardio-Respiratory;
- Nutritional;
- Elimination;
- Mental Health;
- Informal support;
- Housing and finances; and
- Early Intervention and Education

If the individual needs indicate gaps in service provisions or the individual is assessed to be at-risk of community displacement (institutionalized), and reasonable indications of gaps in service provision, the individual is mailed an approval letter titled "Introductory Letter" that provides supportive information about the waiver. The letter also introduces the waiver participant to home and community-based planning; the roles and responsibility of State Medicaid Agency and the case management entity, freedom of choice and services available to him or her while participating in the waiver. The individual or current approved waiver participant is requested to select a case management entity for the assignment of a case manager to assist with the develop of a person-centered service plan. The interested individual or waiver participant may request individuals he or she prefers to participate in the service plan development phase. The case management entity or the State Medicaid Agency does not place restriction of who may participate in the service plan development, unless there is an obvious conflict of interest.

The development of a person-centered service plan is triggered by risk indicators of medical, behavioral, social and functional needs identified by the independent multidisciplinary assessment team. The case manager is assigned to complete the service plan and assists the waiver participant to identified preferences, likes and dislikes to create services needs for both formal and informal support systems. These identified needs will auto-populate to the service plan worksheet, for consideration and planning. The CAP Business system will not allow a service plan to be completed until there is

a plan for each identified risk indicators by service need.

The case management entities shall participate in continuing education throughout the calendar year. Continuing education shall be provided to build and ensure capacities in service plan development. The following are the initial and annual refresher mandatory trainings:

- a. Person-centered thinking and planning training;
- b. Abuse, neglect, exploitation;
- c. Program integrity (PI);
- d. Conflict resolution;
- e. Mental Health First Aide;
- f. Critical incident reporting;
- g. Health, Safety and Well-being and Individual Risk Agreement;
- h. Medicaid Due Process Appeal Rights and EPSDT;

- i. Consumer-Direction;
- j. Quality Assurance and Performance Outcomes
- k. Cultural Awareness; and
- l. Motivation interviewing or a similar training

In addition, the case manager shall complete other required trainings sponsored by their organization annually:

- a. Bloodborne Pathogens and Infection Control;
- b. Health Insurance Portability Accountability Act (HIPAA)
- c. End of Life planning;

Once the assessment is completed, the service plan must be initiated within 5 business days by the case manager. The service plan must be completed and approved by the 5th day of the anniversary month for active waiver participant and within 30 calendar days of the home visit to complete the comprehensive assessment for new individuals entering the waiver. The plan is approved for 12 months and can be updated at any time due to a change in status or request for a new or expanded need.

The assessment team meets with the potential waiver participant/primary caregiver and others at his or her request in his or her primary residence, to initiate the multidisciplinary comprehensive assessment that includes a historical overview of interested individual or waiver participant's life. The assessment team collects and enters the data in the CAP Business system

to initiate the analysis of health care needs. During this process, the assessment team collaborates with current providers and the primary physician to confirm assessed needs to further validate functional level. Upon the completion of the comprehensive assessment as described above, the CAP Business system provides the assigned case manager an overview of

assessed needs and areas that are critical to consider during the service plan development phase. The assigned case manager meets with the potential waiver participant/primary caregiver and others at his or her request, to review the findings of the assessment, to begin the discussion of a person-centered plan, the potential waiver participant/primary caregiver uses this information to begin the construction of a person-centered service plan. The case manager collaborates with the waiver participant to develop the

plan of care that will consist of both waiver and non-waiver services. The assessment must be completed and approved within 14 business days for initial and 7 business days for an annual when assigned to an independent assessor. This timeline is tracked by the CAP Business system. Once all needs are identified and the data analysis is received, the file is transferred to a selected case management entity to initiate the service plan.

The service plan development consists of:

- a. A multidisciplinary comprehensive assessment that identifies LOC, the waiver participant's preferences, strengths, needs, and ability to live safely in the community; and
- b. an approved person-centered service plan that includes cultural influences, likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity and services in the amount and duration of complexity of need. The services documented on the service plan must address the needs identified in the assessment.

An annual, every 12 months, reassessment is required during the month of the original waiver entry date. The annual reassessment

is called a Continued Need Review (CNR) assessment. The CAP Business system tracks all Continued Need Review and reassessments. The CAP IT system provides monthly alerts to CME or IAE, when applicable, of when annual reassessments are due.

The annual service plan must be approved by the fifth day of the month following the waiver participant's anniversary month. The CNR service plan is effective for the first day of the month following the anniversary month and expires one year later.

Changes and revisions to the Service plan are initiated by the assigned case manager as the waiver participant's needs change. Changes to the service plan are submitted in the CAP Business system within 30-days of identified needs and approved

within five (5) business days. The assigned case manager determines whether to revise the service plan when there is a change in the waiver participant's needs. A service plan revision is required when a waiver or Medicaid State Plan service is added, reduced, increased, deleted or when there are changes in amount, duration or frequency of a waiver service. A service plan update is required for a change in provider agency, but the change is not considered a revision. The case manager will obtain a signed agreement from the waiver participant or the responsible party consenting to the change in providers.

Service plan revisions are approved by an approval authority of the Case management entity. Revisions may be approved retroactively for up to 30 calendar days for specific services prior to the date that the plan is revised. The waiver participant or the primary caregiver shall agree to and sign service plan. The CAP Business system places prior approval

limits

on all authorized waiver services to ensure accurate reimbursement. The assigned case manager monitors the services monthly with the waiver participant and authorized waiver providers to identify deviations of services and review provision of care. If there are consistent deviations and the service is authorized on the service plan, the case manager must review this with the waiver participant and discuss a possible change in providers. If the waiver participant's needs may be maintained at the deviated service level, a service plan revision must be completed.

The Case management entity shall send a written adverse notice in accordance with State Medicaid Agency Due Process policy to the waiver participant or responsible party if a service is denied, reduced, terminated, or if the waiver participant is disenrolled from the program. The service plan will be active on the date of the effective date and all approved services will be rendered regardless if a requested service on the original POC was denied.

When CAP participation is approved, the case management entity will notify the participant in writing of the approval through a Welcome Letter. The Welcome letter outlines the following:

All approved waiver services along with its definition; contact information, information of freedom of choice, conflict of interest, abuse, neglect and exploitation and fraud waste and abuse. Additional information is provided about resources available in the community- a list of resources is provided to the participant that describes Medicaid services and other community resources. The local department of social services is provided an official letter of notification of waiver approval. The notice informs of the CAP effective date and the special coverage code to enter into the eligibility system to ensure the adjudication of all CAP claims that are submitted.

Each service provider is provided an official notice called a service authorization to authorize the waiver service that is listed on the service plan. In addition, Medicaid provider of other Medicaid services are provided a participation letter to acknowledge approval of receipt of other Medicaid services.

The CAP Business system forwards electronic files to the MMIS to validate the prior approval of LOC as well the prior approval of waiver services in the amount, duration and frequency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The State has procedures in place to comprehensively assess the waiver participant's needs to identify adverse health, safety and well-being indicators that potentially pose risks and strategies to mitigate those risks. Risk Assessment and Mitigation begins during the multidisciplinary comprehensive assessment. Each waiver participant will be carefully assessed for health and well-being to plan for safe living in the community. An initial assessment is performed on all new enrollees and annual assessments are performed on all active waiver participants. Upon the completion of the assessment, the CAP Business system analyzes the data fields to identify areas that could be a potential risk for the waiver

participant. Data from the assessment generated by CAP Business system informs the potential waiver participant/primary

caregivers and the assessment team of risk factors to consider during the service plan development to keep the waiver participant safely in the community. The results of the assessment are combined into a composite score. This score identifies the acuity level through a calculation that yields an acuity level of low to moderate needs or high to skilled needs. The composite score consists of:

1. ADL cumulative score;
2. Use of skilled services;
3. Current diagnoses; and
4. Beneficiary/caregiver risk indicators.

Each domain of the composite score is an indicator of fragility or complexity of need. The composite score uses a 100-point scale. A waiver participant with a score between 0-36 is represented to have low acuity needs, while a score between 37-64 is represented as intermediate acuity and a score between 65-100 is represented to have high acuity needs. The results of the assessment are used as a driver to develop a person-centered service plan to mitigate risk, upon initial and annual planning. During the development of the service plan the assigned case manager meets with the potential waiver participant/primary caregiver and other of his or her choice to review assessed risks to develop a plan of action to address each risk factor. Waiver and non-waiver services, assistance from the informal supports system are included in the service plan to aid in mitigating risk factors.

On a quarterly basis, a multidisciplinary team is held to perform a mini-assessment to ensure the person-centered service plan continues to meet the assessed needs of the waiver participant. During the multidisciplinary meeting or at any other monitoring interval, if a determination is made that the current service plan is not meeting the waiver participant's needs, one of two steps is followed: 1. The service plan is revised to add services to meet current needs; or 2. A change of status assessment is performed to conduct a full comprehensive assessment to reevaluate the composite score and risk indicators. Upon the completion of a change in status assessment, a new person-centered service plan is developed to mitigate risk.

Another safeguard the SMA uses to mitigate risk when indicators are present that may potentially jeopardize the health, safety and well-being of the waiver participant or caregivers is an Individual Risk Agreement (IRA). This is an agreement that permits a waiver participant to assume more responsibility for his or her personal choices through surrogate decision making or through planning team consensus. This agreement outlines the risks and course of action. The IRA is primarily used to manage behavioral concerns, non-compliance of the service plan and other well-being concerns that can't be mitigate by a formal service. The individual risk agreement is in conjunction with the service plan and does not replace the service plan. The individual risk agreement is instrumental in creating a think-tank for the case manager and the waiver participant to process risks and identify ways to minimize them and to assume responsibility and accountability of decisions.

During the development of the service plan the assigned case manager meets with the potential waiver participant/primary caregiver and other of his or her choice to review assessed risks to develop a plan of action to address each risk factors. Waiver and non-waiver services, assistance from the informal supports system are included in the service

plan to aid in mitigating risk factors. If waiver services, the informal supports system, and regular Medicaid Services are not able to fully address the risk factors, a waiver participant has the discretion to enter an Individual Risk Agreement (IRA) to assume responsibility and accountability of decisions. A risk agreement permits waiver participant to assume responsibility for his or her personal choices through surrogate decision making or through planning team consensus. This agreement in conjunction with the person-centered service plan outlines the risks and course of action. Enrollment and continuous participation in the waiver may be denied based upon a determination that the waiver participant may be unable to participate in the HCBS program despite the implementation of an individual risk agreement. Based on the evaluation of the risk agreement and the assessment of the waiver participant's medical, mental, psychosocial, physical condition and functional capabilities may indicate inability to participate in the waiver when the following conditions cannot be mitigated:

- a. Waiver participant cannot cognitively and physically devise and execute a plan to safety if left alone when over the age of 18 years;

b. Waiver participant lacks the emotional, physical and protective support of a willing and capable caregiver, who must provide adequate care to oversee 24-hour hands-on support or supervision, to ensure the health, safety, and well-being of the individual with debilitating medical and functional needs; or

c. Waiver participant's needs cannot be maintained by the system of services that is currently available to ensure the health, safety, and well-being despite an individualized risk agreement.

d. Waiver participant's primary private residence is not reasonably considered safe to meet the health, safety and wellbeing in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the waiver participant's safety, and these issues cannot be resolved through waiver services or other means;

e. The waiver participant's residential environment would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager/care advisor due to: a) the presence of a physical or health threat due to the proven evidence of unlawful activity conducted in the primary private residence; b) threatening or physically or verbally abusive behavior, by the waiver participant, family member or regular visitor or household member in that home; c) more than two incidences of physically and verbally abusive behavior or threatening language; or d) the presence of a health hazard due to pest infestation.

f. Waiver participant's, legally responsible person or caregiver's safety of self and others is impeded by the participant's, legally responsible person's, or caregivers': a) continuous intrusive and oppositional behavior; b) attempts of suicide; c) behavior that is injurious to self or others; d) verbally abusive or aggressive behavior; e) destruction of physical environment; or f) repeated noncompliance of service plan and written or verbal directives; or

g. Waiver participant or primary caregiver or responsible party, continuously impedes the health, safety and well-being of the waiver participant, by refusing to comply with the terms of the service plan, refusal to sign a plan, and other required documents; when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal), refuses to keep the care manager or care advisor informed of changes in the status of the waiver participant, or the participant's, caregiver's, or other resident's behavior makes it impossible to staff aides to provide the required assistance

h. Waiver participant chooses to remain in a living situation, where there is a high risk, or an existing condition of abuse, neglect, or exploitation as evidenced by a Child Protective Services or Adult Protective Services assessment or care plan or the parent or responsible party refused to comply with Child or Adult Protective Services where there is a high-risk factor of existing conditions of abuse, neglect, or exploitation.

For new individuals with any of the listed conditions addressed above, an acknowledgement agreement for a 90-day conditional waiver participation period may be implemented. During this 90-day period, an evaluation can be made to determine waiver participation is option for that individual and risks can reasonably be mitigated to ensure health and welfare. If not, disenrollment may be initiated.

For an active waiver participant, three (3) failed individual risk agreements for any one of the listed reasons may result in a disenrollment when a waiver participant willingly chooses to not follow care plan or IRA.

When a serious risk of harm is imposed upon a hired worker (in-home aide, respite worker, case manager or other professional), this serious threat may result in an immediate recommendation for disenrollment from the waiver if a plan cannot be created to assure the safety of the hired worker.

In addition to Risk Assessment and Mitigation Plan, each waiver participant will be required to have an emergency backup plan. The emergency and disaster plan is created by the waiver participant with the assistance of the case manager. This plan specifies who will provide care when key direct care staff cannot provide services or tasks as indicated in the current service plan. Because both personal and home maintenance tasks are essential to the well-being of the participant, the case manager is responsible for ensuring that an adequate emergency and disaster plan is in place. In the event of an emergency or an unplanned occurrence, the plan can include family, friends, neighbors, community volunteers and licensed home care agencies when possible. An emergency and disaster plan is necessary for times when the personal care aide or personal assistant is unavailable during regularly scheduled work hours or when the unpaid informal support is unavailable for the balance of the remaining 24-hour coverage period. The emergency and disaster plan is also necessary to document and outline what the care needs are required to be maintained during a disaster.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Each waiver participant is supported in selecting their providers through information and education during each step of waiver entry process (referral, LOC, assessment and service plan development). The CAP Business system generates letters at each step to inform the waiver participant about freedom of choice. This information informs of the right to choose any provider to render waiver and non-waiver services listed on the plan of care. When the waiver participant meets the criteria for waiver participation and is at the point to be assessed, a freedom of choice form is signed by the waiver participant to identify available providers of choice including choice of a case management entity. Each waiver participant is provided notices about informed choice of providers through a Participant disclosure letter, Waiver Introductory letter, Welcome Letter and a Waiver Anniversary Letter. Each letter clearly identifies what informed choice of providers is and how to make a complaint if choice is restricted or when there appears to be a conflict of interest. The waiver participant is supported through this process by making available to him or her listings of available qualified providers and information about the providers. A resource /customer service line is available for the waiver participant to call and seek guidance. The case manager also supports the waiver participant to select a provider of his or her choice by linking the waiver participant to a qualified provider to engage in an interview or request additional information.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

On an ongoing basis, the State Medicaid Agency selects a representative sample of service plans completed by case management entities and assessments completed by the case management entity and independent assessment entity (after May 2020) for review and auditing to assess compliance. This sampling is performed on a quarterly basis. The representative sample consists of .95 confidence interval with a margin of error of 5%.

A quality assurance (QA) review will be conducted quarterly. Each case management entity is required to maintain a 90% compliance rate in service plan development. When a case management agency is performing less than 90% of compliance, the State Medicaid agency will provide technical assistance for 30- calendars days. Technical assistance will include a retraining, review of non-compliant areas, questions and answers sessions and monitoring. After the 30-day technical assistance time, an assessment of performance is measured. If the performance continues to be less than 90%, a corrective action plan is implemented that includes corrective steps negotiated by the case management entity and approved by the State Medicaid Agency. The corrective action plan will have a duration period for six (6) months that includes monthly over-the-shoulder monitoring by the State Medicaid Agency. Adjustment to the corrective action plan will be made as needed. If after the six (6) month's corrective action period, the case management entity compliance rate remains 89% or less in-service plan development, the State Medicaid Agency will implement a transition plan to remove this responsibility from the case management entity.

The person-centered plan must include the following:

1. Have the required signatures on or before services begin;
2. Plan effective date;
3. Identification of services by name and in the amount, frequency and duration;
4. Have person-centered goals to meet care needs;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems;
7. Include a schedule of coverage over a 24-hour period;
8. Have a completed emergency and disaster plan

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ☐ Every three months or more frequently when necessary

- ☐ Every six months or more frequently when necessary
- ☒ Every twelve months or more frequently when necessary
- ☐ Other schedule

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- ☒ Medicaid agency
- ☐ Operating agency
- ☐ Case manager
- ☐ Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The service plan implementation and monitoring are performed at the local case management entity's level. The appointed case management entity initiates a person-centered service plan with the waiver participant and monitors the plan. The State Medicaid agency ensures conflict-free case management through checks and balances managed by State staff. One particular check and balance that will be implemented by July 2020 is the assignment of an independent assessment entity to complete the initial eligibility phases of waiver consideration and validation of the developed service plan to ensure conflict of interest protections and appropriateness of care needs. As a safeguard, each case management entity is required to disclose potential conflicts of interest to the waiver participant and provide guidance of how conflict will be managed and resolved. Case management entities are not permitted to render HCBS in conjunction with case management services unless that entity is in a rural, service-deprived county or area.

Upon the approval of waiver participation, the day-to-day ongoing case management needs are provided by a case management entity the waiver participant/primary caregiver selects through freedom of choice. Upon an approved service plan, the case management entity authorizes or acknowledges the waiver and non-waiver services within 5 business days to qualified Medicaid providers in the amount, duration and frequency

listed in the service plan. Prior to authorizing or acknowledging waiver services to a Medicaid provider, the assigned case manager confirms that the provider can provide the services within a reasonable timeframe (within five days to initiate the care plan). Each waiver participant is contacted monthly by the case management entity to undergo an assessment of his or her care needs and changes to medical condition, functioning level and social support system. Quarterly multidisciplinary team meetings are held with the waiver participant and all care providers to review the service plan, person-centered goals and desired outcomes to ensure the health and well-being of the participant. If during these scheduled times, a need is identified to revise the service plan or to conduct a new assessment of needs, the case management entity will initiate that process. The waiver participant also has the autonomy to reach out to the assigned case management entity, State staff or a representative from a provider to inform of concern(s) or a change in status to assure health and safety. The State Medicaid Agency has access to data that informs of hospitalizations, ER visits and APS referrals which is monitored regularly to allow for quick intervention to avert health and well-being issues.

Monitoring tasks include assessing, planning, referring, linkage and follow-up. Upon the implementation of waiver services, the assigned case manager monitors the delivery, effectiveness and efficiency of all waiver services monthly with the waiver participant /responsible party. On a quarterly basis and as needed, the assigned case manager conducts home visits and on-site agency visits to monitor and observe the provision of waiver services. During these monitoring visits, the assigned case manager assesses medical, social, behavioral and functional areas to identify a change in status which may warrant a services plan revision.

The CAP Business system provides the quality assurance for service plan implementation and monitoring. Monthly reports and

alerts are provided to the case manager to ensure appropriate implementation of the service plan as per policy. Real time reports and data are made available to the State Medicaid Agency to monitor the compliance rate and performance of all case management entities to ensure services are implemented within 5 business days of a services plan approval. The QIS is monitored monthly to ensure the safety and well-being of each waiver participant. The data analytic of service utilization, risks factors, incident reports and complaints and grievances for the CAP QIS framework also allows for quick remediation.

