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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in section 1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The state has broad discretion to design its waiver program to address the needs of the waiverï¿½s 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 a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

Changes that will be implemented during this renewal waiver cycle include:
Expansion of HCBS:
1. A higher acuity level of CAP In-Home Aide. This higher acuity level will offer CNA Level II service to individuals enrolled in the CAP/DA waiver. This service will be reimbursed at a higher rate than CAP In-Home Aide.
2. Expanding the utilization limit for equipment, modification, and technology
3. Expanding the utilization limit for Personal Emergency Response Services (PERS).
4. Remove the medication dispensing box as a standalone HCBS service and add it to the goods and services HCBS for continuous accessibility.
5. All types of falls and specifically falls requiring hospitalization or results in death from a Level I to a Level II incident under Appendix G.1.b.
6. By year two of the waiver cycle, during the annual assessment of need, the person-centered service plan will be reviewed; if the assessed needs do not warrant a change to the plan of care (POC), the waiver participant and team will agree to maintain the POC unchanged. The plan of care will remain active, and the service listed will continue to be authorized.

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 section 1915(c) of the Social Security Act (the Act).

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

Community Alternatives Program for Disabled Adults (CAP/DA)

C. Type of Request: renewal

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.0132
Waiver Number:NC.0132.R08.00

Draft ID: **NC.015.08.00**

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

Regular Waiver

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

11/01/24

Approved Effective Date: 11/01/24

PRA Disclosure Statement

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

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

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

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

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

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

☒ **Nursing Facility**

Select applicable level of care

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

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

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

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

440.150)

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

1. Request Information (3 of 3)

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

Select one:

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of section 1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under section 1915(b) of the Act.**

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

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

  - ☐ **section 1915(b)(1) (mandated enrollment to managed care)**
  - ☐ **section 1915(b)(2) (central broker)**
  - ☐ **section 1915(b)(3) (employ cost savings to furnish additional services)**
  - ☐ **section 1915(b)(4) (selective contracting/limit number of providers)**
- ☐ **A program operated under section 1932(a) of the Act.**

  Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:
- ☐ **A program authorized under section 1915(i) of the Act.**
- ☐ **A program authorized under section 1915(j) of the Act.**
- ☐ **A program authorized under section 1115 of the Act.**

  Specify the program:

