3K-1, Community Alternatives Program for Children CAP/C Clinical Coverage Policy Public Comments Track Document

Sections of the Policy that were Updated	Previous Language in the 3K-1 Clinical Coverage Policy	Update Language to 3K-1 Clinical Coverage Policy
Section 2.1.2 # 2, 4, and 6 A number 5 was added to this section	2. is member of a CAP/C waiver target population that is contained in the waiver; 4. requires one or more CAP/C service(s) that must be coordinated to function in the community; 6. Is age 0 through 20 years of age, and meets one of the following medically complex conditions: A number 5 was added to this section.	2. is member of a CAP/C waiver target population; 4. requires one or more CAP/C service(s) that must be coordinated by a CAP/C case manager to function in the community; 5. is determined to be at-risk of institutionalization based on risk factors identified in a completed comprehensive assessment; 6. Is age 0 through 20 years of age, and meets all the following medically complex conditions:
Section 3.2.2.a.3	Requires CAP/C services (excluding incontinence supplies, home and vehicle modification and assistive technology) monthly that mitigate institutionalization through coordinated case management and hands on personal assistance;	Requires CAP/C services monthly that mitigate institutionalization through coordinated case management and hands on personal assistance;
Section 3.2.2.a.4	Requires an installation of a home or vehicle modification or assistive technology to return to or remain in the primary private residence that prevents risk of institutionalization (the installation of equipment or modification must be completed within three (3) calendar months of approval;	Requires only an installation of a home or vehicle modification or assistive technology to return to or remain in the primary private residence that prevents risk of institutionalization (the installation of equipment or modification must be completed within three (3) calendar months of approval);
Section 3.2.4 Section 6.2.1, note provided	The CAP 1915 (c) HCBS waiver arranges for service consideration on a first-come first-serve basis due to similar acuity needs of individuals applying for participation in the CAP/C Waiver. Individuals meeting specific criteria shall be expedited for immediate consideration of CAP/C participation, and prioritized for immediate participation, or prioritized to the top of	The CAP 1915 (c) HCBS waiver arranges for service consideration on first-come first-serve basis due to similar acuity needs of individuals applying for participation in the CAP/C Waiver. When a statewide waitlist is implemented, individuals meeting specific criteria shall be expedited for immediate consideration of CAP/C participation, and prioritized for immediate participation, or prioritized to the top of an

	an existing waitlist. Prioritization criteria apply to individuals meeting the following: a. Individuals who were receiving personal care-type services through private health insurance plan and the policy is terminating. c. Individuals transitioning from a hospital or nursing facility stay utilizing service of community transition services.	existing waitlist. Prioritization criteria apply to individuals meeting the following: a. Individuals who were receiving personal care-type services through private health insurance plan and the policy holder has determined the need to terminate the policy. c. Individuals transitioning from a hospital with a stay of 90-days or more, or nursing facility stay utilizing service of community transition services.
Sections of the Policy that were Updated	**Previous Language in the 3K-1 Clinical Coverage Policy**	**Update Language to 3K-1 Clinical Coverage Policy**
Section 4.2.2b, g, h, l, p	b. The beneficiary does not require and use CAP/C services planned in the service plan during a 90-calendar day period despite case management coordination. g. The beneficiary's currently approved services (Medicaid and non-Medicaid) are meeting assessed care needs; h. The installation of a home or vehicle modification or assistive technology and is completed through evidence of an invoice and a prior approval claims submitted to NCTracks; l. When an employee of the agency providing CAP/C services is the legal guardian or primary caregiver of the beneficiary p. The beneficiary is not approved for disability to qualify for Medicaid in the specified categories in **Subsection 2.1.2**;	b. The beneficiary does not require and use CAP/C services planned in the service plan that are available to the beneficiary during a 90-calendar day period despite case management coordination. If services designated in the service plan are not available for more than 30 calendar days, the case manager must contact DMA and provide information related to the lack of services to avoid potential disenrollment; g. The beneficiary's currently approved services (Medicaid and non-Medicaid) are meeting assessed care needs and the beneficiary is not determined to be at-risk of institutionalization (refer to Appendix F); h. When the only assessed waiver need is a home or vehicle modification or assistive technology and evidence is provided of the installation and an invoice and prior approval claims have been submitted to NCTracks; l. When a legal guardian or primary caregiver of the beneficiary is employed to be the paid caregiver of CAP/C services;