A home visit must be conducted at least quarterly. However, a waiver participant with moderate to high risk indicator scores as identified in a completed assessment must have a face-to-face visit as indicated per risk and monthly multidisciplinary team meeting. This visit is conducted in waiver participant's primary residence to ensure health and well-being.

The CME will observe the home environment for the provision of services by paid caregiver(s). Annually, a home visit must be conducted to perform the annual service plan or more frequently when needed.

- Make a monthly or as needed visit, based on risk indicators with the beneficiary/responsible party to review the health and care needs, satisfaction with services, and assess the provision of all services/supplies to confirm their continued appropriateness.

- Hold a quarterly multidisciplinary treatment team meeting with providers receiving a service authorization/participation notice to review the provision of and continued appropriateness of service plan.

- Document changes in medical, functional and psychosocial status.

- Review quality assurances reports monthly to remedy any identified issues.

- Contact the waiver beneficiary/responsible party following the construction/installation of home modifications to confirm that the modifications safely meet the waiver beneficiary's needs.

- Contact the waiver beneficiary/responsible party within 2 business days of learned discharge from a hospital/rehabilitation facility to assess health status and changes in needs.

- Ensure that services offered to a waiver beneficiary do not duplicate other services.

- Locate and coordinate sources of assistance from informal sources, such as the family and community, so that the burden

of care is not exclusively the responsibility of formal supports.

Case Manager should complete monthly contact via telephone or other secured means of contact with the participant. Case Managers shall make sufficient (more than quarterly) face to face contact contingent to the risk factors and other factors that may jeopardize their health safety and wellbeing.

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

The case manager must perform a monthly monitoring activity with the waiver participant and other service providers. During this monthly visit, the case manager can identify concerns with the service plan or other indicators that may jeopardize the waiver participant's well-being. If by routine monitoring, the case manager determines the service plan is not meeting the current and newly identified needs of the waiver participant, an ad-hoc multidisciplinary meeting must be scheduled within 15-day of awareness to discuss the concerns and to create a plan to mitigate risk and monitor care needs. These types of monitoring tools must be secured and permission to use such devices granted by the waiver participant.

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

b. Monitoring Safeguards. *Select one:*

- ☐ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ☒ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

As a quality assurance to manage the monitoring of the service plan and to reduce conflict of interest for a case management entity that may be considered a dual agency, provider of case management and other Medicaid and waiver services, a clearly defined definition for COI is in place and is a requirement of the CME to follow and adhere and specific restrictive assurances are carefully monitored by State Medicaid Agency. These restrictive assurances include an analysis of network adequacy in that service region and a phone or mail questionnaire by representatives from the State Medicaid Agency to the waiver participant regarding access to his or her freedom of choice and engagement with the case management entity. As a means of documenting monitoring requirements and ensuring the waiver participant's needs are adequately met, the case management entity must review with the waiver participant information about disclosure of potential conflict of interest. The waiver participant must voice an agreement or provide written information that the person-centered plan continues to meet current health and social status. The CAP Business system has a function called a Local Authority Review which prompts an unbiased reviewer to ensure the monitoring of the service plan is conducted monthly and quarterly. This agreement is approved by the SMA.

When a CME is granted authority to act in a dual role, safeguards are in place to assure the CME administratively separates the plan monitoring function from the direct service provider functions. Two safeguards are placed to manage potential conflict of interest in this area. The first safeguard is for the monitoring staff and the service rendering staff to be provided by two distinct units or personnel within that organization. The second safeguard is for the CME to have an independent reviewer to perform quality checks on a quarterly basis to assess concerns of conflict and needs of the waiver participant are adequately met. The case management entity is also required to assess provider network in the service region routinely for available providers and discuss free choice of provider (disclosure form) with the waiver participant on a quarterly basis. The SMA shall provide a quality review of all service plans to ensure the appearance of conflict is not indicated.

The SMA identifies in advance the potential agencies that will fall in this threshold through a network analysis on a quarterly basis. When an agency is approved to function in this dual role, the SMA monitors these agencies closely by the initial service plan, paid claims, revisions to service plans, monitoring of monthly and quarterly visit summary reports, incident reports and annual surveys.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

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

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

Performance Measure:

SP-A1 Number and percent of waiver beneficiaries who had an Individual Risk Agreement (IRA), when indicated, to mitigate serious health and safety risk factors identified in the assessment. Numerator: number of waiver beneficiaries who had an IRA Denominator: number of waiver beneficiaries who had serious health/safety risk factors identified in the initial, annual or Change in status assessment

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and APS and CPS data reports.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system and APS and CPS data reports</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

SP-A2 Number and percent of waiver beneficiaries who had a signed service plan that identified person-centered goals and strategies to meet those goals. Numerator: number of waiver beneficiaries who had a signed service plan that identified person-centered goals and strategies to meet those goals Denominator: number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entity's file.

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

		95% 5% margin of error
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business system and case management entity's file</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

b. Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.

Performance Measures

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

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

Performance Measure:

SP-B1 Number and percent of waiver beneficiaries who had a service plan updated within 12 months of the initial waiver enrollment date. Numerator: number of waiver beneficiaries who had a service plan updated within 12 months of the initial waiver enrollment date Denominator: number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entity's file.

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

		<div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

SP-B2 Number/percent of waiver beneficiaries who had a revised SP, when indicated, to meet needs, based on monthly monitoring and CI reports. Numerator: number of waiver beneficiaries who had a revised SP, when indicated, to meet needs, based on monthly monitoring and CI reports Denominator: # of waiver beneficiaries who needed a revised service plan based on monthly monitoring and CI reports

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entity's file.

Responsible Party for data	Frequency of data collection/generation	Sampling Approach (check each that applies):
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collection/generation (check each that applies):	(check each that applies):	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system and case management entity's file</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px;"></div>	

Data Aggregation and Analysis:

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

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

c. *Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.*

Performance Measures

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

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

Performance Measure:

SP-C1 #/% of waiver beneficiaries whose files were transmitted to NCTracks with PA waiver service limits in the amount, frequency, and duration authorized in the service plan. Numerator: number of beneficiaries whose files were transmitted to NCTracks with PA waiver service limits in the amount, frequency and duration of service approvals Denominator: number of waiver beneficiaries reviewed

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

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

		Confidence Interval = <div>95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business system and NC Medicaid MMIS</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

SP-C2 #/% of beneficiaries who had a current service auth. on file that authorized services to a waiver provider in the amt, freq, & duration approved in the SP.

Numerator: #of beneficiaries who had a current service auth on file that authorized services to a waiver provider in the amt, freq, and duration approved in the SP

Denominator: number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entity's file.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system and case management entity's file</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

SP-C3 Number and percent of waiver beneficiaries who report overall waiver services were adequately assessed and planned for in the amount, frequency, and duration of their needs. Numerator: number of waiver beneficiaries who report overall waiver services were adequately assessed and planned for in the amt/freq/duration of their needs. Denominator: number of experience respondents

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system retrieved from survey respondents.

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

		95% 5% margin of error
<input checked="" type="checkbox"/> Other Specify: <div>CAP IT case management system retrieved from survey respondents</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

- d. *Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.*

Performance Measures

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

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

Performance Measure:

SP-D1 #/% of waiver beneficiaries who received an introductory/annual packet informing of waiver services & freedom of choice of waiver services and providers N: # of waiver beneficiaries who received an introductory/annual packet informing of waiver services & freedom of choice of waiver services and providers D:# of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entity's file.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system and case management entity's file</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	Ongoing	Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

SP-D2 Number and percent of waiver beneficiaries who had services that were received as authorized in the approved service plan
Numerator: Number of wavier beneficiaries who had services that were received as authorized in the approved service plan
Denominator: Number of wavier beneficiaries reviewed

Data Source (Select one):**Record reviews, on-site**

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, MMIS system and case management entity's file.

Responsible Party for data	Frequency of data collection/generation	Sampling Approach <i>(check each that applies):</i>
-----------------------------------	--	--

collection/generation (check each that applies):	(check each that applies):	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system and MMIS</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
CAP It case management system and MMIS	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

e. Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.

Performance Measures

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

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

Performance Measure:

SP-E1 Number and percent of waiver beneficiaries' records who had a signed freedom of choice form that specified the waiver provider of choice. Numerator: number of waiver beneficiaries' records who had a signed freedom of choice form that specified the waiver provider of choice. Denominator: number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entity's file.

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

		Interval = 95% 5% margin of error
<input checked="" type="checkbox"/> Other Specify: CAP Business system and case management entity's file	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

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

The State reviews each service plan that is developed by the case management entity to validate the accuracy of the information. To monitor compliance and conflict-free, the e-CAP system performs a compliance audit monthly to validate each report. A quality data report is provided to NC Medicaid and outliers are carefully reviewed and assessed by NC Medicaid for discovery, remediation and continuous quality improvement. The CAP Business system for the waiver is designed to evaluate all waiver beneficiaries and provider agencies in the implementation and performance in the service plan development which is a critical component of health, safety and well-being of waiver beneficiary. Staff at NC Medicaid reviews each service plan or other waiver activities that is developed and created by the case management entity to validate the accuracy of the information. A quality data report is provided to NC Medicaid and outliers are carefully reviewed and assessed by NC Medicaid for discovery, remediation and continuous quality improvement.

To validate the efficiency and capacity of the CAP Business system programmed to support NC Medicaid administrative operation on this waiver, the sampling methodology will be 100% for waiver year one.

The CAP Business system has service plan functionality that produces data reports during each stage of eligibility and through the implementation of the service plan to ensure approved waiver services are rendered and billed in the amount, frequency and duration specified on the service plan to selected providers. A selected provider will receive a service authorization with the amount, frequency and duration authorized by the case management entity. NC Medicaid fiscal agent will only reimburse the prior approved limits and deny any claims over the approved limits.

The CAP Business system reviews 100% of cases monthly to determine errors in service plan development. These reviews assist to remediate deficiencies that result from failure to complete the care planning assessment tool accurately. Each case management entity has access to these quality assurance reports to track their performance and identify non-compliance areas that may require remediation.

Monthly, annual and ad-hoc audits, desktop or on-site, are conducted to monitor the safeguards established for service plan development.

b. Methods for Remediation/Fixing Individual Problems

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

Upon discovery of non-compliance of the case management entity, a corrective action plan is developed to remediate the noncompliance with a completion date within 30 days. Repeated findings of non-compliance by a Case management entity results in termination of new enrollment until compliance is achieved. Staff training and technical support are also provided. If waiver services are authorized by the case management entity outside of policy, the case management entity will be fined the amount of the unauthorized waiver services. Continued noncompliance in this assurance area for three consecutive reporting quarters will result in termination of provider's rights as a case management entity.

Upon discovery of non-compliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within 3 business days. Repeated findings of non-compliance by a CAP IT contractor results in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

ii. Remediation Data Aggregation

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

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

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

☒ **No**

☐ **Yes**

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

Appendix E: Participant Direction of Services

Applicability (*from Application Section 3, Components of the Waiver Request*):

- ☒ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ☐ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (*select one*):

- ☐ **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- ☒ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver is designed to afford every waiver beneficiary (or the legally responsible party), the opportunity to elect to direct care using consumer-directed services. The program affords increased beneficiary's choice and independence in meeting home care needs and increasing satisfaction with long term supports. This waiver offers both provider-lead and direct-led service options. Waiver services may be directed by the waiver beneficiary or a legally responsible party of the waiver beneficiary. Waiver services may also be directed by a representative freely chosen by an adult beneficiary or a legally appointed representative.

Description of Consumer Direction for the purpose of this waiver; consumer-direction, waiver beneficiary will be able to:

- Choose (hire), the personal assistant who will provide their care;
- Train, supervise, and evaluate the worker;
- Negotiate the rate of pay and other benefits;
- Release (terminate) the worker should this become necessary;
- Select individual providers and direct reimbursement for several other waiver services (identified previously in Appendix C-1/C-3); and
- Engage in a cooperative working arrangement, with a financial manager who will pay the beneficiary's worker, handle federal and state taxes and other payroll or benefits related to the employment of the worker, and reimburse other service providers under the direction of the waiver beneficiary.

To be eligible for consumer-direction, a waiver beneficiary or designated responsible party must:

Meet basic criteria to be assessed for HCBS waiver participation (e.g., at risk of institutional care; be eligible for Medicaid); Understand the rights and responsibilities of directing one's own plan of care; be willing and able to self-direct or select a representative who is willing and capable of assuming this responsibility. A self-assessment questionnaire must be completed to assess ability of the waiver beneficiary/primary caregiver to direct care. If there are areas for improvement or additional support, the case advisor works with the waiver beneficiary/primary caregiver to build these competencies. Approval to direct care is not approved until the waiver beneficiary/primary caregiver shows evidence of competencies in all areas.

The State Medicaid agency, case management entities, financial management agencies, waiver service providers and other providers interacts with and participate in the beneficiary's service plan.

The Case management entity provides care advisement to the beneficiary on a monthly and quarterly basis. The care advisor is a specialized case manager from a case management entity, with an understanding of consumer direction. The care advisor focuses on empowering waiver beneficiaries to define and direct their own direct staff and services. The care advisor guides and supports the waiver beneficiary, rather than directing and managing the waiver beneficiary throughout the service planning and delivery process. The care advisor provides four basic functions of case management (assessing, care planning, referral/linkage, and monitoring/follow-up). These functions are done under the guidance and direction of the consumer-directed beneficiary.

The Fiscal Intermediary (FI), through financial management services (FMS), provides financial services to the waiver beneficiary. Financial management services are provided to ensure that consumer-directed funds outlined in the family/person-centered service plan are managed and distributed as intended. The FI files claims through NC Medicaid MMIS and reimburses the direct staff and individual providers. The FI deducts all required federal, state taxes, including insurance prior to issuing reimbursement or paychecks. The FI entity is responsible for maintaining, separate accounts on each beneficiary's services, and producing expenditure reports as required by the State Medicaid agency. The FI also provides payroll statements, on at least a monthly basis, to the direct staff and the case management entity. The FI must conduct background checks and age verification on all direct staff.

The CAP Business system has a knowledge exchange that provides additional education and resource materials about consumer-directed services which is readily available to the case management entity for self-use and distribution to the waiver participant.

Waiver beneficiaries selecting consumer-directed care are able to direct the personal care type services and participant goods and services.

Training requirements are required for direct staff who are caring for waiver beneficiaries who are medically fragile and with special care needs. Training, Education, and Consultative services is a waiver service and may be included in the service plan to arrange for mandatory training and have met the initial qualifications and have begun providing services. The direct staff must exhibit core competencies in the specialized areas which are checked off by the waiver beneficiary or responsible party and reviewed by the care advisor before services are authorized. This service is not to provide training to qualify the individual to be hired by the waiver participant.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)**b. Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver.*Select one:*

- ☐ **Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ☐ **Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ☒ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- ☒ Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
- ☐ Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- ☐ The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services**E-1: Overview (3 of 13)****d. Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- ☐ Waiver is designed to support only individuals who want to direct their services.
- ☐ The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- ☒ The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

The CAP waiver has two options, CAP (traditional option) and consumer-directed option. A waiver beneficiary has the opportunity to select either option during the initial or annual assessment; or any time during waiver participation. To be eligible for consumer-directed care, a waiver beneficiary, responsible party, or legally appointed representative, must meet all of the following criteria: 1. Understands the rights and responsibilities of directing one's own care; 2. Willing and intellectually capable to assume the responsibilities for directing care, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care; and 3. Complete a self-assessment questionnaire to determine ability to direct care or identify training opportunities to build competencies to aid in self-direction. At any given time, a waiver beneficiary directing his own care can request to return to the traditional option of the waiver. The care advisor will work with the waiver beneficiary for a smooth transition back to the traditional option.

The following conditions are carefully analyzed prior to approval of consumer-direction:

1. Decline in mental or physical health and/or loss of informal support that would affect the ability of the beneficiary to self-direct. If this occurs, care advisors will reassess the beneficiary's situation, to determine whether the consumer -directed option continues to be appropriate for the individual. Personal care assistants and other direct care workers, who are in touch with the beneficiary on a daily or regular basis, are instructed to report problems in these areas to the care advisor;
2. Consistent misappropriation of previous Medicaid services
3. Past and present criminal involvement; and
4. Violation of the Beneficiary Rights and Responsibilities, while participating in the waiver.

The Beneficiary Rights and Responsibilities is listed below:

Beneficiary Rights and Responsibilities

By signing the form, I, as the waiver beneficiary or the responsible party (parent, legally responsible party, or designated caregiver) for [name of waiver beneficiary], MID# [insert MID #] acknowledge my understanding of the Community Alternatives Program (CAP) and my rights and responsibilities as a waiver beneficiary.

I understand:

1. The CAP Waiver is an alternative option to institutionalization. I must meet a nursing facility LOC initially and annually to participate in this program.
2. I agree to select this program as an option to institutionalization.
3. The CAP Waiver waives some Medicaid requirements to allow in-home care services (institutional-like services) to be provided and received in my home and community.
4. This CAP Waiver supplements rather than replaces the formal and informal services already available to me and my family.
5. The CAP Waiver has two service options, direct-lead (in-home aide and home health providers), and consumer-lead (consumer-directed), from which to receive my services. To qualify for and maintain qualification for consumer-directed care, I or my designated representative must be intellectually able and willing to direct my care as evidenced by a self-assessment tool. Quarterly reviews of performance are conducted by the care advisor and financial manager to ensure ongoing competencies.
6. The CAP Waiver provides an array of services, known as waiver services, to meet my assessed needs to keep me integrated in the community.
7. The CAP Waiver allows me the right to select any of the available waiver services to meet my assessed needs and any provider to provide those services.
8. The waiver services I select to meet my needs will be listed on a service plan in the correct amount, frequency, and duration that are consistent with my assessed needs. The service plan will be assessed quarterly and can be revised at any time based on my changing needs.
9. If I have a concern, complaint or grievance, I can notify my case management entity, State staff or my provider agency to assist with my concerns. I also understand that a grievance or complaint does not result in a fair hearing.
10. If a waiver service I request is denied, reduced, terminated or suspended, I will be notified in writing and be given instructions on how to appeal the denial.
11. The CAP Waiver requires work verification documentation and a listing of household members to assist in planning for my care needs. Work time and family support must be reported accurately to prevent a program integrity review.
12. If I have a Medicaid spend down, deductible or premium, I must incur the established medical expenses before my CAP Medicaid is made available. I must also pay my identified providers the cost of these incurred medical expenses to prevent a gap in my care provision.
13. The CAP Waiver allows my waiver services to be provided by individuals and agencies of my choosing. However, waiver beneficiaries between the ages of 0-17, the following identified parties cannot directly provide waiver services and receive payment through payroll: a parent; stepparent, parent's spouse/significant other (live-in

or not), foster parent, custodial parent or adoptive parent, sibling under the age of 18, anyone acting as “loco parentis”. The following identified parties cannot directly provide waiver services for waiver beneficiaries 0-18 years of age or older and received payment through payroll: an appointed guardian appointed Health Power of Attorney or Power of Attorney or executor the estate.

14. The CAP Waiver is required to protect my health, safety, and well-being, at all times, while I participate in the program, I am able to assume some risks in my decisions making. This assumed risk must be outlined in an Individual Risk Agreement or emergency back-up plan. When choices are made that expose me to abusive situation, cause me to be neglected, abused, or exploited, the IRA may be terminated and a referral will be made to Adult or Child Protective Services. An assessment of my continued eligibility to participate in the waiver will be conducted.

15. The CAP Waiver may initiate disenrollment from the waiver when any one of the following occurs:

- The beneficiary’s Medicaid eligibility is terminated;
- The beneficiary’s physician does not recommend nursing facility;
- The SRF is not approved for nursing facility LOC;
- DSS removes the CAP evidence code;
- The CAP case management entity has been unable to establish contact with the beneficiary or the primary caregiver(s) for more than 60 calendar days despite two written and two verbal attempts;
- The beneficiary fails to use CAP services as listed in the service plan during a 90 consecutive day time period of CAP participation despite case management coordination;
- The beneficiary’s health, safety, and well-being cannot be mitigate through a risk agreement and other interventions;
- The beneficiary or primary caregiver will not participate in development of or sign the service plan;
- The beneficiary or primary caregiver(s) fail to comply with all program requirements, such failure to arrive home at the end of the approved hours of service, or manipulation of the coverage schedule without contacting the case management entity for approval; or
- The beneficiary demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of CAP as outlined in the “Beneficiary Rights and Responsibilities” form, and signed by the CAP beneficiary.