H. Dual Eligiblity 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.

The HCBS waiver application is designed to establish a secure and supportive network of services. It aims to foster community integration and autonomy of choice for Medicaid beneficiaries who are 18 years and older with a physical disability or who are 65 years and older with functional deficiencies due to age. This wraparound network of services complements Medicaid State Plan services by addressing deficits in the performance of ADLs, IADLs, and gaps in the support systems. The HCBS includes a wide range of services such as adult day health, in-home aide, equipment, modification and technology, meal preparation and delivery, respite, personal emergency response services, specialized medical supplies, individual and participant goods and services, community transition and integration services, training, education, and consultative services, case management, personal assistant services, financial management, and coordinated caregiving.
Goals: 1. To provide an alternative to institutional care for individuals in the target population who meet a nursing facility level of care and choose to remain integrated in their community or indicate a desire to transition from a facility. 2. To authorize HCBS to ensure each waiver participant's health, safety, and well-being through person-centered planning while respecting their right to assume risk. 3. To provide each waiver participant access to HCBS that enables freedom of choice, participation in decisions, and activities related to service and provider selection and service delivery. 4. To manage the health care needs of this target population while ensuring average expenditures of HCBS are at a cost equal to or less than individuals in an institution.
Objectives: 1. To evaluate LOC and assess all individuals requesting initial participation in this waiver to ensure a person-centered plan is created to mitigate risk factors that may jeopardize community placement. 2. To ensure waiver participants reach their maximum potential for safety using case management services. 3. To ensure conflict of interest protections by using an independent assessor to determine initial eligibility. 4. To evaluate quarterly quality metrics to ensure compliance and continuous quality improvement. Organizational Structure: Use local entities and contracted vendors to administer and monitor services to waiver participants. 1. The State Medicaid Agency – Administrator; 2. Case management entities- local day-to-day overseers of waiver participants to ensure health, safety, and well-being; and 3. Contracted Entities: CAP IT Business system; Independent Assessment Entity- Eligibility and plan of care reviewers and MMIS. The State Medicaid Agency– provides: 1. Analysis and evaluation of six waiver assurances and associated performance measures. 2. Development of policies and guidelines for waiver participants and providers. 3. Development and management of rate methodology. 4. Management of critical incidents, complaints, and grievances. 5. Management of expenditure and utilization limits. 6. Management of prior approval of services. 7. Development of guidelines for Participant's rights and responsibilities. A Comprehensive Independent Assessment Entity (CIAE) will: 1. Conduct initial assessments. 2. Provide notice of information to waiver participants by written format. 3. Provide education and outreach to waiver participants and providers about waiver access and entry. 5. Participate in Due Process proceedings when necessary. Case management entities (CME) will: 1. Conduct the initial (when applicable), annual, and change of status assessments and develop a person-centered plan with each waiver participant. 2. Perform core case management activities of assessing, care planning, monitoring, linking, and following up. 3. Provide written notice of information to waiver participants. 4. Provide education and outreach to waiver participants and providers about waiver access and entry. 5. Participate in Due Process proceedings when necessary. 6. Manage the health, safety, and well-being of waiver participants. Contracted IT Vendor: 1. Provide an IT platform to manage the HCBS workflow in eligibility, service plan, critical incident management, and monitoring. Contracted IT Vendor- Medicaid Management Information System (MMIS): 1. Provide a process for reimbursement of claims and provider enrollment. Service Delivery Model: waiver participants must: 1. Met a level of care; 2. Be assigned an assessment slot while a comprehensive assessment is performed to identify medical, functional, and psychosocial needs; 3. Have risk indicators that place them in jeopardy of community placement (institutionalized); 4. A service plan is needed to mitigate risk factors to maintain community placement or transition from an institution; 5. Choose to participate in this HCBS waiver by accepting a slot; and 6. Identify providers to render HCBS services. Individuals and providers approved for participation: 1. Will be provided a notification letter that includes all approved services with a description in amount, frequency, and duration. The notice letter will also provide information on ANE, fair hearings, freedom of choice, and grievances. 