		p. The beneficiary is not approved for Medicaid in the specified categories in **Subsection 2.1.2**;
Sections of the Policy that were Updated	**Previous Language in the 3K-1 Clinical Coverage Policy**	**Update Language to 3K-1 Clinical Coverage Policy**
Section 5.5e	e. Calculate the beneficiary cost of care for all CAP/C services and ensure the waiver services costs and limits do not exceed the plan of care limit associated with the beneficiary's acuity level determined through the most recent beneficiary assessment;	e. Summarize plan of care cost totals to ensure the Medicaid and waiver services are within the average established cost limit;
Section 5.5.1	Service plan revisions may be approved retroactively for up to 30 calendar days prior to the date the plan is revised. The beneficiary or the primary caregiver shall agree to and sign and date the service plan acknowledging changes for CAP/C provision.	Service plan revisions, excluding home and vehicle modifications and assistive technology, may be approved retroactively for up to 30 calendar days prior to the date the plan is revised. The beneficiary or the primary caregiver shall agree to and sign and date the service plan acknowledging changes for CAP/C provision. NOTE: Specified plan of care revisions may require a pen and ink change to the approval without the legal guardian or the primary caregiver's signature. The e-CAP system will provide guidance in that area.
Section 5.6.2	The effective date for CAP/C participation is the **latest** of the following: a. the date of the Medicaid application; b. the date the case was approved for an assessment and placed in assessment-assignment in e-CAP; or c. the date of deinstitutionalization;	The effective date for CAP/C participation is the **latest** of the following: a. the date of the Medicaid application; b. the date the case was approved for an assessment and placed in assessment-assignment in e-CAP; c. the date of deinstitutionalization; or d. in the event of an appeal, the date the Court issues the order, settlement decision, or other document concluding the appeal.
Section 5.7.f	f. when quotes are required for purchase, adaption or modification, DMA determines how many quotes are required	g. when quotes are required for purchase, adaption or modification, DMA determines, based on the request and the geographical region, how many quotes are

		required to yield a decision of the approved cost for the adaption or modification; and
Sections of the Policy that were Updated	**Previous Language in the 3K-1 Clinical Coverage Policy**	**Update Language to 3K-1 Clinical Coverage Policy**
Section 5.7.3 and letter b	To assure cost neutrality of the waiver, a cost analysis of the total waiver budget and each beneficiary's cost expenditure must be conducted quarterly. When the average per capita cost of waiver services is significantly over the average per capita cost of the waiver budget. DMA must do the following: b. implement a 60 calendar-day cost adjustment plan if the 90 calendar-day cost utilization plan is not able to align with the established budgetary limits; and at end of the 60 calendar days, if the cost adjustment plan fails to align the waiver budget with the established budgetary limit, individual service utilization limits must be implemented until the waiver is within the cost neutrality limits. A beneficiary impacted by utilization plan, limitation during this time is referred to other formal and informal resources.	To assure cost neutrality of the waiver, a cost analysis of the total waiver budget and each beneficiary's cost expenditure must be conducted quarterly. When the average per capita cost of waiver services are 75 percent over the average per capita cost of the institutional care, DMA must do the following: b. Implement a 60 calendar-day cost adjustment plan if the 90 calendar-day cost utilization plan is not able to align with the established budgetary limits; and at end of the 60 calendar days, if the cost adjustment plan fails to align the waiver budget with the established budgetary limit, individual service utilization limits must be implemented until the waiver is within the cost neutrality limits. A beneficiary impacted by cost adjustment plan utilization limitation during this time is carefully case managed to identify other formal and informal resources to absorb a portion of the cost of care.
Section 6.2.1	Language was added to approve agencies with less than five years of experience as apprentice-type case management agencies A note was added under the case manager or care advisor shall meet tone of the following qualifications	If a case management entity does not meet the requirement of five (5) years of experience, DMA will provide technical assistance for a period of one (1) calendar year for the agency to build competencies to become approved to provide CAP/C services. DMA will approve the case management entity once it demonstrates the ability to provide CAP/C services. **Note:** An individual with a Bachelor's degree or who holds a nursing license as described above, without the number of years of experience, may be designated as an apprentice and shall be hired to act in the role of case manager. The supervisor of the