16. I or the primary responsible party must maintain monthly telephone contact and monthly-to- quarterly face-to-face contact with the assigned case manager for the purpose of monitoring health and well-being and coordinating to include referrals, linkage, assessments and care planning.

17. I or the primary responsible party will receive an annual letter of appointment to complete my annual continued need review for going participation in the waiver program. Failure to comply or keep the arranged appointment may interrupt the provision of my services or initiate disenrollment from the CAP waiver.

18. NC Medicaid has sole approval authority over the administration of the CAP waiver.

I have read and understand the above information. By signing this document, I willingly accept to participate in the CAP Waiver and agree to abide by the policies and procedures of the CAP Waiver. I also understand my rights and responsibility as a waiver beneficiary.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case management entity is responsible for providing waiver beneficiary/primary caregivers/legally responsible party sufficient information to ensure informed decision-making and understanding of the consumer-directed service option and of the traditional provider-managed service delivery option. The information includes the responsibilities and choices individuals may make with the election of the consumer-directed service option. The assigned case manager reviews the consumer-directed services option at program enrollment, at least annually, or upon request. This information is provided orally and in writing to the waiver beneficiary, and the legally authorized representative by the case management entity. The information that is provided includes:

- An overview of the consumer-directed services option;
- Explanation of responsibilities of the individual or individual's legally authorized representative and the consumer-directed service agency in the consumer-directed service option;
- Explanation of benefits and risks of participating in the consumer-directed services option;
- Self-assessment questionnaire requirement for participation in the consumer-directed services option;
- Explanation of required minimum qualifications of service providers through the consumer-directed services option;
- and
- Explanation of employee/employer relationships, that prohibit employment under the consumer-directed services option.

During the initial enrollment, the Financial Management Services (FMS) performed by a financial intermediary (FI) organization will be responsible for providing the following:

- Information, training and outreach;
- Information in completing and filing IRS tax forms;
- What are the roles and responsibilities of FI?
- What are the roles and responsibilities of the waiver participant?
- Conducting criminal background checks and explaining the criminal background that is identified during the check;
- Processing referral applications;
- How applicants must complete the employment application;
- How to submit Medicaid personal care claims for reimbursement;
- An explanation of Bill of Rights;
- How to contact a representative of the FI contractor; and
- Access to customer services to submit claims and guidance for technical problems or concerns.

On an ongoing monthly basis, the FMS is responsible for the following:

- Filing Medicaid claims for reimbursement of personal care claims;
- Managing and paying payroll;
- Arranging to reimburse hired assistants when payroll is missed;
- Trouble shooting concerns or problems;
- Conducting criminal background checks on newly hired personal care assistants;
- Maintaining monthly contact with the care advisor; and
- Assuring accessibility to customer service for waiver participants to submit claims and seek guidance for technical problems or concerns.

The FI and the case management entity will monitor the compliance of all self-assessment tools to ensure appropriateness of directing care.

The care advisor will inform roles and responsibilities associated with a self-directed model, explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual/representative to modify individual budget. The care advisor will also provide:

- Assessment of individual risk;
- Assessment of health, safety, and well-being of the person as well as the continued appropriateness of services and supports;
- Identification of the need for a representative for the waiver beneficiary, who desires to direct his/her own services and supports, and ensures that the representative, meets established criteria to assist the participant to self-direct their supports/services;
- Quality assurance of the person-centered plan, identifies how emergency back-up services will be furnished for workers employed by the individual, and authorizes the provision of on-call emergency back-up services;
- Report critical incidents; and
- Addresses complaints, grievances and appeals.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative (*select one*):

- ☐ The state does not provide for the direction of waiver services by a representative.
- ☒ The state provides for the direction of waiver services by representatives.

Specify the representatives who may direct waiver services: (*check each that applies*):

- ☒ Waiver services may be directed by a legal representative of the participant.
- ☒ Waiver services may be directed by a non-legal representative freely chosen by an adult participant.

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A representative is appointed when the waiver beneficiary or legal guardian request assistance or has demonstrated a need for assistance. The financial manager works with the beneficiary to identify an individual who will be appointed as the representative. The legal representative is a neutral party. The care advisor plays a significant role in identifying the need for a representative and ensuring that the representative meets the criteria outlined above. Additionally, the care advisor, as part of ongoing monitoring activities, ensures that the representative continues to act in the best interest of the waiver beneficiary.

The representative may NOT be the paid hired staff (i.e. personal assistant) for the waiver beneficiary. The following

requirements must be met prior to approval of designating a representative:

- Demonstrated knowledge and understanding of the beneficiary's needs and preferences;
- Agreement to a predetermined level of contact with the beneficiary;
- Willingness to comply with program requirements;
- 18 years of age or older; and,
- Agreement by the waiver beneficiary/ primary caregiver for someone to act in that capacity

A parent/legal guardian, significant other to a parent of an individual 0-17 is not eligible to be the representative if a representative is required to be designated by NC Medicaid. The representative may be a family member, friend, someone who has power of attorney, income payee, or another person, who willingly accepts responsibility for performing tasks that the waiver beneficiary or legal guardian is unable to perform and must be at least 18 years old. The representative must be committed to follow the waiver beneficiary or legal guardian's needs and preferences while using sound judgment to act on the waiver beneficiary or legal guardian's behalf.

The representative may NOT be paid to be the representative or to provide any other service to the participant with the exception of guardianship services.

If a representative is identified, the representative will be asked to sign the "Representative Agreement" provided by the FI. This agreement outlines the requirements and expectations of the representative and explains that the representative may be removed for not complying with the agreement. The assigned care advisor monitors the delivery of services monthly and reports any concerns to the FI and the State Medicaid Agency. In addition, any concerns about the well-being of a waiver beneficiary or legal guardian must be reported through a critical incident report.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual-Directed goods and services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Pediatric Nurse Aide Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
In-Home Care Aide Service	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Coordination of Care- case management and care advisement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Respite-Institutional and In-Home	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- ☒ **Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

☐ **Governmental entities**

☒ **Private entities**

- ☐ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** Do not complete Item E-1-i.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- ☒ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

- ☐ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Public or private entities are eligible to provide FMS as long as they meet the required credential to enroll as a Medicaid provider of this service. The provider credential is as follows:
The vendor shall have a minimum of two (2) years similar project experience with other departments or divisions of state government, county government, municipal governments, or large corporation employers in North Carolina, or in other States with similar projects. The vendor must be authorized to transact business in North Carolina and be approved as a Medicaid provider.
A solicitation for vendors is posted to the Division of Medicaid Assistance website to procure vendors for this service.

Waiver beneficiaries are informed of the providers of this service and given a choice of providers to select.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The payment for FMS is a waiver service which is added to the cost budget of the waiver beneficiary. The FMS files claims to Medicaid for reimbursement of FMS fees. The case management entity closely monitors the FMS to ensure services were rendered in the amount, duration and frequency. The CAP Business system will also submit prior approval claims directly to NC Medicaid MMIS for reimbursement of FMS. The case management entity will also monitor customer service to address any concerns, complaint or grievance the waiver beneficiary may have.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- ☒ Assist participant in verifying support worker citizenship status
- ☒ Collect and process timesheets of support workers
- ☒ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
- ☐ Other

Specify:

Supports furnished when the participant exercises budget authority:

- ☒ Maintain a separate account for each participant's participant-directed budget
- ☒ Track and report participant funds, disbursements and the balance of participant funds
- ☒ Process and pay invoices for goods and services approved in the service plan
- ☒ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other services and supports

Specify:

Additional functions/activities:

- ☐ Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
- ☒ Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
- ☒ Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget
- ☐ Other

Specify:

- iv. Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS must enroll as a Medicaid provider and meet all provider credentials as established by the State Medicaid Agency. The State Medicaid's Fiscal Agent oversees provider enrollment to ensure enrollment is consistent with the State's policies and procedures, monthly and on an ongoing basis. The fiscal agent conducts and OIG checks regularly to ensure good standing with Medicare and Medicaid. A provider application recertification is required every five(5) years.

The State Medicaid Agency and the case management entities monitor closely the execution of FMS services to ensure the health, safety and well-being of the waiver beneficiary. The case management entity reviews monthly budget summary sheets provided by the FMS and also address concerns of service utilization, both over and under.

The CAP Business system provides the case management entity and the State Medicaid Agency real time reports to assist in the monitoring of the FMS to ensure criminal and registry background checks are conducted and that enrollment paperwork is completed and the rate is within the approved Medicaid limits.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- ☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Information and assistance are available to support the waiver beneficiary when participating in consumer-direction. This support is provided through a care advisor. Care advisors will inform waiver beneficiaries and families of the option to self-direct prior to and during the assessment and person centered planning process. Waiver beneficiaries and family members are provided information by the care advisor as well as the FI of their roles and responsibilities in directing care. The care advisor's role is to empower the beneficiary to define and direct their own personal assistance needs and services. Those services and functions assist participating families and individuals to make informed decisions about what will work best for them, services consistent with their needs and reflect their individual circumstances. Those services are available to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. A person-centered approach is used. Care advice offers practical skills training to enable waiver beneficiary and primary caregiver to remain independent. The service and function of consumer-direction include providing sufficient information to ensure waiver beneficiary and the primary caregiver understand the responsibilities involved with consumer-direction and assist in the development of an effective back-up and emergency plan.

The care advisor will also provide information and assistance with the following:

- Explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual/representative to modify their individual budget.
 - Assessments of individual risks.
 - Assessment of health, safety, and well-being of the waiver beneficiary as well as the continued appropriateness of services and supports.
 - Identification of the need for a representative for the beneficiary who desires to direct his or her own services and supports, and ensures that the representative meets established criteria to assist the beneficiary to self-direct his or her supports and services
 - Assurance that the Person-Centered Plan identifies how emergency back-up services will be implemented and how and when to authorize the provision of on-call emergency back-up services.
 - Assessment of critical incidents and completing necessary reports and referrals
 - Assistance with grievances and appeals
 - Assist and support the waiver beneficiary/primary caregiver in transitioning to the provider-lead model of the supports if the waiver beneficiary/primary caregiver decides that he or she no longer desires to continue to self-direct; or for those beneficiaries who have been unable to maintain budget authority.
 - Notification of any concerns with implementation and on-going utilization of the consumer-direction option.
- This waiver will provide financial management services as a waiver service for a waiver beneficiary choosing to direct their care. This service will be included in the waiver benefit packet as a fee-for-service item.

☐ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Accessibility and Adaptation	<input type="checkbox"/>
Individual-Directed goods and services	<input type="checkbox"/>
Pediatric Nurse Aide Services	<input type="checkbox"/>
Assistive Technology	<input type="checkbox"/>
Specialized Medical Equipment	<input type="checkbox"/>
In-Home Care Aide Service	<input type="checkbox"/>
Training, Education, and Consultative Services	<input type="checkbox"/>
Financial Management	<input type="checkbox"/>

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Coordination of Care- case management and care advisement	<input type="checkbox"/>
Nutritional Services	<input type="checkbox"/>
Participant Goods and Services	<input type="checkbox"/>
Pest Eradication	<input type="checkbox"/>
Community Transition	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Respite-Institutional and In-Home	<input type="checkbox"/>
Non-Medical Transportation	<input type="checkbox"/>

- ☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy (select one).

- ☐ No. Arrangements have not been made for independent advocacy.
- ☒ Yes. Independent advocacy is available to participants who direct their services.

Describe the nature of this independent advocacy and how participants may access this advocacy:

Waiver beneficiaries choosing consumer-directed care are provided information on opportunities to access independent advocacy. This information is provided during screening and referral for support planning and during the enrollment process for ongoing support. The Division of Vocational Rehabilitation Services provides education, information and training in consumer-direction and how to efficiently arrange and access services in community. The Department of Health and Human Services (DHHS) has a Customer Service Center to provide information, referrals, education and outreach to individuals choosing to direct their own care. The DHHS Customer Service Center can be reached by dialing 1-800-662-7030. The DHHS Customer Service Center is available 24-hours, 7-days per week and includes interpretive services for non-English speaking callers. Vocational Rehabilitation Services are available Monday-Friday from 8am -5pm for direct assistance in person, in writing or by telephone. There is no fee for accessing and using these advocacy programs. Waiver beneficiaries seeking legal guidance are able to access services from NC Legal Aide Services.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

I. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A waiver beneficiary selecting consumer-directed care may withdraw from the option at any time by notifying the assigned care advisor. The assigned care advisor prepares a revision to the service plan, so provider-directed services are authorized for the waiver beneficiary with no service lapse.

The following steps are followed:

- (1) Beneficiary or legally responsible party requests that the assigned care advisor terminates the consumer-direction option and returns the beneficiary back to the traditional waiver services.
- (2) Care advisor asks the beneficiary or legally responsible party to select a provider and updates the service plan to reflect termination of the consumer-direction option and the provider agency selected by the beneficiary or legally responsible party to provide provider-directed services.
- (3) The legally responsible person signs the service plan and the care advisor upload to the CAP Business system.
- (4) The CAP Business system analyzes the service plan for accuracy and the case management entity or the State Medicaid Agency approves the service plan, authorizes provider-directed services and terminates participant-direction option.
- (5) The assigned case manager sends a letter to the beneficiary or legally responsible party and all providers notifying of the termination of consumer-direction option per the request that includes the date of the termination of payroll for employees. The letter is copied to the care advisor.
- (6) The Employer of Record or Agency with Choice notifies staff that they are no longer employed under the consumer-direction option.

A Care advisor works with the waiver beneficiary to transfer to regular waiver services or other State plan service(s) and monitors health and safety until the new service is fully implemented.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

This waiver will allow for both provider-lead and direct-lead services. Provider-lead services are referred to as the traditional agency oversight. If a waiver beneficiary is not successful in directing own care and continues to need the intervention of this waiver, arrangements will be made to transition this waiver beneficiary to a provider-lead agency for waiver planning. Upon the transition, the beneficiary will receive all services from a provider agency and the assigned case management entity will take a more active role in directing the care needs of the waiver beneficiary.

When a waiver beneficiary demonstrates the inability to self-direct waiver services, whether due to misuse of funds, consistent non-adherence to program rules, or an ongoing health and safety risk, he or she will be required to select a representative to assist them with the responsibilities of self-direction. If a waiver beneficiary refuses to select a representative or if waiver beneficiary loses a representative and cannot locate a replacement, the waiver beneficiary will be required to transfer to traditional programming of the waiver for closer oversight. Care advisors will assist the waiver beneficiary with the transition. Waiver beneficiaries are given Due Process rights for any changes, termination or removal of a service or program.

The State Medicaid Agency will initiate an involuntary termination from consumer-directed care under the following circumstances:

- (1) Immediate health and safety concern including maltreatment of the waiver beneficiary;
- (2) Repeated unapproved expenditures and misuse of waiver funds;
- (3) No approved representative available when deemed necessary;
- (4) Refusal to accept the necessary care advisement and training service when deemed necessary;
- (5) Refusal to allow care advisor to monitor services;
- (6) Refusal to participate in mandatory monthly and quarterly monitoring requirements, state or federal monitoring;
- (7) Non-compliance with individual and family supports, Financial Supports Agency, Agency with Choice or employee support agreements;
- (8) Inability to implement the approved service plan or comply with waiver requirements despite reasonable efforts to provide additional training assistance and support.

The State Medicaid Agency will dis-enroll a waiver beneficiary from consumer-direction if the same major mistakes occur more than three times in a twelve-month period. However, the recommendation to termination from consumer-direction may occur immediately if the waiver beneficiary's health and safety are at risk or misuse of funds is suspected. For example, an incident of substantiated abuse by a paid employee could lead to termination if a plan cannot be implemented to ensure health and safety. Prior to considering a termination from consumer-direction, the case management entity will report concerns and allegations of major problems with the implementation of consumer-direction to each State Medicaid Agency. The State Medicaid Agency consultant investigates the concerns or allegations. The consultant will review all available plans of correction and documentation.

The termination date from the consumer-direction program will occur on the last day of a given month. When the termination is due to a threat to the waiver beneficiary's health and safety, such as physical abuse, termination occurs immediately and traditional waiver participation resumes immediately.

If the employer/Agency with Choice disagrees with the decision of the State Medicaid Agency, the employer/Agency with Choice may file a reconsideration request or a grievance.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. Goals for Participant Direction.** In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1	<input type="text"/>	<input type="text" value="500"/>
Year 2	<input type="text"/>	<input type="text" value="575"/>
Year 3	<input type="text"/>	<input type="text" value="650"/>

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 4		725
Year 5		800

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both:*

- ☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- ☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- ☒ **Recruit staff**
- ☒ **Refer staff to agency for hiring (co-employer)**
- ☒ **Select staff from worker registry**
- ☒ **Hire staff common law employer**
- ☒ **Verify staff qualifications**
- ☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Associated costs for staff recruitment, hiring, and verification of qualifications may be compensated by the participant's participant goods and services budget.
Staff criminal history and background verification is reimbursed to the FMS agency by Medicaid through the waiver service, Financial Management Services.

- ☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

None

- ☒ Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
- ☒ Determine staff wages and benefits subject to state limits
- ☒ Schedule staff
- ☒ Orient and instruct staff in duties
- ☒ Supervise staff
- ☒ Evaluate staff performance
- ☒ Verify time worked by staff and approve time sheets
- ☒ Discharge staff (common law employer)
- ☒ Discharge staff from providing services (co-employer)
- ☐ Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- ☒ Reallocate funds among services included in the budget
- ☒ Determine the amount paid for services within the state's established limits
- ☒ Substitute service providers
- ☒ Schedule the provision of services
- ☒ Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
- ☒ Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
- ☒ Identify service providers and refer for provider enrollment
- ☒ Authorize payment for waiver goods and services
- ☒ Review and approve provider invoices for services rendered
- ☐ Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

- ii. Participant-Directed Budget** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Each waiver beneficiary is provided a Welcome Letter initially and annually that identifies the average per capita cost. The case management entity also provides training and orientation to the waiver beneficiary about the budget and budget management when directing care. Information about the budget methodology is made available to the public by the posting of a current and updated Fee Schedules and communication from the state Medicaid Agency and financial management agencies.

Budgets will be calculated based on the methodology currently in place for the waiver. The process involves an assessment to identify needs; development of person-centered goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. The estimated monthly cost of each waiver service is calculated based on approved waiver Fee Schedules. The costs of waiver and non-waiver services cannot exceed the average per capita cost as established for this waiver. The waiver beneficiary is informed by the financial manager about the IRS process and how taxes and insurances are calculated and how those taxes need to be considered when negotiating a rate. The waiver beneficiary is also informed of the need to set the rate at a medium range, but not less than minimum wage, in order to plan for unexpected changes and to also plan for rate increases for worker to compensate for longevity or tasks that require extensive assistance.

A rate fee range is provided to the waiver beneficiary for consideration of hire. The waiver beneficiary is counseled by the care advisor as well as the FI on how to set that rate that allows for flexibility and maximal utilization of waiver services. The waiver beneficiary is also provided information and education about the Department of Labor Final Rule regarding overtime pay, maintaining task sheets and assigning pay wages at or above minimum wage.