2. A service authorization will be provided to render approved services in the amount, frequency, and duration specified in the service plan. The service authorization identifies the authorized period and the tasks associated with each approved service. 3. A prior approval segment will be provided for claim reimbursement. 4. A case manager will be assigned to ensure approved waiver services are provided within five days or sooner of authorization based on the waiver participant's needs. 5. A case manager will be assigned to monitor services monthly to ensure health, safety, and well-being.

3. Components of the Waiver Request

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

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

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

care.

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**
- ◉ **Yes**

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

- ◉ **No**
- ○ **Yes**

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

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

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver

participants. This information will be consistent with a data collection plan designed by CMS.

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients 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:

Before the posting and circulation of an announcement to notify waiver participants and the public of the expiring CAP/DA waiver and the state's efforts to engage in activities to renew the waiver application, the Eastern Band of Cherokee Indians (EBCI) and Unity Healing Center were notified through the state's official notification process to solicit their comments and feedback on the operation and administration of this waiver. They were chiefly interested in aligning the CAP/DA services to be comparable with other 1915 (c) waivers in North Carolina, expanding HCBS and addressing social determinants of health. Upon feedback from EBCI, a written public notice was electronically posted to the NC Medicaid website and the VieBridge and NCLIFTSS websites announcing the opportunities for stakeholder engagement to assist the State Medicaid Agency (SMA) in renewing the CAP/DA waiver. The stakeholder engagement started in December 2023. In addition to the public notification bulletin, the existing waiver application was posted to the CAP/DA webpage on the NC Medicaid website and to the VieBridge and NCLIFTSS websites to grant opportunities for stakeholders to review the current waiver processes. A copy of the waiver application was also provided to the local Department of Social Services (DSS) to offer the opportunity for those who wanted a hard copy of the waiver application to receive a manual copy. An email address and a telephone number were provided as contact to permit commenters to offer their recommendations and feedback. During the public comment period, suggestions and feedback were received from EBCI, as well as waiver participants and providers. Before drafting the renewal waiver application to incorporate proposed changes, another engagement was held with EBCI to discuss the recommendations and feedback from the comment period to seek their feedback in incorporating changes that included expanding service limits on specific HCBS, expanding the categories of critical incidents, and reducing administrative tasks. EBCI was in complete agreement with these proposed changes and commended the state for updating the waiver to align with other HCBS. The dates of engagements are listed below.
Jan 23, 2024
Feb 20, 2024
Mar 19, 2024
July 18, 2024
September 17, 2024
October 17, 2024
After the comments and feedback were reviewed with EBCI, the waiver application was drafted and posted for public comments on August 27 through September 27, 2024. The CAP/DA waiver participants were notified by mail of the proposed changes of the CAP/DA waiver application. Providers were notified through a posted Medicaid Bulletin. During this comment period, comments were accepted via email and voice messages. An address was provided to mail in comments. A webinar was held to hear comments from stakeholders. During the webinar, more than 500 people attended. The audience consisted of CAP/DA beneficiaries, case managers, families and service providers. The comments received from all engagement platforms are listed below.