		case management shall provide direct supervision and approve all waiver workflow documentation and tasks.
Section 7.6. b	b. a monthly or quarterly (*based on risk indicators)* multidisciplinary treatment team meeting with all providers identified in the service plan to:	b. a monthly or quarterly (*based on identified risk indicators in the completed comprehensive assessment)* multidisciplinary treatment team meeting with all providers identified in the service plan to:
Sections of the Policy that were Updated	**Previous Language in the 3K-1 Clinical Coverage Policy**	**Update Language to 3K-1 Clinical Coverage Policy**
Section 7.10.b and c	CAP/C provider or beneficiary's caregiver shall not use interventions that: c. CAP/C provider or beneficiary's caregiver shall not use the following: 1. Personal restraints; 2. Drugs used as restraints; 3. Mechanical restraints; or 4. Seclusion	CAP/C provider or beneficiary's caregiver shall not use unauthorized or unnecessary interventions that: 1. restrict CAP/C beneficiary's movement; 2. restrict CAP/C beneficiary access to other individuals, locations, or activities; 3. restrict participant rights; or 4. employ aversive methods to modify behavior, (unless provided for a CAP/C beneficiary for whom it is not used as a restraint, but for safety-such as bed rails, safety straps on wheelchairs, standers, adaptive car seats, and specialize crib beds). c. CAP/C provider or beneficiary's caregiver shall not use the following unauthorized or unnecessary restraints: 1. personal; or 2. mechanical; or d. CAP/C provider or beneficiary's caregiver shall not use the following: 1. Drugs used as restraints; or 2. Seclusion.
Section 7.12 - Temporary Out of Primary Private Residence	If a beneficiary temporarily (for 30 calendar days or less) leaves their primary private residence the case management entity shall suspend the delivery of CAP/C services by contacting the provider agencies. No CAP/C services can be provided during this	If a beneficiary temporarily (for 30 calendar days or less) leaves their primary private residence without knowledge of the case manager, the case management entity shall suspend the delivery of CAP/C services by contacting the provider agencies. No CAP/C services can be provided during this absence. The local