This information is available to the public by accessing the information on the Division's website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. Informing Participant of Budget Amount.** Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Upon approval of waiver participation, a waiver beneficiary is provided a Welcome Letter that informs of the waiver services, resources and utilization limits provided under the waiver. The waiver beneficiary is informed of acuity level he or she is assessed based on the results of the comprehensive assessment. The acuity level identifies the average per capita cost of service provision based on assessed needs. When developing the service plan to ensure budget management, the care advisor and the financial manager assist the waiver beneficiary in strategizing and structuring services at a negotiated rate. This budget is based on the number of support hours needed during the day, the utilization of other waiver and non-waiver services and the hourly wages to be paid to the employee. The FI takes this information and creates a budget to ensure the services and pay rate are within the average per capita cost and the pay rate including all taxes, insurances and overtime is within the Medicaid maximum reimbursement. Upon the completion of this budget, the FI reviews and explains to the waiver beneficiary for understating and agreement. The approved budget by the waiver beneficiary is shared with the care advisor to finalize the service plan. If an adjustment is need during the annual participation in consumer-direction, the waiver beneficiary is able to negotiate additional services using the same methods described above that continues to align within the average per capita cost.

A change to the waiver beneficiary's status may warrant a change in the acuity level of care, thus changing the average per capita cost. The beneficiary, the care advisors, physician or provider agencies can request a change in status assessment to identify an adjustment in the care needs. If the acuity level increases, the waiver beneficiary has more negotiation power and resources to plan care. If the acuity level decreases, the care advisor and financial manager assist the waiver beneficiary in realigning their service needs to ensure service provision is within average per capita cost. The care advisor assists the waiver beneficiary to develop a 90-day transition plan to align waiver services as to not create a health and safety risk factor. Each waiver beneficiary is given a total of 6 months to align within the average per capita cost upon the discovery of exceeding the average per capita cost. When the discovery is made, the waiver beneficiary is informed and the case manager works with the beneficiary to identify other formal or informal services to align within the average per capita cost. If after the third month of intervention, the cost of care is significantly over the average per capita cost and the cost of care will not align because of the severity of care needs, a transition plan will be created for a three-month transitioned to traditional Medicaid services and other community services where an average per capita cost is not a factor in planning the care needs. The waiver beneficiary is provided Due Process rights through a participant change notification letter. The notification letter clearly describes what has changed, when the change will take effect and the timeframe for the waiver participant to appeal the adverse decision. Medicaid beneficiaries or their personal representatives have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 et seq. and N.C.G.S. §108A-70.9.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one:*

- ☐ Modifications to the participant directed budget must be preceded by a change in the service plan.
- ☒ The participant has the authority to modify the services included in the participant directed budget without prior approval.

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

A change to the waiver beneficiary's status may warrant a "change in status assessment" to reassess needs and level of acuity and the consumer-directed budget. This reassessment may change the maximum average per capita cost of the budget. When a change in status is identified or a request to reevaluate the service plan is made, the care advisor meets with the waiver beneficiary to assess needs and to determine the validity of revising the service plan. Evidence to support the reassessment or a revision to the service plan prepares the care advisor to initiate the process to update the service plan with the waiver beneficiary. This information is documented in the beneficiary service record by the case management entity.

If an unexpected situation occurs, the waiver beneficiary has the autonomy to utilize unauthorized waiver services by notifying the provider agency. The care advisor, the FI and CAP Business system must be notified by provider agency and the waiver beneficiary within 24 hours of the unauthorized service. If the service was a short-term intensive intervention, the service plan would not be updated. The care advisor would give a written approval to the financial manager to reimburse this one-time short-intensive service and the CAP Business system will send a prior approval record to NCTracks for approval of reimbursement. If the service is ongoing, the service plan and service authorizations must be updated and disseminated to all authorized providers. The care advisor would update the service plan and notify providers.

Prior approval of services would be required for short-term intensive interventions with a longer duration and when the waiver beneficiary wanted to provide a pay increase to their direct staff.

All changes that are made to the consumer-directed budget are documented on the service plan that is electronically stored in the CAP Business system. The service plan identifies all waiver and non-waiver services in the amount frequency and duration. The service plan provides a comprehensive overview of the person-centered plans and how services needs will meet the beneficiary care needs.

The FI provides the waiver beneficiary a budget that only identifies the services that are self-directed and the total average budget per month and annually. When changes occurs, the budget is updated and shared with the waiver beneficiary. The case advisor uploads this budget in the supporting documents in the CAP Business systems.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards that are put in place to prevent the premature depletion of the beneficiary's budget include:

- 1) monthly budget analysis reports that are provided directly to the waiver beneficiary and the care advisors; and
- 2) quarterly data reports from the CAP Business system provided to NC Medicaid and the case management entity that informs of the average per capita cost of each waiver beneficiary.

The waiver beneficiary is provided a Welcome Letter that informs of the utilization limits of the waiver and an explanation of how cost of care should fall within the average per capital cost of waiver planning. The care advisors meeting monthly with the wavier beneficiary to assess expenditures and other concerns. The case advisor also reviews the expenditure reports submitted by FI and discusses any concerns with expenditures when warranted. Post-approval and post-payment reviews are performed by the case management entity using data from the CAP Business system and FMS.

The service plan and service provision will be continually monitored by the Care Advisor, the FMS and the CAP Business system to ensure needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the Care Advisor will work with the waiver beneficiary to resolve them. If the problem cannot be resolved, the care advisor and case management entity will consult with NC Medicaid Program Consultants prior to taking any adverse action towards the waiver beneficiary.

If changes occur that impacts the consumer-directed budget, the waiver beneficiary is provided written information about the impact and the need to address impact with the care advisor or the FI. The care advisor and financial manager provide counsel and guidance to the waiver beneficiary about how to maintain care needs within the average per capita cost while assuring health, safety and well-being.

The financial manager provides monthly aggregate budget reports that clearly identify authorized expenditures and actual expended cost. If the waiver beneficiary has reached or is near to reach the authorized expenditure, the financial manager will notify the waiver beneficiary and the care advisor. The care advisor will assist the waiver beneficiary to realign spending.

Another safeguard is the transmittal to NCTracks of prior approval limits of all waiver services. When an approved service plan is completed, the CAP Business system automatically transmits the approved limits to the Medicaid management system for claim reimbursement. Claims submitted over that amount will not be reimbursed.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In accordance with Due Process, the State Medicaid Agency ensures the waiver beneficiary, legal representative(s), or both are provided written notice of all adverse decisions. A waiver beneficiary whose SRF is denied, or whose waiver services are denied, suspended, terminated, or reduced, has the right to appeal.

Examples of appealable decisions are:

- a. denial of initial or continued participation in the waiver program;
- b. denial of increase, or reduction, of waiver services included in the service plan; or
- c. Disenrollment from the waiver program.

Only actions initiated by the State Medicaid Agency and appointed case management entities may be appealed. The following decisions may not be appealed:

- a. A provider's refusal to serve a waiver beneficiary;
- b. A physician's level of care recommendation; or
- c. A physician's order.

A waiver beneficiary will not be given the opportunity to a fair hearing by NC Medicaid, when basic LOC is not recommended by a physician. The State Medicaid agency's policy, states that a recommendation of a LOC decision must be rendered and fully documented by the treating physician to demonstrate medical necessity. When the physician is not able to document medical necessity to make a level of care recommendation, the individual must dispute that decision directly with the physician. The individual will have the opportunity to present additional information directly to the physician that supports institutional level of care. The physician's decision will impact initial level of care determination as the CAP Business system and Case management entity will not be able to process the assessment without an established LOC recommendation. The individual is provided a referral list of other community resources that are available to meet needs.

Each waiver beneficiary will receive a copy of his or her rights at the time of eligibility screening for home and community based waiver services. In addition, each waiver beneficiary will be provided appeal rights when a CAP service is denial, reduced, or terminated or when the waiver beneficiary is dis-enrolled from waiver participation. The CAP Business system will manage and create adverse notices for the Case management entity to use when an adverse decision is reached.

The adverse notice will contain information on:

- The right to a Fair Hearing;
- The method for obtaining a Fair Hearing;
- The rules that govern representation at Fair Hearings;
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the individuals may use to file a Grievance, complaint or to request assistance;
- Rights, procedures and timeframes for voicing or filing Grievances and Appeals or recommending changes in policy and services.

The requirements of the appeals process must be consistent with fair hearing established at 42 CFR Part 431, Subpart E.

An approved waiver beneficiary will be granted a fair hearing when dis-enrolled from participation or for any waiver service that is denied, reduced, terminated or suspended. When an incomplete application is submitted, the waiver participant and family is informed of the missing information or the incompleteness of the application. Technical assistance is provided to collect the missing information in order to make an informed decision about the appropriateness of the request. The CAP Business systems will not generate an appeal notice when any one of the conditions listed are presented: 1. The Community Alternatives Program (CAP) special coverage codes/CAP evidence have not been entered or has been removed from eligibility system which indicates the individual has not been approved or is no longer approved to receive Medicaid (the Medicaid Eligibility Unit will provide the appeal notice); 2. The HCBS Service Request Form is incomplete or has been denied due to technicality that did not result in enough information to process the request; 3. The waiver beneficiary's Medicaid eligibility is terminated or the beneficiary is in a Medicaid sanction period (a hearing will be offered to the participant by the Medicaid eligibility department); Waiver beneficiaries who misappropriate assets invoke a violation to Medicaid rules which places them in a sanction period. This sanction period temporarily deems the waiver beneficiary ineligible for Medicaid; and 4. The waiver beneficiary's Medicaid coverage is in deductible status. Individuals participating in the waiver are afforded deeming of income which waives resources and assets over the established poverty limit. The calculation of income and assets may impose a monthly spend down, the waiver beneficiary must incur prior to effective date of Medicaid. When a deductible is not met, the beneficiary is informed of the amount of medical expenses that are needed to incur the deductible. Technical assistance is provided to the waiver participant to identify if expenses were incurred for a specific month. Errors in the calculation of incurred expenses are shared with the Medicaid eligibility unit for follow-up.

Under the provision of the CAP waiver, if an adverse decision is made due to Medicaid eligibility reasons, a waiver beneficiary must grieve to the Medicaid eligibility department to allow the CAP services to continue as authorized. A waiver beneficiary must be fully authorized for Medicaid in the categories of Medicaid for the Blind(MAB) and Medicaid for the Disabled (MAD)-ABD, Medicaid for Children Receiving Adoption Assistance (I-AS), Medicaid for Children Receiving Foster Care Assistance

(H-SF).

The State Medicaid Agency and case management entity are primarily responsible to educate the waiver beneficiary about their rights to appeal an adverse decision. When an adverse decision is reached, the case management entity will provide the waiver beneficiary a trackable adverse notice the decision to deny a requested service. This adverse notice will cite the reason(s) for the denial, provide policy citations and provide guidance on how to file an appeal to this adverse decision. The waiver beneficiary is given in instructions on how to file the appeal within the guidelines of NC Medicaid State Plan. When an appeal is filed, the beneficiary is granted an option to mediate as the first attempt to come to an agreement between the requestor of service and NC Medicaid. If the adverse decision cannot be resolved in mediation, the waiver beneficiary is entitled to a hearing in front of Administrative Law Judge (ALJ). The waiver beneficiary or the initiator of the adverse decision must adhere to the final decision of the ALJ.

The CAP Business system will manage all adverse decisions to ensure accuracy of notice dates, appropriateness of maintenance of service and compliance to the final decision. The case management entity uploads the adverse notice in the State's data warehouse (Public Consulting Group). The Office of Administrative Hearing will monitor this data bank to initiate and follow through with all appeal requests.

When a referral is made for waiver participation under the consumer-directed option, the waiver beneficiary/responsible party is provided educational information about consumer-direction and their right to request a fair hearing when a choice of provider is denied. The Case management entity and FMS are responsible for explaining to the waiver beneficiary the reason that a selected provider will be denied. The CAP Business system and Case management entity are responsible for providing additional education to the waiver beneficiary/responsible party regarding the procedures once a request for a hearing is made. When the waiver beneficiary has met basic eligibility to participate in the waiver and consumer-direction, the CAP Business system is programmed to request copy of the signed and dated self-assessment questionnaire that describes consumer-direction and the agreed upon terms. Prior to the approval and initiation of waiver services, the CAP Business system validates the file as complete to ensure the self-assessment survey and a freedom of choice are exercised by the waiver beneficiary.

For direct hire staff, the waiver beneficiary will also be informed that if the requested provider met any one of the lifetime bans, employment could not be offered. The lifetime ban includes:

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

In addition to the above, the waiver beneficiary/responsible party also receives information about participant's rights that pertains to:

- All providers on the freedom of choice list have met specific NC Medicaid criteria for enrollment to provide the particular service;
- How to explore the possibility of a provider not listed, yet desired by the waiver beneficiary/ responsible party, to be enrolled with NC Medicaid;
- A statement to inform the waiver beneficiary/ responsible party that a provider, not currently enrolled with NC Medicaid would need to meet specific criteria to be enrolled with NC Medicaid, before the provider could be authorized to provide service and be reimbursed by Medicaid for services rendered;
- Information on how to contact the NC Medicaid consultant if problems are not resolved at the local level or by CAP Business system; and
- How to change agencies or lodge a complaint if unhappy about the care provided or the person rendering the care.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ☒ **No. This Appendix does not apply**
- ☐ **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ☐ **No. This Appendix does not apply**
- ☒ **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

NCDHHS

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The case management entity provides the waiver beneficiary training and orientation about the CAP program. This training and orientation provides definitions and explanations about grievances and complaints. The waiver beneficiary is given information about the appeal process. This information is also outlined in the Welcome Letter that is mailed to the waiver beneficiary initially and annually.

Constituents who contact their governmental representatives or any human service professional with complaints concerning this waiver are referred to the NCDHHS. When a complaint is received, Office of Citizen Services (OCS) staff serves as a liaison between the complainant and the NC Medicaid program specialist. NCDHHS staff ensure that complaints are thoroughly examined and investigated. Staff determines the most appropriate parties to contact and work with to resolve the situation. Feedback is provided to elected officials regarding constituents concerns. Ensuring that consumers have the proper channel for addressing concerns is key to this program. Steps are taken to rectify the complaint or concern and time is spent with the person to educate on the process and help them understand why the situation was handled in a certain manner.

There is a three day timeline to address grievances and complaints. Grievances and complaints may consist of customer service concerns, missed timelines, provider treatment and access to providers. Filing a grievance or complaint is not a prerequisite or a substitute for a Fair Hearing. Waiver participants are notified of this and the differences between the two.

The CAP Business system is also equipped to receive and manage complaints and grievances initiated by the waiver beneficiary or primary caregiver or other service providers. The case management entity has 3 days to address the complaint.

The State Medicaid agency reviews the complaint and the resolution by the case management agency for quality assurance and improvement.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program. *Select one:*

☒ **Yes. The state operates a Critical Event or Incident Reporting and Management Process** (*complete Items b through e*)

☐ **No. This Appendix does not apply** (*do not complete Items b through e*)

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

To safeguard the health and welfare of each approved waiver participant, the State Medicaid Agency, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation (ANE) and other critical incidence. To assure the health, safety, and well-being of each waiver participant, the case management entities (CMEs) shall engage in a multidisciplinary treatment team (MDT) meeting with each waiver participant quarterly and, on an ad hoc basis when needed. To mitigate the waiver participant's health and welfare when a critical incident occurs, it is mandatory for all case management entities to complete a critical incident report and investigate the incident each time a waiver participant has been involved in a critical incident that jeopardizes his or her health, safety and well-being. Upon knowledge of the critical incident, a report must be completed within 3 business days. Each case management entity is provided access to the critical incident report (CIR) developed by the State Medicaid Agency (SMA).

The Critical Incident Form has automatic fill-in responses through drop-down box options. The form is accessible through the CAP Business system. The CAP Business system will track receipt of all critical incident reports to assure timeline is adhered. State Medicaid Agency staff will also follow-up to assure the identified waiver participant is receiving the necessary services as identified through the recommendation of the incident report.

Level of reporting is managed by two incident levels: Level I and Level II.

Incident reports, including follow-up action requirements, are defined as one of two levels.

Level I incidences must be reported within 3 business days in the CAP Business system. These incidences include: hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered.

Level II incidences must be reported within 3 business days to State Medicaid Agency. These incidences include, APS/CPS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, falls requiring hospitalization or results in death, traumatic injury, medication administration that results in injury or hospitalization, wandering away from home, homicide/suicide and media related events.

Incidences of abuse, neglect and exploitation must be reported to the appropriate authority and carefully followed to assure services are adequately met to keep the waiver participant safe in the community.

Level I Critical Incidents Accident or Injury (LEVEL I)

Accident or Injury is defined as an incident resulting in the need for medical services beyond first aid (e.g. fractures, some falls, burns, lacerations/wounds, etc.) and/or patterns of injuries that may potentially indicate an immediate or serious risk of participant safety. This could include a pattern of repeated falls.

Deaths by Natural Causes – Explained Death (LEVEL I)

Death caused by a long-term illness, a diagnosed chronic medical condition, serious acute illness or other natural/expected conditions resulting in death.

Emergency Room Visit (LEVEL I)

Emergency Room visit means an emergency room visit for an assessment or for the management of an unstable health condition or high-risk behavior that does not result in a hospital admission.

Hospitalization (LEVEL I)

Hospitalization means an overnight admission, whether scheduled or unscheduled, but not expressly for psychiatric issues.

Inpatient Psychiatric Hospitalization (LEVEL I)

Inpatient psychiatric hospitalization means an emergency, overnight admission for assessment or management of an unstable psychological condition or high-risk behavior that require management by a physician.

Level II Critical Incidents

Abandonment (LEVEL II)

Abandonment is defined as the desertion of a participant by an individual who has the responsibility for providing care for that participant, or by a person with physical custody of that participant. This may include desertion of a participant at a hospital, nursing home or other location.

Abandonment may need to be reported as neglect.

Abuse (LEVEL II)

Abuse can be physical, sexual, emotional or verbal.

1. Physical Abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment.

Physical abuse may include, but is not limited to such acts of violence as: striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, or burning. Additionally, use of physical restraints, force feeding,

and physical punishment of any kind are examples of physical abuse.

2. Sexual Abuse is defined as non-consensual sexual conduct of any kind with a participant. It includes, but is not limited to, exposure to unwanted sexually explicit material or verbal harassment of a sexual nature, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.

3. Emotional or Psychological Abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse may include, but is not limited to verbal assaults, threats, intimidation, insults,

humiliation, and harassment. In addition, treating a participant in a manner not appropriate for their age, isolating participant from his/her family, friends, or regular activities, giving a participant the "silent treatment," and enforcing social isolation are examples of emotional/psychological abuse.

4. Verbal abuse is defined as the use of any oral or gestured language that includes disparaging or derogatory terms to participants, or within their hearing distance, regardless of the participant's age, ability to comprehend, or disability.

Death – Unexplained Deaths (LEVEL II)

Death means the end of life. ALL DEATHS MUST BE REPORTED in as much detail as possible. The reportable event must describe the circumstances surrounding a participant's death. Unexplained deaths need to be differentiated from deaths that are explained deaths (meaning they were expected or considered a result of natural causes). An Unexplained Death is defined as a death suspected to have resulted from other than natural causes, potentially due to abuse or neglect or such as an occurrence of medical error by others. The circumstances surrounding an unexplained death must document fully all available information about the death including contributory events and a clear explanation of why the death is considered unexplained (resulting from other than natural causes). If autopsy, protective services or police reports are available, they should be uploaded into the Critical Incident form.

Exploitation – Financial/Theft (Immediate Jeopardy) (LEVEL II)

Exploitation means taking advantage of a waiver participant for personal gain by manipulation, intimidation, threats, or coercion. It involves the misuse of a vulnerable participant's funds, property, or person. Examples may include, but are not limited to:

- alleged fraud,
- use of participant funds for purchases without providing and maintaining itemized receipts
- cashing an individual's checks without authorization or permission, forging a participant's signature,
- misusing or stealing a participant's money or possessions,
- destruction of a participant's personal property,
- withholding a participant's funds,
- coercing or deceiving a participant into signing any document, or
- improper use of conservatorship, guardianship, or power of attorney.