The Medicaid agency also solicits comments on rate determination through a published Medicaid Bulletins informing of changing rates. The Bulletin is posted 45 days in advance of a rate change. The waiver application was posted that included Appendix J that showed the rates for each service included in the waiver. Public comments were received regarding the rates.

A summary of the comments received during these engagements are listed below and more detail in additional needed information.
Comments were received on coordinated caregiving to reconsider limitations on utilization of this service.
State action: Updates were made on how this service can be used and its limitations.
caregiver.
Comments were made on the ability of a legal guardian to be hired as an employee.
State's action: Updates were made to allow a legal guardian to be hired as a worker or live-in caregiver when qualifying conditions are met.

J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a

Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

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

7. Contact Person(s)

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

Last Name: Staton

First Name: Betty

Title: State Plan Administrator

Agency: DHHS- North Carolina Medicaid, Division of Health Benefits

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 Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Ashley Blango

State Medicaid Director or Designee

Submission Date: Dec 6, 2024

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

Last Name: Ludlam

First Name: Jay

Title: Deputy Secretary, NC Medicaid

Agency: Division of Health Benefits, North Carolina Department of Health and Human Services (NCDHHS)

Address:
2501 Mail Service Center

Address 2:

City:
Raleigh

State: **North Carolina**

Zip:
27699-2501

Phone:
(919) 855-4105 **Ext:** ☐ **TTY**

Fax:
(919) 733-6608

E-mail:
Jay.Ludlam@dhhs.nc.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Continuation of comments during public comment period from Dec. 2023-September 2024:
Comment: 3.4.6 states In-Home Respite Services- Medicaid shall cover a service that provides temporary relief to a caregiver in an in-home setting. These services are provided through direct-led, consumer-led or coordinated caregiving providers and authorized by the case manager to provide temporary care. This service may be used to meet a wide range of needs, such as family emergencies; planned special circumstances (i.e., vacations, hospitalizations, or business trips, etc.,); relief from the daily responsibility and stress of caring for a beneficiary with a disability; or the provision of time for the caregiver(s) to complete essential personal tasks while section 5.8.12 states: A CAP/DA beneficiary receiving coordinated caregiving services shall be restricted to specific HCBS services as personal care services, Personal Emergency Response System, respite and home delivered meals when indicated by the assessment and service plan. Room and board payment is excluded.
Response: This comment is in reference to the governing clinical coverage policy and not the waiver application.
Comment: Respite-Beneficiary's that participate under this service option should not be excluded/discriminated against certain services. Respite should be allowed under this service option. If this same paid caregiver under Coordinated Caregiving was the paid PAS under CAP Choice, beneficiary would have access to respite. Respite is needed for all caregivers. The goal of CAP/DA is to allow beneficiaries to remain in their home as opposed to going to an institution. Caregivers need relief in order to maintain their own health, safety and well-being. If you do not have a "healthy focused caregiver" beneficiary's care is compromised.
Response: Respite service is available when using coordinated caregiving services.
Comment: Add CNA II level of care to renewed CAP/DA waiver as CAP/C beneficiaries aging out and transitioning to CAP/DA services do not have a code (T1019) for level II CNA or respite and therefore must decrease LOC to IHA. Employees transitioning with beneficiary are forced to take a decreased pay rate in order to continue providing the same care for the beneficiary.
Response: This comment is in reference to the IT system functionality to manage changing needs of the waiver participant
Comment: The annual service plan must be approved by the first day of the month following the CNR assessment. The annual service plan must have an effective date for the first day of the month following the initial CAP/DA effective month. The service plan expires 13 calendar months after the service plan effective date, if the beneficiary is not determined to meet the eligibility requirements of program participation.
Response: This comment is in reference to the IT system in the management of service plans. The CAP effective date and the service plan date are two distinct dates. The CAP effective date is the initial date the person was approved for waiver services. This date is a legacy date and is used to trigger the annual level of care re-evaluation
Comment: Acuity levels should be included in the Policies; these levels are currently missing in the CAP/C Policy.
• CAP/DA - High and Moderate/Low
• CAP/C – Skilled, High and Low
Response: This comment is in reference to the governing clinical coverage policy and not the waiver application.
Comment: Update to current policy for both DA option and CD option on vacations when paid employee goes with beneficiary to provide services that help meet their goals in POC, for trips within NC, out of state and out of country.
Response: Appendix C: In-home aid, personal care assistant services and coordinated caregiving will be updated to include guidance on vacation.
Comment: Allow Home Care Agency RN to do monthly skilled visit and be able to bill for it. Home Health agencies are not able to fulfill this need any more in several counties.
Response: This comment is in reference to the governing Medicaid rules for medically necessary services. Waiver participants are assigned a Home Health visit when medically necessary.
Comment: The deductible status is a challenge when you put someone on CAP, their income changes and they lose services. Can the rates be adjusted?
Response: Medicaid eligibility in North Carolina assesses an individual enrolled in at 1915(c) HCBS waiver using community living assets and resources versus institutional budget planning. A selection of Special Population Group 217 needs to be included in North Carolina’s State Plan Amendment to make changes on how assets and resources are calculated for this waiver
Comment: Please have the CAP deductible match Pace deductible. No one can live off 262 a month. Medicaid doesn’t allow choice of programs for people over age of 62. People under 62 can’t use PACE and can’t afford the deductible.
Response: Medicaid eligibility in North Carolina assesses an individual enrolled in at 1915(c) HCBS waiver using community living assets and resources versus institutional budget planning. A selection of Special Population Group 217 needs to be included in North Carolina’s State Plan Amendment to make changes on how assets and resources are calculated for this waiver.
Comment: Please simplify the Incident Report and the Risk Agreement, the Risk Agreement needs to be read at the beneficiary's level.
Response: The comment is related to the incident report and is referencing the IT system each incident is entered into. Categories of incidents and definition of types of incidents will be updated in the IT system to align with updates made in the renewal waiver application.
Although the waiver application only describes the purpose of the risk agreement, the tool used by case managers will be updated to align with the reading/comprehensive level of some waiver participants
Comment: PERS- This service should be an option under Coordinated Caregiving. The lack of this service increases the safety risk. Under Coordinated Caregiving, the paid person can also work outside the home, thus leaving the participant (that does not