	absence. The local DSS Medicaid eligibility staff is notified when an extended absence occurs. The CAP/C slot remains available to the beneficiary. The case management entity shall track the absence, since an extended absence can affect Medicaid eligibility and continued CAP/C participation. Unless prior approved by the case management entity, CAP/C participation is terminated after 90 calendar days of absence from the primary private residence.	DSS Medicaid eligibility staff is notified when an extended absence occurs. The CAP/C slot remains available to the beneficiary. The case management entity shall track the absence, since an extended absence can affect Medicaid eligibility and continued CAP/C participation. Unless prior approved by the case management entity, CAP/C participation is terminated after 90 calendar days of absence from the primary private residence.
Sections of the Policy that were Updated	**Previous Language in the 3K-1 Clinical Coverage Policy**	**Update Language to 3K-1 Clinical Coverage Policy**
7.19	Case management entities shall comply with the waiver mandate of conflict-free case management.	Case management entities shall comply with the waiver mandate of conflict-free case management as found in 42 CFR Part 441 Subpart G, Home and Community-Based Services: Waiver Requirements and HCBS Final Rule.
Attachment A, H	Approved CAP/C providers shall bill for, adult day health, financial management, In-Home aide, CAP/C nursing, pediatric nurse aide, home accessibility and adaptation, assistive technology, meal preparation and delivery, personal emergency response services and medical equipment and supplies per **Subsections 6.4, 6.5, and 7.3**, their own agency policy	Approved CAP/C providers shall bill for, financial management, in-home aide, pediatric nurse aide, home accessibility and adaptation, assistive technology, and medical equipment and supplies according to **Subsections 6.4, 6.5, and 7.3**, their own agency policy and *NCTracks Provider Claims and Billing Assistance Guide*:
Appendix B-Respite	Respite, total to 720 hours/fiscal year, can be used for the following two purposes: a. CAP beneficiary or primary caregiver needs physical time away from home; or Caregiver personal time for emotional, physical or psychosocial balance (caregiver personal time for emotional balance such as sick or snow day, shopping , meeting a friend -total time per fiscal year 420 hours); or b. Primary caregiver or beneficiary needs physical time away from home (such as institutional	Respite, total to 720 hours/fiscal year, can be used for the following two purposes: a. CAP beneficiary or primary caregiver needs physical time away from home; or Caregiver personal time for emotional, physical or psychosocial balance; or b. Primary caregiver or beneficiary needs physical time away from home; The maximum allotted days or hours for respite include both institutional respite care and non-institutional respite; in situation of more than one CAP beneficiary in a household,

	placements, vacation, and business trips-total time per fiscal year 300 hours) The maximum allotted days or hours for respite include both institutional respite care and non-institutional respite; in situation of more than one CAP beneficiary in a household, respite hours are assigned per household. When acute care needs of one beneficiary in the household are identified, an assessment by the case management entity is performed to determine if additional respite hours are needed. Respite hours should not be used for situations in which short-term-intensive hours or [ ] could be approved.	respite hours are assigned per household. When acute care needs of one beneficiary in the household of two or more CAP/C beneficiaries are identified, an assessment by the case management entity is performed to determine if additional respite hours are needed to meet the needs of that individual CAP/C child. Respite hours should not be used for situations in which short-term-intensive hours or an unplanned waiver service occurrence request could be approved.
Sections of the Policy that were Updated	**Previous Language in the 3K-1 Clinical Coverage Policy**	**Update Language to 3K-1 Clinical Coverage Policy**
Appendix B- Pediatric Nurse Aide	Services must be substantial. This means that the beneficiary's needs can only be met by unlicensed personnel. Nurse Aide services could not and shall not be provided by personal care aides or home health aides not registered with DHSR. An additional paragraph was added to his area. This paragraph was deleted: Parents, step-parents, loco parentis, legal guardian, or significant others to a parent shall be hired to provide personal care services to CAP beneficiaries under the age of 18. This applies for both traditional and consumer-directed services.	Services must be substantial. This means that the beneficiary's needs can only be met by certified professional such as an NA I or II. Nurse Aide services could not and shall not be provided by personal care aides or home health aides not registered with DHSR. Paragraph added to this section: Unplanned waiver service occurrence requests are eligible to be used with this services. Unplanned waiver services occurrence requests are used to request an adjustment beyond the approved waiver service for a day(s) due to an unexpected event (for example a sick or snow day).
Appendix B- In-Home Nurse Aide	An additional paragraph was added to his area This paragraph was deleted: Parents, step-parents, loco parentis, legal guardian, or significant others to a parent shall be hired to provide personal care services to CAP	Paragraph added to this section: 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 waiver service for a day(s) due to an unexpected event (for example a sick or snow day).