Injuries of unknown source (Level II)

An injury should be classified as an "injury of unknown source" when both of the following criteria are met:

- The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
- The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one point in time or the incidence of injuries over time.

Missing Person (LEVEL II)

Missing Person / Elopement is defined as a participant whose whereabouts are unknown and he/she is considered missing. A missing person does not include a participant who is able to leave the facility to pursue activities, shop or visit with friends or relatives, unless the participant cannot be located after a reasonable time has elapsed without contact. A missing person report is not needed for a participant who lives with unpaid caregivers or housemates (such as natural family) unless the families have requested assistance locating the missing person or while the participant was receiving a waiver service. Even if the participant has been located, a completed Reportable Event form is required.

Neglect (Immediate Jeopardy) (LEVEL II) Neglect is defined as the refusal or failure to provide a participant with such life necessities as food, water, clothing,

shelter, personal hygiene, medicine, medical care, personal care, comfort, personal safety, supervision, and other essentials included in an implied or agreed-upon responsibility to a participant.

Self-neglect is characterized as the behavior of a participant that threatens his or her own health or safety including substance abuse and dangerous behavior. Self-neglect generally manifests itself as a refusal or failure to provide himself or herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.

Restraints / Seclusions (LEVEL II)

Restraints / Seclusions are defined as physical, chemical or involuntary seclusion. Physical restraint means any manual method, physical device, material, or equipment attached or adjacent to a participant's body, that: a participant cannot remove easily,

- restricts freedom of movement or access to the participant's own body, or
- is used for discipline or convenience.

Physical restraint may include, but are not limited to a device or garment that interferes with freedom of movement or withholding assistance or mobility device to a dependent participant for interfering with the participant's free movement.

Chemical restraint means the administration of drugs with the intent of significantly curtailing the normal mobility or normal physical activity of a participant.

Involuntary seclusion means the separation of a participant from others such as in a locked room, or from the participant's room or against the participant's will or the will of the participant's guardian/representative. Involuntary seclusion does not mean separating the participant from other individuals on a temporary and monitored basis.

Suicide (combine with death) (LEVEL II)

Suicide is the act of taking one's own life voluntarily and intentionally.

Suicide Attempt (LEVEL II)

Suicide attempt is the act of deliberately harming one's self with the intention of causing death.

Treatment and Medication Errors (LEVEL II)

A treatment error involving medication is defined as any medication management event that results in participant requiring medical services beyond first aid. This would include any preventable event that may cause or lead to inappropriate medication uses or omission or harm while the medication is in the control of the health care professional, family member, or participant. This may also include mistakes by prescribers or pharmacists regarding type of medication, labeling, dosage or packaging.

Other treatment errors may include, but are not limited to the improper delegation of a task or the inadequate or poorly performed actions of a delegating nurse or personal assistance aide.

Other Incident Types (Level II)

Other incident types may include, but are not limited to:

- Infectious diseases,
- Insect infestations,
- Any unusual incident, which may involve law enforcement or may attract media attention, emergency closure of a participant's home or program facility for one or more days, or
- Bankruptcy or loss of lease by program

The critical incident report has fields that identify the participant demographic information, description of the incident, participant's response, action taken/prevention/disposition, notification/reported to other authority, recommendation by the case manager or care advisor of how to mitigate future incidences and the recommendation by the State Medicaid Agency against the data report and action taken.

Each case management entity is provided annual training in critical incident reporting approved by the state Medicaid agency. The case management entity is responsible to educate and inform waiver participants/responsible parties and service providers on 1) types of critical incidences, 2) how to make a report, and 3) the timeframe to make a report. The case management entity must provide training and education initially, quarterly, annually and as needed to all waiver participants.

For incidences of abuse, neglect and exploitation, the state has prescribed guidelines to react to a report and create an action plan.

To assure the health, safety and well-being of waiver beneficiaries, the goal is to report a critical incident immediately when it happens. However, for incidences that the case management entities are not immediately aware, upon of the knowledge of the incident the case management entity is expected to file a report and follow through to assure the health, safety and well-being of the waiver participant. The report must be submitted through CAP Business system within 72 hours.

When the case management entity is notified of an incident, notification or report to other providers or entities must occur within 72 hours of the reported incident.

The types of events that warrant notification to state Medicaid agency are reports of abuse, neglect and exploitation that are referred to the local DSS Adult or Children Protective Services.

Article 6, Chapter 108A of the North Carolina General Statutes requires that county departments of social services perform certain activities for disabled individuals alleged to be abused, neglected, or exploited and in need of protective services. In accordance with its authority under N.C.G.S. 143B-153, the North Carolina Social Services Commission has established rules and regulations for the provision of Protective Services for Adults and Children.

The County Departments of Social Services must accept all reports alleging abuse, neglect, or exploitation of a disabled individual who needs protective services. This includes anonymous reports.

North Carolina has a mandatory reporting law. Any incidents containing allegations of abuse, neglect or exploitations must be immediately reported to the local Department of Social Services responsible for investigation of abuse, neglect or exploitation allegations. Any person having reasonable cause to believe that a disabled individual needs protective services

shall report such information to the director of the county Department of Social Services, or his representatives, where the disabled individual resides or is present. Other reports may be required by law, such as reports to law enforcement.

The report may be made orally or in writing. The report shall include the name and address of the disabled individual; the

name and address of the disabled individual's caretaker; the age of the disabled individual; the nature and extent of the disabled individual's injury or condition resulting from abuse or neglect; and other pertinent information. (G.S. 108A-102)

North Carolina conducts a comprehensive functional assessment (evaluation) to determine whether there is a need for protective services in situations where it is alleged that a disabled individual has been abused, neglected, or exploited. Protective Services are those services provided by the State or other government or private organizations or individuals that are necessary to protect the disabled individual from abuse, neglect, or exploitation. (G.S. 108A-101)

North Carolina General Statutes require that any director receiving a report that a disabled individual needs protective services shall make a prompt and thorough evaluation to determine whether the disabled individual needs protective services and what services are needed. The evaluation shall include a visit to the disabled individual and consultation with others having knowledge of the facts of the particular situation. A thorough evaluation of a protective service report shall include identifying indicators of abuse, neglect, or exploitation and the disabled individual's strengths and limitations by assessing physical health, mental health, social support, activities of daily living, and instrumental activities of daily living,

financial support, and physical environment. Other reports The State Medicaid Agency is provided "need to know information:" to assure the appropriate planning of all waiver participants from the DHHS-Division of Aging and Adult Services. The case management entities and the DSS-APS/CPS workers consult with one another about the facts of a situation for appropriate care planning and referrals.

Natural disasters such as hurricanes are considered critical events. Every locality/county must have a disaster plan in place and shelters available that can provide care for individuals and families, including those with special needs, who must evacuate their homes. Each waiver participant is required to have an emergency plan that covers disaster planning.

- c. Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Initially an annually each waiver participant is provided information about abuse, neglect and exploitation and how to make a report when concerns arise. The multidisciplinary assessment captures information about informal support systems

and their burden of care that identifies potential risk factors for abuse, neglect and exploitation. Additional information is provided when requested or when the case management entity is concerned about abuse, neglect and exploitation.

During the waiver enrollment process, the individual is given information about the waiver through a participant disclosure letter, an Introductory letter and a Welcome letter that includes information about ANE. This information describes signs of ANE, contact information and mandatory reporting requirements. The following statement is included in the letter "If you think that you are not safe or have any concerns about abuse, neglect or exploitation you can call your local Department of Social Services for assistance with Adult and Children Protective Services. You can also call your Case Management Entity or the Independent Assessment Entity" (after May 2020) to provide guidance to the waiver participant if he or she feels abused, neglected or exploited. In addition, During the planning for the agreement of the Beneficiary Rights and Responsibilities, the Case Management Entity and the Independent Assessment Entity (after May 2020) educate and provide information to participants, families and legal representatives. Participants sign the Beneficiary Rights and Responsibility form indicating that they have received information about incident reporting. Each member of the case management entity is required to have annual mandatory training that includes what constitutes abuse, neglect and exploitation; and how to complete, assess, report and mitigate critical incidences of waiver participants. The State Medicaid Agency provides a high-level training in ANE in supporting waiver participants. The DHHS-Division of Aging and Adult Services provides semi-annual training in ANE to the case management entities. In addition, providers are required to provide on-going training to direct service staff in how to recognize abuse, neglect and exploitation, and where to go for help.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When a waiver participant experiences a critical event or incident, the case management entity is responsible to receive the details of the event or incident to complete a critical incident report using the CAP Business system. The report is designed to document: who the report is from; the type of event or issue; the date and time of the event/issue, if applicable; the location of the incident (participant's home, etc.); details of the event; involved parties; the source of the information;

individuals who have first-hand knowledge of the event; whether the attending physician was notified; and the name, address and phone number of the physician and any other agencies or individuals that were also notified. The specific nature of an event or issue will determine if notification to others is warranted, e.g., APS/CPS, DHHS and law enforcement.

The Critical Incident Form has automatic fill-in responses through drop-down box options. The form is accessible through the CAP Business system. The CAP Business system will track receipt of all critical incident reports to assure adherence to timelines. State Medicaid Agency staff will also follow-up to assure waiver participant with a level II critical incident report is receiving the necessary services as identified through the recommendation of the incident report. The State Medicaid Agency has trained each case management entity on how to detect and accept critical incident reports (CIR). Upon the knowledge of an incident, each case management entity is required to submit a CIR via CAP Business system within 72 hours. The CAP Business system will compile all critical incident reports to assure accuracy of policy compliance and that the incident was clearly followed-up. Each incident is placed in a data query to track the frequency of each incident to identify trends.

Level of reporting is managed by two incident levels: Level I and Level II.

Level I incidences must be reported within 3 business days the CAP Business system. These incidences include: hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered.

Level II incidences must be reported within 3 business days to State Medicaid Agency. These incidences include, APS/CPS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, falls requiring hospitalization or results in death, traumatic injury, medication administration that results in injury or hospitalization, wandering away from home, homicide/suicide and media related events.

Incidences of abuse, neglect and exploitation must be reported to the appropriate authority and carefully followed to assure services are adequately met to keep the waiver participant safe in the community.

To assure the health, safety and well-being of each waiver participant, the case management entities shall address remediation efforts that mitigate the waiver participant's health and welfare when a critical incident occurs. It is mandatory for all case management entities to evaluate each report to identify the best course of action for waiver participant. When an event or incident occurs, the case management entity must respond to the following bulleted items that are associated with the event to evaluate the validity and concern listed in the report and to ensure the health, safety and well-being of the waiver participant.

- The waiver participant or family member is considered at risk of health, safety and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a personal emergency response system;
- The waiver participant lacks the emotional, physical and protective support of a willing and capable caregiver who must provide adequate care to oversee 24-hour hands-on support or supervision to ensure the health, safety, and wellbeing of the individual with debilitating medical and functional needs;
- The waiver participant's needs cannot be met and maintained due to unwillingness or uncooperativeness by the system of services that is currently available to ensure the health, safety, and well-being;
- The waiver participant's primary private residence is not reasonably considered safe to meet the health, safety and wellbeing in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the waiver participant's safety, and these issues cannot be resolved;
- The waiver participant's primary private residence presents a physical or health threat due to the credible allegations of unlawful activity conducted; verbal abusive behavior, threatening or physically or verbally abusive behavior, presence of a health hazard due to pest infestation, hoarding of animals, or animal excretion and evidence of ANE; or
- The waiver participant's continuous intrusive behavior impedes the safety of self and others by attempts of suicide, physical abuse or injury to self or others, verbal intimidation, destruction of physical environment, or repeated noncompliance of service plan and written or verbal directives;
- The waiver participant's primary caregiver or responsible party continuously impedes the health, safety and wellbeing of the waiver participant by refusing to comply with the terms of the plan of care, refusal to sign a rights and responsibilities form and other required documents, refusal to keep service providers informed of changes and status changes, refusal to implement or follow-through with an individual risk agreement to remove or lessen the risk or refusal to necessary waiver services approved in the service plan; or
- The waiver participant chooses to remain in a living situation where there is confirmed, abuse, neglect, or exploitation

as evidenced by an APS/CPS assessment or care plan.

When an event/issue is identified by, or reported to the case management entity, a Critical Incidents Report form is completed and the case management entity arranges an investigation for a Level II critical incident within 5 calendars days.

The case management takes the following steps to investigate the report information:

- Contact with reporter, if provided to discuss the event/incident or concern;
- Contact with involved service providers listed on the POC to discuss waiver participant 's care needs and any concerns related to the incident report
- Home visit with the waiver participant to conduct a risk assessment of needs against the incident report
- Review of past incident reports, hospital visits and ER visits and other data elements to identify trends
- Contact with pertinent individuals or formal agency to identify concerns.

The case management entity also evaluates the following areas during the investigation:

- Human factor (staffing levels, knowledge, training and competency)
- Prior addressed risk factors
- Equipment-related factors (maintenance)
- Environmental factors (lighting, noise, clutter)
- Communication factors (training and adequate tools)

A plan of protection or assurance of health, safety and well-being is put in place when the case management entity conducts the investigation of the event/ incident. The case management entity collects all this information to complete a root cause analysis report to assist with closing out the investigation to decide about the best course of action for the waiver participant. The following questions are asked:

- Was the incident preventable?
- If staff was involved, did they respond to the incident appropriately?
- If family was involved, did they respond to the incident appropriately?
- Were resources utilized in an appropriate and cost-effective way?
- Did the Case Manager/Care Advisor handle the incident appropriately?

The answers to the questions lead to the remediation plan for the waiver participant such as a risk of dignify declaration form, a revision to the service plan, additional support from formal and informal support systems or disenrollment from the HCBS program when health, and safety cannot be met or mitigated regardless of tried attempts. The state Medicaid agency will make the final remediation plan based on the nature of the incident and the findings in the investigative report. The data query generated by the CAP Business system is reviewed by the State Medicaid Agency on a quarterly basis

and compared against the data query generated by DAAS. These two reports are used to identify trends and strategies to mitigate future occurrences. The waiver participant or the primary caregiver and other pertinent individuals are notified about the results of the root cause analysis (investigation) within 5 business days of the closure of the case.

The case management entity shall initiate an investigation within 5 business days of a Level II incident report to ensure health, safety and well-being of waiver participant. The waiver participant must be notified of the recommendation of the investigations within 15 business days of the incident.

The Department of Social Service, APS/CPS section is responsible for evaluating all cases of abuse, neglect and exploitation.

The Adult and Children Protective Services unit has a prescribed timeframe of 24, 48 and 72 hours to investigate a report of ANE. The

reporter is provided a disposition of the results of the initial home visit to investigate the allegations of ANE within 30-45 days, depending on the allegation type. APS/CPS have specific guidelines of evaluating a case to determine if a waiver participant is at risk and needs protection. The assigned Adult or Child Protective Service Worker evaluates the waiver participant

cognitive skills to determine capacity to make decision and the need for supportive care. If waiver participant is deemed not to be able to make appropriate cognitive decision, APS/CPS will provide an order of protection.

The state has an agreement with the state aging and adult agency (Division of Aging and Adults Services-DAAS) to provide quarterly data query of waiver participants reported to be abused, neglected or exploited. The data query provides the date of the report, the alleged perpetrator, and the disposition of the case confirmed or substantiated. The report is compiled by county, the waiver program, type of report, disposition decision, and the number of reports received on a given waiver participant. The local DSS trains the APS/CPS workers on how to capture and complete the needed information on the report. A planning meeting is scheduled quarterly with the NC Medicaid staff and the DAAS staff to review and analyze the data query to identify trends and implement strategies to mitigate future occurrences.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for

overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The State Medicaid Agency is responsible for overseeing the operation of the incident management system for this waiver population.

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each waiver participant are identified as part of the intake and assessment process. The CAP Business system generates reports of risk indicators identified in the comprehensive assessment for use by the case management entity for continuous care planning of health, safety

and well-being. These data elements of risk indicators assist the case management entity to proactively identify services and supports to mitigate potential risk(s) that may lead to an unfavorable event or incident for the waiver participant.

When a waiver participant encounters an event or incident, a Critical Incident Report is filed through the CAP Business system.

This system aggregates the data on the critical incident report and sends alerts regarding needs and recommendations to the case management entity and the State Medicaid Agency. The reports provide information about the incidents, who were involved in the incident and recommendations made regarding the incident. The State Medicaid Agency reviews these reports quarterly to identify trends and strategies to reduce similar occurrences in the future. Questions that are posed when reviewing the data consist of the following:

- How can the State Medicaid Agency prevent this from happening again with this individual/family?
- How can State Medicaid Agency prevent some of these incidents from happening again on a statewide program level?
- Are waiver resources utilized in an appropriate and cost-effective way?
- Were there signs or indications that may have prevented this event/incident?
- Are the staff and family members adequately trained on how to manage health condition?
- Is the waiver participant fully aware of health care needs and how to follow care plan requirements?

A Critical Incident committee meets quarterly to track and trend Level II incidences. The committee reviews summary of care history, age and gender of the participant, date of enrollment in the program, the significant diagnosis, participant's extent on formal and informal supports, summary of events, contributing factors, participants enrollment/action surrounding the event, immediate action taken, participant status, identification of risk points and potential contribution to the event.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

☒ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Waiver services does not permit the use of unnecessary or unauthorized restraints, including personal restraints and drugs used. This waiver 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. Refer to:

<http://www.cms.gov/surveys/certification/geninfo/downloads/SCletter07-22.pdf>

Restraints may be used when determined necessary such as to prevent an infant or small child from inadvertently dislodging a feeding tube, tracheostomy tube during the normal movement throughout the day.

If the case management entity determines that use of the unnecessary or unauthorized restraints are being used on a waiver beneficiary, law enforcement and child protective services will be contacted immediately to report the event. Any known or observed use of restraints is referred to CPS, federally recognized Tribes and DHSR to investigate and report on findings. The State Medicaid Agency is responsible for monitoring investigative reports and findings to ensure the health, safety and well-being of the waiver beneficiary.

Also, if a waiver provider or CAP Program consultant observes or learns that unnecessary or authorized restraints are being used, an incident report must be completed with the date of discovery and submitted to the State Medicaid Agency on same date. The State Medicaid Agency will initiate referrals and investigatory steps within 2-days of notification.

The use of unnecessary/unauthorized restraints or seclusion on the waiver beneficiary indicates a need to reassess or complete a root cause analysis of the incident to allow review of the waiver beneficiary's current medical and functional needs, caregiver's ability and stress level to determine appropriateness of CAP services (safety and well-being, ability to self-direct). The findings of the root cause analysis will inform the need for a plan revision, risk agreement or additional support to the child and family.

- ☐ **The use of restraints is permitted during the course of the delivery of waiver services.** Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

- ☒ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

If a waiver provider or CAP Program consultant observes or learns that unnecessary and authorized restrictive interventions are being used, an incident report must be completed within 3 days of discovery.

This waiver program does not permit the use of unnecessary and authorized restrictive interventions that restrict waiver beneficiary movement; waiver beneficiary access to other individuals, locations, or activities; restrict waiver beneficiary rights; or that employ aversive methods to modify behavior, unless provided for a waiver beneficiary for whom it is not used as a restraint, but for safety - such as bed rails, Gerri chair, lift chair, safety straps on wheelchairs.

If the State Medicaid Agency determines unauthorized use of restrictive interventions or the use of the restrictive interventions is out of compliance with the service plan and physician's orders (bed rails, Gerri chairs, lift chairs, or safety straps on wheelchairs as a safety precaution), the appropriate law enforcement and children protective services be will contacted on the day of discovery to report the event. Unauthorized use of restrictive interventions is referred to law enforcement and CPS/federally recognized Tribes for investigation. The State Medicaid Agency is responsible for monitoring investigations and findings to ensure the health, safety and well-being of the waiver beneficiary.