require 24-hour supervision) at home alone. In the event of an emergency, PERS could be utilized. Also, PERS can be utilized if the paid person is at home. An emergent situation could arise with the paid caregiver and the beneficiary could use PERS services. Lack of this service increases the risk of safety issues.
Response: PERS will be added as a service that can be used with coordinated caregiving when the care plan developed by the coordinated caregiver provides the PERS to assist with managing HSW due to fall documented falls, wandering, and left at home unattended for four or more hours during the day
Comment: Home delivered meals-This service needs to be an option for Coordinated Caregiving. There may be a financial issue in the home that causes barriers with obtaining food. Social determinants prevail no matter what service option someone chooses. A proper well-balanced meal should be available to all beneficiaries. An example would be the need for a pureed diet. If caregivers do not have access to ways to puree food, this option could serve this purpose.
Response: Coordinated caregiving service is intended to provide supportive services to the waiver participant. These supportive services include assistance with ADLs and IADLs. Meals Preparation and delivery is a service intended to provide a meal to an aged individual who does not have support or assistance to prepare and provide a meal daily.
Comment: Could you clarify the policy in Appendix B under Equipment Modification, what equipment needs a PT eval. We have been told that a handheld shower, non-skid mat, and grab bar do NOT have to have a PT eval. PT evaluations should be for bathroom modifications, etc.
Response: This comment is in reference to the governing clinical coverage policy and not the waiver application.
Comment: Increase home modification budget and quick turnaround in making these modifications
Response: A fiscal impact will be conducted to determine funds needed to expand the service limit for equipment, modification, and technology to the CAP/DA renewal waiver and if by expanding the utilization limit, cost neutrality can be met
Comment: Increase limits on equipment and Goods and services.
Response: Past utilization expenditures of Goods and services do not identify a fiscal need for an increase in the budget limit

Comment: I am a case manager in Guilford County and one barrier my clients have experienced is the recent cancellation of free or discounted internet services. I believe this is a health equity issue as the clients who had to let services lapse have lost a common line of communication with their medical providers. $80-100/month for internet is exorbitant. Can internet services be added to the waiver?
Action taken by SMA: Smart devices are available through the home and community-based services in the waiver; however, coverage on monthly recurring costs for internet service is not a coverage service. This recommendation will not be incorporated in the renewed waiver application.
Comment:
1. The amount for Participant Goods and Services needs to be increased from $ 800.00 per year.
2. The amount for Pest Eradication needs to be increased from $ 800.00 per year. In homes that have bedbugs, it can cost over $1200.00 to treat a one-bedroom apartment. It would benefit more of our beneficiaries if the amount was increased.
3. Case Management reimbursement should be increased

The requirements or process for the CIAE should be updated. We have received over initial assessments that have been completed telephonically resulting in beneficiaries being approved who have no identified support system as outlined in the clinical policy, no Medicaid benefits, do not meet the requirements for CAP services, and/or do not want CAP services but they are still approved to move forward to the plan of care process. Then the Case Management Entity spends time (they are unable to bill for and will not be reimbursed) reach out to the client only to find they are unable to receive CAP services to due being ineligible for Medicaid or do not meet the requirements for CAP as outlined in the Clinical Policy. They do not refer to the people they assess to other community resources that may benefit the person better than CAP.
Action taken by SMA: An evaluation was conducted on utilizing participant goods and services over five years. The findings indicated that participant goods and services were not used in the amount and frequency as projected. This service limit will not increase.
Support and training will be provided to the case manager and CIAE vendor on collaboration of assessment and service planning.

Comment: What do we have to do on our end to get ready for the renewal process?
Action taken by SMA: No update will be made to the waiver application. Training and support will be provided to the waiver participants on transitioning to the new waiver application.
Comment: The CAP program has been a blessing for me and my wife. She was approved for Medicaid in 2022. Later that year she was granted entry into the program. I began taking care of her in January 2023. The CAP program has allowed us to stay in Surry County where my family lives. Her family lives in Transylvania County. My family cannot offer assistance as my mother is suffering from dementia and my father is her full time caregiver. The program has allowed me to focus on caring for my wife rather than worry about money and time to do so. If the CAP program is not renewed, I will be forced to work outside the home and my wife will not get the care she needs. We do not want to place her anywhere else. She refuses to go and if forced to go the change would most likely kill her .If the program doesn't get renewed then our lives will change drastically again for the third