	beneficiaries under the age of 18. This applies for both traditional and consumer-directed services.	
Appendix B-Assistive Technology	Assistive technology for CAP beneficiaries includes items, product systems, supplies, and equipment, acquired commercially, modified, or customized, and used for An additional statement was added to this area	Assistive technology for CAP beneficiaries includes items, product systems, supplies, and equipment, that are not covered by State Plan Home Health or Durable Medical Equipment and Supplies, acquired commercially, modified, or customized, and used for This statement was added to this area: Assistive technology for CAP beneficiaries excludes items that are covered under the Home Health Final Rule.
Sections of the Policy that were Updated	**Previous Language in the 3K-1 Clinical Coverage Policy**	**Update Language to 3K-1 Clinical Coverage Policy**
Appendix B-Home Accessibility and Adaptation	i. Floor coverings when existing floor coverings are in disrepair and pose increase risk to a beneficiary with documented falls, or when those floor coverings are contributing to asthma exacerbations, documented medical records, requiring repeated emergency room or hospital treatment; An additional statement was added to this area	i. Floor coverings when existing floor coverings contributed to documented falls resulting in injury as evidenced by hospital and emergency room visits, or when those floor coverings are contributing to asthma exacerbations, documented medical records, requiring repeated emergency room or hospital treatment; This statement was added to this area: Home Accessibility and Adaptation for CAP beneficiaries excludes items that are covered under the Home Health Final Rule.
Appendix B-Specialized Medical Equipment and Supplies	a. Incontinence Supplies: These supplies are intended to assist in avoiding institutionalization and to promote continuous community integration. A signed physician's order certifying medical necessity, quantity, type and frequency for the incontinence supply is required. b. Medication Dispensing device assists the CAP beneficiary in knowing when to take their medication	These items were deleted This statement was added to this area: Specialized Medical Equipment and Supplies for CAP beneficiaries excludes items that are covered under the Home Health Final Rule.

	An additional statement was added to this area	
Sections of the Policy that were Updated	**Previous Language in the 3K-1 Clinical Coverage Policy**	**Update Language to 3K-1 Clinical Coverage Policy**
Appendix B-Vehicle Modification	The vehicle that is adapted must belong to the individual, to a parent or the legally responsible representative, refer to **Appendix F**. The service does not cover the purchase or lease of the vehicle itself. Vehicle modification may in some cases be used to pay for a lift that is existing on a previously modified van. All the following information must be submitted to DAM when approval for an existing lift is being requested:	The vehicle that is adapted must belong to the individual parent or the legally responsible representative, refer to **Appendix F**. The service does not cover the purchase or lease of the vehicle itself. Vehicle modification may in some cases be used to pay for a lift that is on a previously modified vehicle. The lift is the only modification that will be paid for when purchasing an already modified vehicle. In this case, vehicle modification may be used to pay for the depreciated price of the lift.
Appendix C	The approval of hours is based on the CAP beneficiary's care needs, the caregiver's availability, medical necessity and other available formal and informal resources. The hours will be authorized on a weekly basis based on the care needs of the CAP beneficiary. This paragraph was deleted: The approval of hours is based on the care needs of the CAP beneficiary. All the hours authorized are contingent upon interventions being provided for the CAP beneficiary's care needs. For example, a CAP beneficiary may have interventions done during the day, but sleeps through the night with no interventions needed; night covered care would not be covered because beneficiary's care needs can be met at night primary caregiver(s). Hours are only authorized when there are medically necessary interventions taking place.	The approval of hours is person-centered and is based on the CAP beneficiary's care needs, the caregiver's availability, medical necessity and other available formal and informal resources. The hours will be authorized on a weekly basis based on the care needs of the CAP beneficiary.
Appendix F	Additional definitions added to this Appendix	This definition was added: Average waiver cost limits To maintain cost neutral service provision of that of institutional care, a mandatory requirement of a 1915 (c) HCBS waiver, the average cost limits for this waiver is $129,000 per year. This

		average cost of beneficiary's care needs may be less than, equal to or more than the specified average cost. Medical treatment Treatments that must be provided by a registered nurse or medical doctor.