The use of unauthorized restrictive interventions on the beneficiary indicates a need to reassess or complete a root cause analysis of the incident to allow review of the waiver beneficiary's current medical and functional needs, caregiver's ability and stress level to determine appropriateness of CAP services (safety and well-being, ability to self-direct). The findings of the root cause analysis will inform the need for a plan revision, risk agreement or additional support to the child and family. The report will identify the beneficiary's needs, caregiver's ability and stress level to determine appropriateness for CAP services (safety and well-being, ability to self-direct).

When a waiver provider or CAP Program consultant observes or learns restrictive interventions are being used, an incident report must be completed on the date of discovery and submitted to the State Medicaid Agency on the same date. The State Medicaid Agency will initiate referrals and investigatory steps within 2-days of notification.

- ☐ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

- ☒ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this

oversight is conducted and its frequency:

The State of North Carolina does not permit the use of seclusions including personal restraints and drugs for any waiver beneficiary. All waiver services and regular State Plan services must be provided in accordance with all requirements specified in this waiver and the State's governing clinical coverage policy; all applicable federal and state laws, rules, and regulations; the current standards of practice; and provider agency policies and procedures. Each case management entity must have a policy on seclusion that complies with the definition of seclusion as stated in the June 22, 2007 memo to State Survey Agency Directors, Ref S&C-07-22, and re: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Refer to: <http://www.cms.gov/surveycertificationgeninfo/downloads/SCletter07-22.pdf>

When evidence is received that unauthorized use of seclusion is out of compliance with the service plan, a critical incident report must be completed by the case management entity on the date of discovery. The case management entity must notify the appropriate law enforcement and child protective services to report the occurrence. The State Medicaid Agency will follow-up within 2-days of notification to ensure incident is correctly mitigated.

- ☐ **The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- ☒ **No. This Appendix is not applicable** (do not complete the remaining items)
- ☐ **Yes. This Appendix applies** (complete the remaining items)

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ☐ **Not applicable.** *(do not complete the remaining items)*
- ☐ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

- ☐ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the state:

- ☐ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. (For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:

HW-A1 Number/percent of waiver beneficiaries who were screened for ANE where an appropriate action plan was implemented to address risk factors within 45 days of the report. **Numerator:** number of waiver beneficiaries who were screened for ANE where an appropriate action plan was implemented to address risk factors within 45 days **Denominator:** number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and APS and CPS

data reports.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system and APS and CPS data reports</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

HW-A2 Number and percent of waiver beneficiaries who received an introductory/annual letter that provided information and education on abuse, neglect and exploitation, and how to report a concern of ANE. Numerator: number of waiver beneficiaries who received an introductory/annual letter that provided information and education about ANE Denominator: number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entities' case files.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div>95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

CAP Business system and case management entities' case files		
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

HW-A3 Number and percent of death incident reports for unexplained deaths that had a root-cause analysis narrative summation. Numerator: number of death incident reports for unexplained deaths that had a root-cause analysis narrative
Denominator: number of waiver beneficiaries with a death report

Data Source (Select one):**Mortality reviews**

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, case management entities' case files and NC Medicaid MMIS.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business system, case management entities' case files and NC Medicaid MMIS</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

HW-A4 PM: #/% of waiver participants who had an investigative analysis conducted to identify a root cause when CIR was completed for an unexplained death N: # waiver participants who had an investigative analysis conducted to identify a root cause when CIR was completed for an unexplained death D: Total # unexplained deaths

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">CAP Business system</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	

Data Aggregation and Analysis:

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

- b. Sub-assurance:** *The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.*

Performance Measures

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

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

Performance Measure:

HW-B1 Number and percent of Level II Critical Incident Reports that had a follow-up resolution approved by the State Medicaid agency within 15 days of the initial incident date. Numerator: number of Level II critical incident reports that had a follow-up resolution approved within 15 days of the incident date Denominator: number of Level II critical incident reports

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, case management entities' file and APS and CPS data.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business system, case management entities' file and APS and CPS data</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 200px; margin-top: 5px;"></div>

Performance Measure:

HW-B2 Number and percent of Level I and II Critical Incident Reports submitted by the specified timeframe. Numerator: number of Level I and II critical incident reports by the specified timeframe Denominator: number of Level I and II Critical Incident Reports

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, case management entities' file and APS and CPS data.

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

<input checked="" type="checkbox"/> Other Specify: <div>Business system, case management entities' file and APS and CPS data</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

HW-B3 Number and percent of Level I and II Critical Incident Reports that had a

follow-up safety action plan, when indicated, within 15 days of the initial incident.

Numerator: number of Level I and II critical incident reports that had a follow-up safety action plan, when indicated, within specified timeframe
Denominator: number of Level I and II critical incident reports

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, case management entities' file and APS and CPS data.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business system, case management entities' file and APS and CPS data</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

HW-B4 PM: Number and percent of waiver participants with an emergency/disaster plan on file for each waiver participation year N: Number of waiver participants with an emergency/disaster plan on file for each waiver participation year D: Total number of waiver participants

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>
<input checked="" type="checkbox"/> Other	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified

Specify: CAP Business system		Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

HW-B5 PM: #/% of waiver participants with documentation of an updated/reviewed emergency/disaster plan for each recorded Level II CIR
N: # waiver participants with documentation of an updated/reviewed emergency/disaster plan for each recorded Level II CIR
D: Total # waiver participants who had a Level II incident reported

Data Source (Select one):**Critical events and incident reports**

If 'Other' is selected, specify:

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business system</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> CAP Business system	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Performance Measures

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

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

Performance Measure:

HW-C1 #/% of providers with an approved policy by SMA prohibiting unnecessary/unauthorized restrictive interventions (restraints, seclusions)for waiver beneficiaries. Numerator: number of providers with an approved policy by the SMA prohibiting unnecessary/unauthorized restrictive interventions (restraints, seclusions)for waiver beneficiaries. Denominator: number of providers reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and case management entities' file.

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

		Interval = 95% 5% margin of error
<input checked="" type="checkbox"/> Other Specify: CAP Business system and case management entities' file	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

HW-C2 Number/percent of beneficiaries with a Level III CIS for unnecessary/unauthorized restraints/restrictions that were mitigated in the required timeframe. N: # of beneficiaries with a Level II CIS for unnecessary/unauthorized restraints/restrictions that were mitigated in the required timeframe. D: # of waiver beneficiaries with a Level II CIS for unnecessary/unauthorized restraints/ restrictions

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, case management entities' file and APS and CPS data.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <div></div>
<input checked="" type="checkbox"/> Other Specify: <div>Business system, case management entities' file and APS and CPS data</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

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

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

Performance Measure:

HW-D1 Number and percent of waiver beneficiaries who completed recommended annual preventative/wellness appointments. Numerator: number of waiver beneficiaries who completed recommended annual preventative/wellness appointments Denominator: number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, case management entities' file and Provider Portal network data system

Responsible Party for data collection/generation	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
--	--	--

<i>(check each that applies):</i>		
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">Business system, case management entities' file and Provider Portal network data system</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px;"></div>	

Data Aggregation and Analysis:

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

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

Performance Measure:

HW-D2 Number and percent of waiver beneficiaries who were assigned and connected to a medical health home(PCP). Numerator: number of waiver beneficiaries who were assigned and connected to a medical health home(PCP)
Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: <input type="text"/> CAP Business systems and NC Medicaid MMIS	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and	<input type="checkbox"/> Other

	Ongoing	Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

Performance Measure:

HW-D3 Number and percent of waiver beneficiaries who had a scheduled visit with their primary care provider on at least an annual basis. Numerator: number of waiver beneficiaries who had a scheduled visit with their primary care provider on at least an annual basis Denominator: number of waiver beneficiaries reviewed

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system, case management entities' file and provider portal informatics.

Responsible Party for data	Frequency of data collection/generation	Sampling Approach <i>(check each that applies):</i>
-----------------------------------	--	--

collection/generation (check each that applies):	(check each that applies):	
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system, case management entities' file and provider portal informatics</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100px; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input type="text"/>	
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

Performance Measure:

HW-D4 Number/percent of waiver beneficiaries who report overall health and well-being was adequately assessed and planned for in their person-centered service plan.

Numerator: number of waiver beneficiaries who report overall health and well-being was adequately assessed and planned for in their person-centered service plan.

Denominator: number of waiver beneficiaries responding to the survey

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP Business system and NC Medicaid file and experience survey respondents.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 30px; margin-top: 5px;"></div>

Business system and NC Medicaid file and experience survey respondents		
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify: <div></div>	

Data Aggregation and Analysis:

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

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

The CAP Business system is designed to collect data and generate reports all waiver beneficiaries and provider agencies in the processing and performance of waiver activities. To validate the efficiency and capacity of the CAP Business system, the sampling methodology will be a 100% for waiver year one. As a safeguard to ensure the health and well-being of all waiver beneficiaries, a comprehensive needs assessment is conducted initially, annually and when the condition changes. This assessment identifies needs and potential risk factors. Health risk and safety considerations are assessed, and interventions are identified that promote health, independence and safety with the informed involvement of the beneficiary/responsible party. The CME ensures that services and supports are included in the service plan to address risk and safety issues identified in the assessment. Case managers monitor specific triggers in the assessment that must have corresponding service plan inclusions. When specific risk triggers are identified during the assessment, both informal and formal services are identified to mitigate risk and promote safety of the waiver beneficiary.

Initially and annually, the waiver beneficiary is provided information about ANE through an Introductory or Annual Letter. This information is also provided during the waiver screening process and the home assessment process. The information includes a statement of: "As a condition to participate in this waiver, your case manager must plan for your health, safety and well-being. He or she must ensure that you are safe at all times. The CM will talk with you on a monthly basis and make a HV with you at least every 90 days to monitor your care needs, to ensure services are provided as planned, and to ensure that your health, safety and well-being are intact. If you think that you are not safe or have any concerns about ANE you can call your local DSS/federally recognized Tribes for assistance with Adult/Child Protective Services or you can also call your case manager or care advisor." Parents/responsible parties of waiver beneficiaries under the age of 18 are informed that per federal regulation, any signs/indication of ANE, the CME is obligated to make a report to the DSS/federally recognized Tribes.

The case management entity must maintain monthly contact by phone or in person with the waiver beneficiary, and also required to conduct a face-to-face visit with the waiver beneficiary on a quarterly basis or more frequently based on the risk factors identified in the assessment. The case management entity must hold a multidisciplinary team meeting to address all needs to ensure health, safety and well-being.

The case management entity is provided a monthly risk indicator summary to review and discuss with the waiver beneficiary and other providers.

On a routine basis, the case management entity must review and evaluate service provision through the review of paid claims and time and record documentation as well as observe a formal service being provided to the waiver beneficiary in the setting the service is approved.

The CAP Business system allows State Medicaid Agency to review a service plan in order to evaluate if the emergency plan is adequate based on risk factors as a result changes in needs and risk factor due to incidences. This review is completed on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

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

The system design allows for quick remediation when noncompliant areas are discovered. Real-time data reports of programmed performance measures and the ability to run ad-hoc reports external to programmed performance measures allows the State Medicaid Agency to evaluate the effectiveness of its system and promote continuous quality improvement measures. Data analysis from the CAP Business system assists with the monitoring of health and welfare of all waiver beneficiaries. This analysis allows the case manager to ensure that the service plan is kept current and updated on a continuous basis with the waiver beneficiary's changing needs. When the case manager discovers a waiver beneficiary is at risk, the potential risk must be addressed immediately or within 72 hours. This may include calling a team meeting to address the issue, getting medical advice for the waiver beneficiary, or seeing that the waiver beneficiary is removed from imminent danger, risk or an unsafe environment. If the case manager or care advisor discovers that the waiver beneficiary has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must staff this with the team to implement a comprehensive safety plan. If it is found that the critical incident was not reported to CPS, the case manager or care advisor must immediately submit a report to CPS. If it is found that the critical incident was not reported timely, technical assistance will be provided by the State Medicaid Agency; the Case management entity must submit a corrective action plan to reduce future occurrences of untimely critical incident reports to CPS.

Upon discovery of non-compliance of ensuring the health and well-being of a waiver beneficiary through regular monitoring and planning, the State Medicaid Agency notifies the responsible Case management entity and assist in structuring a monitoring schedule and areas to monitor. The Case management entity must develop a corrective action plan within 3 days of notification to submit to the State Medicaid Agency. The Medicaid Agency reviews the corrective action plan, makes a final decision and issues directives for the Case management entity to follow. The corrective action plan is monitored and progress or concerns are tracked and discussed with the case management entity monthly. Repeated findings of non-compliance by a Case management entity will result in termination of new enrollment until successful completion of the corrective action plan. The State Medicaid Agency will provide staff training and technical guidance to ensure success. If corrective action plan is not remediated within 90 days, a recommendation may be made to terminate provider enrollment status as case management entity.

If the case manager or care advisor discovers the waiver beneficiary has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must address this with the team to implement a root cause analysis of multiple incidents.

Upon discovery of non-compliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within 3 business days. Repeated findings of non-compliance by a CAP IT contractor results in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

ii. Remediation Data Aggregation

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

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party(<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
	<div data-bbox="824 233 1218 306" style="border: 1px solid black; height: 35px; width: 100%;"></div>

c. Timelines

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

☒ **No**

☐ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

- i.** Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State Medicaid Agency has developed a quality management plan that integrates, analyzes measures and processes data and responds to information from multiple sources across functions within the waiver operation systems (CAP Business system, MMIS and CME) to ensure waiver assurances are met. The primary system used to monitor

the compliance to the waiver assurances and measures the quality of the waiver's performance is the CAP Business system. The CAP Business system is the hub for all waiver activities. Information pertaining to all the waiver assurances

is entered in the CAP Business system by the State Medicaid Agency (SMA), Case management entities (CMEs), Independent assessment entity (by May 2020) and HCBS providers. The CAP Business system correlates this information to

align with the waiver business workflow to allow the SMA the ability to aggregate and analyze trends and areas that may need remediation. The data elements in the system is real-time which promote immediate discovery and quick implementation of remediation steps. The CAP Business system generates data on all six waiver assurances which

allows the SMA to perform daily and ad-hoc analysis of waiver's performance.

To assist in managing the waiver's performance, the CAP Business system is programmed to manage the workflow for

this waiver based on the requirements and deliverables for each assurance drawing from several data sources, including:

1. The web-based case management and business process tool
2. On-site audits and reviews;
3. Desktop audits and reviews
4. The Medicaid Fiscal Contractor
5. NC Division of Health Services Regulation for licensure/certification records;
6. NC Medicaid Program Integrity Unit for audits, reviews, and investigations;
7. Experience Surveys; and
8. Stakeholder's input

The system tracks compliance using mandatory fields, time limits and workflow interruptions when the correct steps are not followed. The users are provided alert notifications and messages to promote compliance to the programmed workflow.

On a quarterly basis, the State Medicaid Agency conducts a comprehensive analysis of data reports to review trends, compliance to timelines and utilization in the areas of LOC, service plan, administrative authority responsibilities, financial accountability and health and welfare, qualified providers to measure the effectiveness of the CAP Business system in assuring each waiver assurance is met. This analysis identifies strengths and opportunities for improvement as well as identification of areas to prioritize. During this comprehensive analysis, discovery methods are used to ensure that staff, processes, data systems, and reporting mechanisms are working as intended to meet minimum standards and desired outcomes of the waiver quality improvement system. As a first step identified areas of weak performance are brought up to minimum standards through an understanding of the problem. Remedial action is taken to correct the root causes of the problem to improve performance in the weak area to prevent similar problems in the future. During analysis review, if a trend is identified that requires more focus or remediation, the case management entities, independent assessment entity (after May 2020) or HCBS provider is

informed of the quality improvement focus within 15 business days of discovery. Depending on the focus of the trend, training/technical assistance is performed, and a remediation plan is put in plan to either enhance what is working well or re-train to enhance efficiency and compliance. If the identified trend requires remediation, a 3-month QIS period is implemented which includes re-training and direct technical guidance. The State Medicaid Agency may impose suspension of specific activities until the issue is remediated to quality improvement. This QIS quarter is provided to all CMEs and IAEs, however, the entities that are directly out of compliance must complete a corrective action plan for review and approval to initiate steps to align to waiver assurances. If compliance is not achieved, a "non-eligible provider transition plan" is developed.

Prioritization of noncompliance areas is made when access to care barriers or gaps in services provision are presented. These gaps may include HCBS providers not receiving authorization timely to render approved services, prior approval records that prohibit reimbursement of services and workflow that restricts ability to the documents the receipt of a request a fair hearing.

A dashboard is updated daily in the CAP Business systems that displays performance of the waiver. An announcement

queue is used to communicate quality improvement information.

To validate the efficiency and capacity of each responsible entity, the CAP Business system measures their performance monthly. Each entity must maintain a 90% quality compliance rate. The CAP Business system is assessed daily to measure ability to manage this HCBS QIS and waiver compliance. The assessment of the system is monitored through:

1. Audits and reviews;
2. MMIS;
3. Experience Surveys;
4. Stakeholder's input
5. Scope of the work; and
6. Weekly discussion and tracking meetings.

When areas of non-compliance are identified, the CAP Business system is informed of the concerns and required to complete a root cause analysis. A corrective action plan is implemented that includes timeframes and any identified system change requests. Refer to H-1bi. This system is in the process of being certified. Stakeholders are notified quarterly through planned stakeholder engagement meetings about waiver trends and performances. Stakeholders are given the opportunity to voice concerns or provide recommendation on how the systems may be more efficient or methods to implement and manage waiver assurances and QIS.

ii. System Improvement Activities

Responsible Party(<i>check each that applies</i>):	Frequency of Monitoring and Analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

b. System Design Changes

- Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

A quarterly assessment of the functionality of the CAP Business system is conducted to monitor the performance and
 wavier specification per the approved scope of work. A State Medicaid representative reviews data reports and
 conducts testing to assess the effectiveness of the waiver functionality and it reliability to design. One hundred
 percent of the data must be processed and made available to the State Medicaid Agency when requested.
 However, on a quarterly basis, the State Medicaid Agency gathers and review the data in the aggregate. The data
 must be able to drill down to the minimal sub-assurances and an individual beneficiary or case managers. Upon
 the discovery of a less of out of compliance areas, a meeting is held with vendor to address concerns, identify
 causes and assist with the implementation of a corrective action plan. If the system is functioning as designed, but
 the waiver functionality is incongruent with processes or workflow, a change request is made to amend the scope
 of work or contract. The vendor must submit specification for approval to the State Medicaid agency that
 addresses the new functionality. After the approval of the specification, a user acceptance test is performed to
 ensure the updated functionality is working as designed. Upon the completion of this process, the State Medicaid
 agency ensure the system is functioning as designed through observation and review. If the system is not
 functioning as designed, the vendor will have 5 business days to correct the area(s) of concern or provide a
 proposal that include timelines.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

A safeguard implemented by the State Medicaid Agency (SMA) to continuously evaluate the Quality
 Improvement Strategy (QIS) for this HCBS program is through data analysis. The State Medicaid Agency
 requires the CAP Business system vendor to generate daily reports on all workflows that are directly connected to
 the
 six waiver assurances. The CAP Business system must also maintain history files. On a quarterly basis, and when
 a
 concern arises, an analysis of the reports is performed to evaluate system's performances. Data from this system is
 crossed-referenced, when applicable, to MMIS to validate compliance or issues of concern. This analysis allows a
 whole system review to identify areas that are working as designed and areas that need improvement. System
 improvements are implemented when areas of weaknesses are identified or when the system warrants
 Another safeguard implemented by the SMA to evaluate the QIS is the recommendations made from the Home
 and Community Care Quality Management committee. This committee meets quarterly to evaluate the QIS.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

- a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population
 in the last 12 months (*Select one*):

- ☒ No
☐ Yes (*Complete item H.2b*)

- b. Specify the type of survey tool the state uses:

- ☐ HCBS CAHPS Survey :
☐ NCI Survey :
☐ NCI AD Survey :
☐ Other (*Please provide a description of the survey tool used*):

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The oversight of the waiver financial integrity and accountability (FIA) is performed by the SMA with data reports received from the CAP Business system (CBS) and the MMIS. The SMA does not require an independent audit of provider agencies specific to this waiver. The FIA oversight consists of the Office of Compliance & Program Integrity (OCPI) and contracted vendor to conduct post/pre-payment reviews of providers that deliver Waiver services, both provider-led and consumer-directed. Post-payment reviews are done by OCPI on complaints that enter the Business Intake Center. These complaints come from internal/outside agencies & beneficiaries. The SMA's IT System receives PAs from utilization reviews and documented and archived authorizations in MMIS. The MMIS has edits/audits programmed to allow claims to adjudicate before payment. PCS is audited the same as other service claims. The weekly Aide Log captures the service approved on the POC & documents deviation from the approved POC. After the service has been provided, both Aide/beneficiary are required to sign to confirm PCS services were provided. The OCPI uses the Fraud and Abuse Management System (FAMS), Java-Surveillance and Utilization Review System (JSURS), and Advantage Suite to detect over/underutilization of services, and improper/aberrant billing practices. FAMS and JSURS can identify providers billing practices/behaviors outside the norm of peers. On a 90-day basis, post-payment review samples with a 95% confidence level & 5% margin of error are sent to the SMA from each of the assigned reviewers that were completed during the previous quarter. For the SMA, the post-payment review process occurs daily during business days. Data Analysis meetings are conducted bimonthly and a case disposition matrix is followed to determine whether a provider should be recommended for post/pre-payment review. Reasons why a provider would be placed on post/pre-payment include: credible allegations of fraud; Identification of aberrant billing practices because of investigations; Aberrant Data analysis results; Failure of the provider to timely respond to a request for documentation. A Data Analytics Team within the SMA identifies data leads for audit and investigation based on the reasons for post/pre-payment placement, as listed above. Advantage Suite has the capacity to identify over/under utilization of services. When providers are identified through data analytics, a Data Analytics Report is created and assigned to an investigator to conduct further research and make a recommendation to refer a provider for post/pre-payment review. Post-payment reviews are conducted to determine if the provider delivered services in accordance with the policies, rules, and regulations for the claim billed. Post-Payment reviews may include a review of service requests, assessments, service plans, prior authorizations, staff qualifications, and claims paid. Prepayment claims review may include review of service requests, service orders, assessments, staff qualifications, service plans, and claims prior to payment. A provider placed on prepayment claims review must obtain a 70% accuracy rate for three consecutive months to successfully complete the program. Providers may stay on prepayment claims review up to 12 months. The provider is provided the audit tools and instructions in the initial notice letter, and TA/support is given throughout the prepay process. If the provider does not meet this standard within six months of being placed on prepayment review, SMA may implement sanctions, including termination of the provider's Medicaid Application. The provider is notified of appeal rights. Pursuant to § 108C-7(b) and federal regulation, providers are not entitled to payment prior to claims review. To ensure that claims presented by a provider for payment meet the requirements of Federal/State laws, regulations and medical necessity criteria, a provider may be required to undergo prepayment claims review. The accuracy rate is determined by the total number of claims and detail line items (from all service locations operating under the NPI number) and determined as approved/denied within each month in which the claims are submitted for payment. 70% of all claim detail lines submitted must be identified by the designated vendor as containing no error(s). A single claim may contain one or more procedures billed on the same/different DOS. In this prepayment review process, the methodology for calculating a provider's accuracy rate is to take all claim detail lines with no identified errors divided by the total number of claim detail lines submitted for review. All the details of the statute are followed to assure that the provider successfully completes the program including the number of claims per month is no less than 50% of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review. There are approximately 90,000 NC Medicaid providers and less than 1% have been placed on pre-payment review. Since 2010, 239 providers, of all types, were placed on prepayment claims review, 197 have either completed the process or are in some phase of the process; 117 have been terminated or are in the process of being terminated for failure to achieve at least 70% claims accuracy for 3 consecutive months; and 62 have passed the pre-payment process. There is no time frame for how often a provider would be placed on pre-payment review. However, a determination can be made during the bimonthly Data Analysis Workgroup meetings. Terminations are the only actions that have been taken for providers failing pre-payment review. An access of care analysis is conducted prior to a pre-payment action being initiated.

SMA provides oversight and monitoring of the contracted vendors' performance on a routine basis to ensure contract compliance and quality performance which may include case referrals, special initiatives, provider performance reports, quality assurance reports, and recommendations. All vendors are invited to participate in joint training sponsored by SMA and The Medicaid Fraud Control Unit on an annual basis. Training often covers case studies, recent provider trends, investigative techniques, policy, rules, and regulation updates, and data analytics used to target reviews and investigations. The CBS contains algorithms with logic that can interpret information from the Service Request Form (SRF) and the assessment that results in the development of a service plan. The assessment tool has key indicators to identify risk factors in the areas of sensory and communication, mental and behavioral health, informal supports, housing and finance, safety and well-being, and medical and diagnostic functioning. Upon the completion of the assessment, the CAP Business system, analyzes the data gathered and provides the case manager a report that contains risk indicators and suggestions on the

types of services the waiver participant would need to maintain health, safety and well-being in the community. The case manager reviews those risk indicators along with the waiver participant to develop the service plan. The CBS also monitors services as listed on the service plan through monthly and quarterly documentation the case manager is required to complete in the CBS. The case manager gathers information about waiver participation and health and welfare during contact with the waiver participant and providers as well as from the review of paid claims. Key responses entered by the case manager populate to the service plan, the participant profile and a risk indicator section to aid in assessing if the waiver participant's needs are adequately addressed and met. The case manager is required to respond to probing questions in the monthly and quarterly monitoring assessment that analyze if services are provided as planned and if these services are meeting needs in the amount, frequency and duration as identified. The CAP Business system provides a summary of each waiver participant which is referred to as "participant at a glance". This summary provides an overview of all care needs, services approved, risk indicators, ADLs composite score and caregiver involvement and availability. If the analysis by the CBS reveals that needs do not appear to be met or there are concerns of risk, the case manager is prompted to complete a change in status assessment, a plan of care revision or a risk agreement. The SMA consultant reviews this information and provides guidance to the case manager. Level of care determination is generated by the CAP Business system. When the assessment is approved which determines the participant reasonable indication of need and appropriate to participate in this HCBS program, the CAP Business system automatically transmits the prior approval (PA) to SMA's MMIS. When the service plan is completed by the case manager that identifies the service types in the amount, duration and frequency, the CAP Business system automatically transmits the service types in the amount, frequency and duration to SMA's MMIS for adjudication of claims. SMA's MMIS will adjudicate claims up to the amount transmitted by the CAP IT system. SMA's contract administrator is responsible to ensure the CAP Business system is transmitting level of care PAs and service limit PAs to SMA's MMIS system timely and correctly. The contractor administrator will review all PAs transmitted to SMA's MMIS and will run data queries each week to assure claims adjudicated per the PA. The CAP Business system reviews 90% cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from consistent failure to comply with service plan. The Office of State Auditor (OSA) is responsible for conducting the periodic independent audit of the waiver program to include consumer-direction under the provisions of the Single Audit Act. Payment Error Rate Measurement (PERM) and recipient eligibility cases are completed every three years to determine whether medical record documentation supports services/products billed and whether the services/products were paid correctly. Post-payment reviews of all Medicaid providers conducted by the SMA look at the complete audit trail including the approval of the service plan; the authorization to the provider that rendered approved services, service provision and service documentation; the authorization for claims submission and actual claims data. The results of monthly monitoring are reviewed by the system and the SMA. The findings are shared with the CME. The findings enable the agencies to improve the way financial integrity and accountability are operated. The QA review process is not a negative process, but one that leads to the continuous quality improvement. Additionally, PA limits are placed on services to assure claims data is billed as planned in the SP. The waiver unit reviews claim data monthly to identify outliers/unusual occurrences. Outliers/unusual occurrences are analyzed to assure financial soundness and integrity. Concerns are referred to SMA's PI unit for an official investigation and follow-up. In addition to this process at the state level, the CME reviews paid claims routinely to ensure accuracy of service provision and reports concerns to SMA for follow-up. Program Integrity Section is tasked with multiple responsibilities. These responsibilities include: resolution of provider fraud, abuse and administrative over-payments; determining the accuracy of Medicaid eligibility determinations; performing reviews of claims filed to identify problem areas; assisting in claim payment audits; conducting periodic reviews with providers who bill for payments; and referring cases of possible fraud to the Attorney General's Medicaid Investigations unit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:

FA-A1 Number and percent of waiver claims that were not suspended or denied for incorrect billing codes
Numerator: number of waiver claims that were not suspended or denied for incorrect billing codes
Denominator: number of waiver claims reviewed

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

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

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

FA-A2 Number and percent of direct support staff reimbursed at their negotiated pay rate. Numerator: number of direct support staff reimbursed at their negotiated pay rate
Denominator: number of direct support staff reviewed

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

The source of these reports are from CAP Business system, FMS records and NC Medicaid MMIS

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review

<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div style="border: 1px solid black; padding: 2px; width: fit-content;">95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div style="border: 1px solid black; padding: 2px; width: fit-content;">CAP Business system, FMS records and NC Medicaid MMIS</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <div></div>

Performance Measure:

FA-A3 Number and percent of waiver claims that prior approval limits were submitted in the correct amount, duration and frequency. Numerator: number of waiver claims that prior approval limits were submitted in the correct amount, duration and frequency
Denominator: number of waiver claims reviewed

Data Source (Select one):**Financial audits**

If 'Other' is selected, specify:

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

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Representative Sample Confidence Interval = <div>95% 5% margin of error</div>
<input checked="" type="checkbox"/> Other Specify: <div>CAP Business systems and NC Medicaid MMIS</div>	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <div></div>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <div></div>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

Performance Measure:

FA-A5 Number and percent of waiver claims successfully paid based on edits and audits for the waiver
Numerator: number of waiver claims successfully paid based on edits and audits for the waiver
Denominator: number of waiver claims reviewed

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

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

		95% 5% margin of error
<input checked="" type="checkbox"/> Other Specify: Business system and Medicaid MMIS	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

Performance Measure:

FA-A6 Number and percent of claims reimbursed according to the rates approved in the waiver application
Numerator: Number of claims reimbursed according to the rates approved in the waiver application
Denominator: Total number of claims reviewed

Data Source (Select one):**Financial records (including expenditures)**

If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<div style="border: 1px solid black; height: 30px; width: 100%;"></div>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 30px; width: 100%;"></div>

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:

Number and percent of waiver claim rates that were adjudicated consistent with the published Fee Schedule for each waiver participation year
Numerator: Number of waiver claim rates that were adjudicated consistent with the published Fee Schedule for each waiver participation year
Denominator: number of waiver claim rates reviewed

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

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

		95% 5% margin of error
<input checked="" type="checkbox"/> Other Specify: Business system and Medicaid MMIS	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify: 	

Data Aggregation and Analysis:

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

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

The CAP Business system for this waiver is designed to evaluate all waiver beneficiaries and provider agencies in the processing and performance of waiver activities. To validate the efficiency and capacity of the CAP Business system programmed to support NC Medicaid administrative operation on this waiver, the sampling methodology will be a 100% sampling for waiver year one.

As a safeguard for financial accountability assurance, the State Medicaid Agency has programmed in its MMIS functionality to place prior approval limits on all waiver services. These limits are electronically transmitted to the State's MMIS to inform claim reimbursement. These prior approval limits will prevent over payments of Medicaid claims processing. The prior approval limits will also prevent providers from submitting Medicaid claims prior to the effective date of service implementation. The Medicaid Fiscal Agent is responsible for ensuring that waiver claims are paid correctly. All services are appropriately coded and audits and edits are placed within the system to ensure claims are paid correctly. Audits have been tested to ensure claims for the waiver services will process as per Medicaid guidelines. The case management entities in conjunction with Business system monitor service authorization against paid claims to ensure that they are coded and paid correctly and that these paid claims correspond with the approved services in each waiver beneficiary's service plan. The CAP Business system in conjunction with the Medicaid waiver services unit monitors expenditures to ensure that monthly benefit limits are not exceeded and the program stays within its approved budget. NC Medicaid Office of Compliance and Program Integrity (OCPI) and/or its agents conduct post-payment reviews of providers that deliver Medicaid Waiver services. The NC Medicaid MMIS receives prior authorizations from utilization review and authorizations are communicated, documented, and archived in system's portal known as NCTracks. NC Medicaid MMIS has edits and audits programmed to allow claims to process appropriately before the provider is paid. NC Medicaid Office of Compliance and Program Integrity uses robust data analytic tools that include the Fraud and Abuse Management System (FAMS), Java-Surveillance and Utilization Review System (JSURS), and Advantage Suite to identify and detect over-utilization, and underutilization of services, as well as improper or aberrant billing practices by providers. FAMS and JSURS have the capacity to identify providers billing practices or behaviors outside the norm of its peers. Advantage Suite has the capacity to identify overutilization and underutilization of services. When providers are identified through data analytics, a Data Analytics Report is created and assigned to an investigator to conduct further research and make a recommendation to refer a provider for post-payment review or prepayment review. Post-payment reviews are conducted by Office of Compliance and Program Integrity (OCPI) and/or its authorized agents to determine if the provider delivered services in accordance with the policies, rules, and regulations for the claim billed. Post-Payment reviews may include a review of service request forms, assessments, family/person centered service plan, prior authorizations, staff qualifications, and claims paid.

b. Methods for Remediation/Fixing Individual Problems

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

Upon discovery of non-compliance, a root-cause analysis is completed to identify the source of the systems error. If a NC Medicaid MMIS issue is discovered, a Medicaid Policy Memo (Change Service Requests) is generated to identify and resolve the issue.

Upon discovery of non-compliance, the State Medicaid Agency contacts the provider to alert of the paid claim error and requests proposal on repayment, which can include recoupment of payment and/or adjustment to future provider payments; if trends or patterns are revealed of continued non-compliance, an audit is conducted, which may result in further sanctions or disbarment as a Medicaid-enrolled provider.

Whenever provider paid claims spike for various reasons, or failed to substantially comply with previous requirements in an audit, provider may be considered for prepayment claims review. Prepayment claims review may include review of service request forms, service orders, assessments, staff qualifications, family/person centered service plan, and claims prior to payment. A provider placed on prepayment claims review has to obtain a 70% accuracy rate for three consecutive months to successfully complete the program. Providers may stay on prepayment claims review up to twelve months. Should a provider not meet the 70% accuracy rate, NC Medicaid may terminate the provider from the Medicaid program.

ii. Remediation Data Aggregation

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

<i>Responsible Party</i> (check each that applies):	<i>Frequency of data aggregation and analysis</i> (check each that applies):
<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>
<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>
<input type="checkbox"/> <i>Sub-State Entity</i>	<input type="checkbox"/> <i>Quarterly</i>
<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>	<input type="checkbox"/> <i>Annually</i>
	<input checked="" type="checkbox"/> <i>Continuously and Ongoing</i>
	<input type="checkbox"/> <i>Other</i> <i>Specify:</i> <div style="border: 1px solid black; height: 30px; width: 100%; margin-top: 5px;"></div>

c. Timelines

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

☒ **No**

☐ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The State does not have a defined timeframe for rebasing of rates. From a review perspective, the State does interact and solicit feedback from the stakeholder community on an ongoing basis including the feasibility of the current fees in place. A formal review/rebase of waiver rates was conducted in SFY 2017-2018. Generally, the State determines rates through a fee-for-service fee schedule methodology. For fee schedule rates, the State has historically solicited data from providers to inform the rate development process. The following components are typical considerations in the State fee development:

- *Staffing Assumptions and staff wages*
- *Employee-related expense (e.g., benefits, employer taxes)*
- *Non-direct program expenses (e.g., supplies, training and supervision)*
- *Provider administrative overhead*
- *Direct staffing hours – this considers the training and other non-billable activities that practitioners are involved in.*

Rates are set to reimburse reasonable cost as defined in section 1861(v) of the Social Security Act. Service rates are developed using various methodologies; Medicaid historical fee schedules, Medicare, historical cost to providers, cost modeling and Medicare established fee schedules; and, in some cases, providers are invited to participate in forums related to rate setting.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The waiver participant is provided information about the waiver and payments when a referral is made and during the initial assessment process and annually thereafter.

North Carolina establishes reimbursement rates applicable to services provided by providers and facilities. The rates are based on the costs incurred and reported by the providers with certain limits. Rates are generally set for the rate period based on the historical costs of the facility for a prior year (adjusted for inflation), rather than on the actual costs of providing the services for which the rate is claimed.

Reimbursement for all providers for the following services is capped:

- *Home accessibility and adaptation -- \$28,000 for the life of the waiver*
- *Participant Goods and Services - \$800 per fiscal year*
- *Assistive Technology- \$28,000.00 per life of the waiver*
- *Community Transition Services- \$2,500.00 per Waiver beneficiary over the lifetime of the waiver*
- *Training and Education Services- \$500.00 per state fiscal year*

Case management – 72 hours or 288 units per calendar year for ongoing case management and 8 hours or 32 units per year for assessments

Vehicle Modification- \$28,000 max. over the lifetime of the waiver

Maximum reimbursement for all providers for the following services is the same per unit rate (one unit = 15 minutes) and is determined at least annually by NC Medicaid:

- *Personal Care Assistant Services*
- *Personal Care Services to include In-home Respite services and Nursing services*
- *Respite Care (Non-Institutional)*
- *Financial Management*
- *Care Advisor*
- *Case Management*

North Carolina establishes per diem rates for the following services

- *Respite Care (Institutional)*

Other:

- *Waiver Supplies - units vary by item and are consistent with State Plan services*
- *Personal emergency response services - paid per month*

NC Medicaid is in constant communication with providers and their associations through frequent meetings. Consumers may submit complaints by phone, or in writing. NC Medicaid complaints are investigated by Program Integrity who is available to receive complaints from patients, their families, other providers, former employees of a provider, and through federal and state referrals. Program Integrity staff investigates the complaint.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The billing flow for waivers services is directly from the providers to the State's claims payment system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

- c. Certifying Public Expenditures (select one):**

- ☒ **No. state or local government agencies do not certify expenditures for waiver services.**
- ☐ **Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- ☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-a.)

- ☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

NC Medicaid contracts with a Fiscal Agent (FA) for the management of the MMIS, claim processing and payment. It is the FA's responsibility to process valid Medicaid claims from enrolled providers in accordance with NCDMA policies, edits, audits, guidelines, and reimbursement methodologies. Payments are made through MMIS and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers.

A prior approval of a LOC determination and a special waiver coverage code must be in the MMIS system before performing and billing any service to Medicaid.

The provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid because Medicaid is the payer of last resort.

Once the provider determines that the invoice is a Medicaid claim, the provider then bills NCTracks for payment.

Validation that services have been provided as billed is a function of quality assurance conducted by the CAP Business system and the case management entities. Audits include verification that the services were provided as billed. Additional validation is through desk and onsite audits and Program Integrity reviews.

Annually the NC Medicaid Accountability Team conducts a Medicaid Compliance Audit that includes waiver services.

Auditors review Medicaid billed events per a sample of enrolled providers. This review includes monitoring of requirements that addresses staff qualifications, service authorizations, family/person centered plans, service documentation, and billing protocol. For the waiver, a validation of the following is reviewed:

1. Have the required signatures on or before services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and
7. Include a 24-hour schedule of coverage, if warranted.

During and prior to waiver participation the State Medicaid Agency validates the CAP Business system:

- reviews 100% of its cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided.
- reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, different LOC and appeals on a monthly basis to assure accuracy and 100% compliance of authorized services.
- conducts quality assurance reviews that include a review of the family/person centered plan and service documentation for each waiver beneficiary. The reviewer reviews the current service request form, the assessment and the approved family/person centered, service documentation, and paid claims to insure that services were billed appropriately as according to the service plan.
- places prior approval limits on all service plans to identify deviations from the providers and review provision of services monthly. If there are consistent deviations and the service is authorized on the service plan, the case manager must review these with the waiver beneficiary for further validation.

The State Medicaid Agency/CAP Business system will provide each case management entities with QI reports to validate all authorized services. The case management entities will contact the CAP Business system representatives/State Medicaid Agency when program integrity concerns are present. The State Medicaid Agency will arrange for a program integrity review of the concerns.

In addition to the activities described above, the State Medicaid Agency utilizes desktop reviews and on-site reviews (audits), reports, and special reviews to ensure program accountability for service plan development and implementation. These desktop reviews and on-site reviews occur annually and as needed.

Submitted claims are systematically reviewed by the fiscal agent to ensure that all required information is present.

Completed claims processed through MMIS are run against system edits to verify:

- Services are prior authorized (i.e., level of care);
- Individual is a Medicaid beneficiary and is enrolled in the waiver (i.e. CAP indicator);
- Provider is an enrolled waiver provider;
- Claim is not a duplicate;
- Claim is paid per the published rates; and the participant was not institutionalized during the time covered.

Payments are made through NC Medicaid MMIS and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers.

Validation that services have been provided as billed is a function of quality assurance conducted by the management of prior approvals and assessment by the case management entity. Additional validation that services were provided as billed is performed during case management entity and provider on-site compliance monitoring reviews, conducted by the State Medicaid Agency's Program Integrity Unit. Validation will also be achieved through participant's surveys by

mail or by telephone; education about fraud and abuse and how to report concerns of payment integrity and quality of care. During enrollment and annually thereafter, each waiver participant will be provided education and information regarding financial accountability. In addition, post payment reviews, review of provider records and claims will also be used for validation.

- e. Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. Method of payments -- MMIS (select one):**

- ☒ **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ☐ **Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ☐ **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):

- ☐ **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- ☒ **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**

- ☐ **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- ☐ **Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:

- ☒ **No. The state does not make supplemental or enhanced payments for waiver services.**
- ☐ **Yes. The state makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. Specify whether state or local government providers receive payment for the provision of waiver services.

- ☐ **No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.**
- ☒ **Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.**

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Case management entities are not providers of waiver services such as specialized medical equipment and supplies, home accessibility and adaptation, participant goods and services and assistive technology. They are used as a pass through. When a waiver service of such is identified as a need, the case management entity assists the waiver beneficiary in identifying a waiver provider based on freedom of choice. When a provider is selected by the waiver beneficiary, a service authorization is forwarded to the selected provider by the CME to initiate the provision of that waiver service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

- ☒ The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
- ☐ The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
- ☐ The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:

- ☒ Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
- ☐ Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. Select one:

- ☒ **No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- ☐ **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. Select one:

- ☒ **No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- ☐ **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ☒ **The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ☐ **The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ☐ **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- ☐ **This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and**

other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The 21115 waiver specifies the types of health plans that are used and how payments to these plans are made.

- ☐ *If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.*

In the textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

- ☒ **Appropriation of State Tax Revenues to the State Medicaid agency**
- ☐ **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

- ☐ **Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

- ☒ **Not Applicable.** *There are no local government level sources of funds utilized as the non-federal share.*
- ☐ **Applicable**

Check each that applies:

☐ **Appropriation of Local Government Revenues.**

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ **Other Local Government Level Source(s) of Funds.**

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:

☒ **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**

☐ **The following source(s) are used**

Check each that applies:

☐ **Health care-related taxes or fees**

☐ **Provider-related donations**

☐ **Federal funds**

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. Select one:

☒ **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

☐ **As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.**

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the

methodology that the state uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. Select one:

- ☒ **No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- ☐ **Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ☒ **No. The state does not impose a co-payment or similar charge upon participants for waiver services.**
- ☐ **Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

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Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:

☒ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***

☐ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols.

4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: Hospital, Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	18912.77	66329.29	85242.06	99797.96	28683.21	128481.17	43239.11
2	19431.25	68319.17	87750.42	102791.90	29534.70	132326.60	44576.18
3	19759.33	70368.74	90128.07	105875.65	30430.01	136305.66	46177.59
4	20831.00	72479.80	93310.80	109051.92	31342.91	140394.83	47084.03
5	21508.75	74654.20	96162.95	112323.48	32283.20	144606.68	48443.73

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

- a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	4000	26	3974
Year 2	4000	26	3974
Year 3	4000	26	3974
Year 4	4000	26	3974
Year 5	4000	26	3974

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for the waiver is 309.8 days. This figure is actual average length of stay for waiver participants from July 1, 2014 through June 30, 2015 (SFY 2015). Note that the overall length of stay for the CAP waiver is comparable the average length of stay across the previous 2010 CAP/C waiver submission.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:

SFY 2015 Medicaid expenditure data for all waiver services for the CAP-C waiver recipients serve as the base data for this estimate of Factor D. Historic Medicaid experience was leveraged in the development of the utilization projections. Historic unit cost experience along with the State fee schedules were leveraged for the initial waiver projection year; for waiver years 2 through 5, the costs were trended using 3% inflation consistent with recent trends for the waiver program. User projections developed for each service are based on the total number of approved waiver slots and the proportion of total clients expected to utilize each waiver service based on Medicaid experience along with past waiver expectations. Historical waiver expenditures for Nursing were removed from the Factor D calculation as these services will be moving to the State Plan.

January 2018 rate increase methodology was based on the following:

A blended fee is reflected in waiver year 1 (CY 2017): $\$3.47 \times (7/12) + \$3.90 \times (5/12) = \$3.65$. For waiver year 2 (CY 2018), \$3.90 is the reflected fee. In waiver year 3 and on, a unit cost trend is applied to be consistent with the methodology used for other fees.

Four new services were added in Appendix C1/C-3, Individual-directed goods and services, Non-medical Transportation, Nutritional Services and Pest Eradication. The number of users, average units per user and average cost per unit were estimated based on data from the most recent CMS-372 and previous service requests inventory data. The number of users, average units per user and average cost per unit may be altered in the future or at the time of reconciliation. These four new services will follow the same Factor D Derivations methodology as described above.

- ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SFY 2015 Medicaid expenditure data for all State Plan services for the CAPC waiver beneficiaries serve as the base data for this estimate of Factor D'. Expenditures were trended using 3% inflation. Historical waiver expenditures for nursing were shifted to the Factor D' calculation as these services will be moving to State Plan; based on estimates provided by Moody's economy.com (refer to the medical care services section under the 'Source' link). The CPI (Consumer Price Index) is the inflation metric that was used.

Part D prescribed drugs are automatically removed from the cost associated with Factor D'. The Medicaid Management System has logic to identify individuals with Part D coverage to deny claims submitted to Medicaid. Data generated for D' do not include costs of prescribed drugs for dual eligibles under Part D

- iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SFY 2015 Medicaid expenditure data from nursing facilities and hospitals were used for the estimate of Factor G. Specific to hospital expenditures, the Medicaid claims experience was adjusted to reflect the total payments to hospitals inclusive of Medicaid supplemental payments. Institutional users comparable to the population eligible for the waiver were identified based on DRG and NPI/taxonomy code criteria. Specific to hospital expenditures, the Medicaid claims experience was adjusted to reflect the total payments to hospitals inclusive of Medicaid supplemental payments. For the waiver projection years, the Factor G estimates were derived by trending the expenditures using 3% inflation. The State uses is a 4% inflation rate which is based on estimates provided by Moody's economy.com (refer to the medical care services section under the 'Source' link). The CPI (Consumer Price Index) is the inflation metric that was used.

- iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SFY 2015 State Plan expenditure data for the institutional population of children that was identified for the estimate Factor G was used for the estimate of Factor G'. In subsequent years the expenditures are trended using 3% inflation. The State uses is a 4% inflation rate which is based on estimates provided by Moody's economy.com (refer to the medical care services section under the 'Source' link). The CPI (Consumer Price Index) is the inflation metric that was used.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “manage components” to add these components.

Waiver Services	
Coordination of Care- case management and care advisement	
In-Home Care Aide Service	
Respite-Institutional and In-Home	
Financial Management	
Individual-Directed goods and services	
Assistive Technology	
Community Transition	
Home Accessibility and Adaptation	
Non-Medical Transportation	
Nutritional Services	
Participant Goods and Services	
Pediatric Nurse Aide Services	
Pest Eradication	
Specialized Medical Equipment	
Training, Education, and Consultative Services	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (5 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care- case management and care advisement Total:						10066025.62
Coordination of Care- case management and care advisement	15 min	3977	179.00	14.14	10066025.62	
In-Home Care Aide Service Total:						23920734.60
In-Home Care Aide Service	15 min	1303	3948.00	4.65	23920734.60	
Respite-Institutional and In-Home Total:						12772450.75
GRAND TOTAL:						75651071.57
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						18912.77
Average Length of Stay on the Waiver:						310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Institutional Respite	per diem	2	1.00	206.00	412.00	
Non-Institutional Respite	15 min	3035	775.00	5.43	12772038.75	
Financial Management Total:						1674.00
Financial Management	15 min	4	18.00	23.25	1674.00	
Individual-Directed goods and services Total:						0.00
Individual-Directed goods and services	15min	0	0.00	1.00	0.00	
Assistive Technology Total:						1543118.85
Assistive Technology	event	1855	13.00	63.99	1543118.85	
Community Transition Total:						24000.00
Community Transition	instance	2	1.00	12000.00	24000.00	
Home Accessibility and Adaptation Total:						2197938.20
Home Accessibility and Adaptation	event	508	1.00	4326.65	2197938.20	
Non-Medical Transportation Total:						0.00
Non-Medical Transportation	instance	0	0.00	1.00	0.00	
Nutritional Services Total:						0.00
Nutritional Services	event	0	0.00	1.00	0.00	
Participant Goods and Services Total:						1543118.85
Participant Goods and Services	event	1855	13.00	63.99	1543118.85	
Pediatric Nurse Aide Services Total:						19323922.80
Pediatric Nurse Aide Services	15 min	1707	3110.00	3.64	19323922.80	
Pest Eradication Total:						0.00
Pest Eradication	event	0	0.00	1.00	0.00	
Specialized Medical Equipment Total:						2067107.86
Specialized Medical Equipment	instance	1369	4441.00	0.34	2067107.86	
GRAND TOTAL:						75651071.57
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						18912.77
Average Length of Stay on the Waiver:						310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Training, Education, and Consultative Services Total:						23320.00
Training, Education, and Consultative Services	instance	53	40.00	11.00	23320.00	
Vehicle Modifications Total:						2167660.04
Vehicle Modifications	instance	482	1.00	4497.22	2167660.04	
GRAND TOTAL:						75651071.57
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						18912.77
Average Length of Stay on the Waiver:						310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care- case management and care advisement Total:						10365016.48
Coordination of Care- case management and care advisement	15 min	3977	179.00	14.56	10365016.48	
In-Home Care Aide Service Total:						24640928.76
In-Home Care Aide Service	15	1303	3948.00	4.79	24640928.76	
Respite-Institutional and In-Home Total:						13031198.88
Institutional Respite	per diem	2	1.00	213.19	426.38	
Non-Institutinal Respite	15 min	3035	775.00	5.54	13030772.50	
Financial Management Total:						1724.40
Financial Management	per month	4	18.00	23.95	1724.40	
Individual-Directed						0.00
GRAND TOTAL:						77724991.74
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						19431.25
Average Length of Stay on the Waiver:						310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
goods and services Total:						
Individual-Directed goods and services	15min	0	0.00	1.00	0.00	
Assistive Technology Total:						481089.00
Assistive Technology	avg cost per year	155	35.00	88.68	481089.00	
Community Transition Total:						24720.00
Community Transition	avg cost per year	2	1.00	12360.00	24720.00	
Home Accessibility and Adaptation Total:						2263876.60
Home Accessibility and Adaptation	avg cost per year	508	1.00	4456.45	2263876.60	
Non-Medical Transportation Total:						0.00
Non-Medical Transportation	instance	0	0.00	1.00	0.00	
Nutritional Services Total:						0.00
Nutritional Services	event	0	0.00	1.00	0.00	
Participant Goods and Services Total:						1827618.39
Participant Goods and Services	event	2133	13.00	65.91	1827618.39	
Pediatric Nurse Aide Services Total:						20704203.00
Pediatric Nurse Aide Services	15 min	1707	3110.00	3.90	20704203.00	
Pest Eradication Total:						0.00
Pest Eradication	event	0	0.00	1.00	0.00	
Specialized Medical Equipment Total:						2127905.15
Specialized Medical Equipment	instance	1369	4441.00	0.35	2127905.15	
Training, Education, and Consultative Services Total:						24019.60
Training, Education, and Consultative Services	instance	53	40.00	11.33	24019.60	
Vehicle Modifications Total:						2232691.48
Vehicle Modifications	avg cost per year	482	1.00	4632.14	2232691.48	
GRAND TOTAL:						77724991.74
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						19431.25
Average Length of Stay on the Waiver:						310

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (7 of 9)****d. Estimate of Factor D.**

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care- case management and care advisement Total:						10255410.36
Coordination of Care- case management and care advisement	15 min or month	3977	78.00	33.06	10255410.36	
In-Home Care Aide Service Total:						25361122.92
In-Home Care Aide Service	15 min	1303	3948.00	4.93	25361122.92	
Respite-Institutional and In-Home Total:						13431072.93
Institutional Respite	per diem	2	1.00	219.59	439.18	
Non-Instititunal Respite	15 min	3035	775.00	5.71	13430633.75	
Financial Management Total:						255611.70
Financial Management	15 min or month	402	15.00	42.39	255611.70	
Individual-Directed goods and services Total:						0.00
Individual-Directed goods and services	15min	0	0.00	1.00	0.00	
Assistive Technology Total:						568425.20
Assistive Technology	instance	178	35.00	91.24	568425.20	
Community Transition Total:						25461.60
Community Transition	instance	2	1.00	12730.80	25461.60	
Home Accessibility and Adaptation Total:						2331791.12
Home Accessibility and Adaptation	event	508	1.00	4590.14	2331791.12	
Non-Medical						0.00
GRAND TOTAL:						79037322.44
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						19759.33
Average Length of Stay on the Waiver:						310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transportation Total:						
Non-Medical Transportation	instance	0	0.00	1.00	0.00	
Nutritional Services Total:						0.00
Nutritional Services	event	0	0.00	1.00	0.00	
Participant Goods and Services Total:						954058.17
Participant Goods and Services	event	1081	13.00	67.89	954058.17	
Pediatric Nurse Aide Services Total:						21341255.40
Pediatric Nurse Aide Services	15 min	1707	3110.00	4.02	21341255.40	
Pest Eradication Total:						0.00
Pest Eradication	event	0	0.00	1.00	0.00	
Specialized Medical Equipment Total:						2188702.44
Specialized Medical Equipment	instance	1369	4441.00	0.36	2188702.44	
Training, Education, and Consultative Services Total:						24740.40
Training, Education, and Consultative Services	instance	53	40.00	11.67	24740.40	
Vehicle Modifications Total:						2299670.20
Vehicle Modifications	instance	482	1.00	4771.10	2299670.20	
GRAND TOTAL:						79037322.44
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						19759.33
Average Length of Stay on the Waiver:						310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care- case management and care advisement Total:						10810162.09
Coordination of Care- case management and care advisement	month	3977	7.00	388.31	10810162.09	
In-Home Care Aide Service Total:						26132759.52
In-Home Care Aide Service	15 min	1303	3948.00	5.08	26132759.52	
Respite-Institutional and In-Home Total:						13830947.36
Institutional Respite	per diem	2	1.00	226.18	452.36	
Non-Institutinal Respite	15 min	3035	775.00	5.88	13830495.00	
Financial Management Total:						269553.06
Financial Management	month	402	7.00	95.79	269553.06	
Individual-Directed goods and services Total:						365454.18
Individual-Directed goods and services	15min	402	13.00	69.93	365454.18	
Assistive Technology Total:						674306.50
Assistive Technology	instance	205	35.00	93.98	674306.50	
Community Transition Total:						26225.44
Community Transition	instance	2	1.00	13112.72	26225.44	
Home Accessibility and Adaptation Total:						2401742.72
Home Accessibility and Adaptation	event	508	1.00	4727.84	2401742.72	
Non-Medical Transportation Total:						307272.42
Non-Medical Transportation	instance	338	13.00	69.93	307272.42	
Nutritional Services Total:						396363.24
Nutritional Services	event	436	13.00	69.93	396363.24	
Participant Goods and Services Total:						906362.73
Participant Goods and Services	instance	997	13.00	69.93	906362.73	
GRAND TOTAL:						83324006.56
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						20831.00
Average Length of Stay on the Waiver:						310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pediatric Nurse Aide Services Total:						21978307.80
Pediatric Nurse Aide Services	15 min	1707	3110.00	4.14	21978307.80	
Pest Eradication Total:						580908.51
Pest Eradication	event	639	13.00	69.93	580908.51	
Specialized Medical Equipment Total:						2249499.73
Specialized Medical Equipment	instance	1369	4441.00	0.37	2249499.73	
Training, Education, and Consultative Services Total:						25482.40
Training, Education, and Consultative Services	instance	53	40.00	12.02	25482.40	
Vehicle Modifications Total:						2368658.86
Vehicle Modifications	event	482	1.00	4914.23	2368658.86	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						83324006.56 4000 20831.00 310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Coordination of Care-case management and care advisement Total:						11134486.44
Coordination of Care-case management and care advisement	month	3977	7.00	399.96	11134486.44	
In-Home Care Aide Service Total:						26904396.12
In-Home Care Aide					26904396.12	
GRAND TOTAL: Total Estimated Unduplicated Participants: Factor D (Divide total by number of participants): Average Length of Stay on the Waiver:						86034995.82 4000 21508.75 310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Service	15 min	1303	3948.00	5.23		
Respite-Institutional and In-Home Total:						14254343.44
Institutional Respite	per diem	2	1.00	232.97	465.94	
Non-Institutional Respite	15 min	3035	775.00	6.06	14253877.50	
Financial Management Total:						277629.24
Financial Management	month	402	7.00	98.66	277629.24	
Individual-Directed goods and services Total:						380452.80
Individual-Directed goods and services	15min	402	13.00	72.80	380452.80	
Assistive Technology Total:						741972.00
Assistive Technology	instance	219	35.00	96.80	741972.00	
Community Transition Total:						27012.20
Community Transition	instance	2	1.00	13506.10	27012.20	
Home Accessibility and Adaptation Total:						2473797.44
Home Accessibility and Adaptation	event	508	1.00	4869.68	2473797.44	
Non-Medical Transportation Total:						387077.60
Non-Medical Transportation	instance	409	13.00	72.80	387077.60	
Nutritional Services Total:						407898.40
Nutritional Services	event	431	13.00	72.80	407898.40	
Participant Goods and Services Total:						968167.20
Participant Goods and Services	instance	1023	13.00	72.80	968167.20	
Pediatric Nurse Aide Services Total:						22615360.20
Pediatric Nurse Aide Services	15 min	1707	3110.00	4.26	22615360.20	
Pest Eradication Total:						686140.00
Pest Eradication	event	725	13.00	72.80	686140.00	
Specialized Medical						2310297.02
GRAND TOTAL:						86034995.82
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						21508.75
Average Length of Stay on the Waiver:						310

<i>Waiver Service/ Component</i>	<i>Unit</i>	<i># Users</i>	<i>Avg. Units Per User</i>	<i>Avg. Cost/ Unit</i>	<i>Component Cost</i>	<i>Total Cost</i>
Equipment Total:						
Specialized Medical Equipment	instance	1369	4441.00	0.38	2310297.02	
Training, Education, and Consultative Services Total:						26245.60
Training, Education, and Consultative Services	instance	53	40.00	12.38	26245.60	
Vehicle Modifications Total:						2439720.12
Vehicle Modifications	event	482	1.00	5061.66	2439720.12	
GRAND TOTAL:						86034995.82
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						21508.75
Average Length of Stay on the Waiver:						310