time in three years.
Action taken by SMA: The SMA will work closely with CMS to renew the CAP/DA waiver.
Comment: I would like to add a suggestion for the CAP DA Consumer Direction participant guidelines. The addition of the mandatory Consumer Direction Training Webinar has caused further delays in the provision of CAP DA services. I would like to propose that this mandatory training be offered every week, each month, for the CAP CD participants.
I would additionally like to propose that an alternate training method be made available for those CAP participants who do not have internet access in their homes. To accommodate for this reasonable need, I think a paper version of the webinar should be made available to participants. Another suggestion would be to add an audio version of the webinar in CD format.
The CAP DA population is a vulnerable population, who often don't have the necessary financial means to have internet in their homes. Many of the clients do not have working smart phones or computers. Many of the clients live in remote areas where it isn't possible to have internet access. It is unethical to withhold needed CAP services in this discriminatory manner. Alternate methods of this required training are absolutely needed.
Action taken by SMA: No changes will be made to the renewed waiver application. Alternative training opportunities will be made available to waiver participants to complete the required training.
Comment: When we complete a client CNR, we are required to upload the signed POC and Letter of Understanding. Are we supposed to do 2 visits to a client's home just to do that? One for seeing if changes need to be made to their services. And the second one just to have them sign the new POC? The reason I ask is because that is what we have been doing and I feel like there should be an easier way to go about doing this without doing the extra work. Before I took out a copy of the current POC and had them sign it if no changes were made to their services. Which I thought was probably wrong, so I quit doing it. Now I have started mailing them out, so I do not have to go out twice just to have paperwork signed. I was wondering if that was something that could be taken off since we have them sign the Beneficiary Rights and Agreement, Conflict of Interest, Emergency Backup, Waiver Letter, and Freedom of Choice and upload those documents. We take that paperwork out with us when we go for the CNR visit.
Action taken by SMA: No change will be made to the renewed waiver application. Annual reevaluation planning consists of a face-to-face visit for an assessment and a face-to-face visit to complete the service plan.
Comment: I have to disagree with Medicaid regarding generators that only beneficiaries using ventilators will receive assistance. There are many other diagnoses that require power for medical equipment.
My son needs his breathing treatments with his Respironics machine for his asthma. My son is a quadriplegic who needs assistance with transfers which a patient lift is used. He's not able to be lifted manually due to his rods in his back from the sacrum to cranial & plates on both hips.
For him to have bowel movements, he needs to use his ceiling patient lift onto an open seat. When changing his foley, he needs to be in a reclining position which is another transfer from chair to power bed. A patient lift is needed 100% of the time.
Another concern is Medicaid provides gasoline generators which are very UNSAFE. This type of generators could cause death due to fires, suffocation, lack of fuel, beneficiaries not able to afford fuel or lack of transportation to purchase.
Action taken by SMA: No changes will be made to the renewed waiver application. NC Medicaid agreed that a future study will be conducted on adding whole home generators as an option within the home and community-based services.
Comment: I've received CAP/DA services for several years now and it's really a godsend for disabled persons like me. I'm a paraplegic since November of 2014 and learned of CAP services through vocational rehab. She's helped me make quite a few modifications to my house so it can be way more wheelchair accessible. These services have greatly improved my quality of life. I would like to graciously thank any and all who is responsible. Knowing how much it improved my life, after the webinar I understand how it has helped thousands just in this state alone. If there's anything I can do to help, please let me know.
Action taken by SMA: No changes will be made to renewed waiver application.
Comment: This is such a blessing as I had no idea of what all is provided. My question is, do you have access to a facility for a disabled member to stay while family members go on vacation? I was told that you do not. However, if not, could this be something that you can propose?
Action taken by SMA: This waiver offers respite in institutional settings. No changes will be made to the renewed waiver application.
Comment: More clarification on Respite: define the eligibility, define limits on how many hours at a time/day (not the vague 30 days a month), separate definition of in home respite and institutional respite (families reading interpret it as 24 hour care in the home for beneficiary). Clarification on IHA hours: families are reading it like they can have 24 hour care or as many hours as they want. Better definition of limitations and uses. Is CAP/DA able to provide services to PDN recipients?
Action taken by SMA: No changes will be made to the renewed waiver application. Training and education will be provided to participants and providers on utilization of respite.
Comment: Do I need to apply for this CAPDA Wavier Renewal?
Action taken by SMA: No changes will be made to the renewed waiver application.
Comment: While reading through the renewal application I noticed an area of concern. In several places, one example is when addressing participant goods and services page 108 and 109, it states under "Other Standard" that "The case management entity does not provide or render the items listed in the service definition." However, on page 154 it states some CMEs are allowed to act as a dual agency. I assume this dual agency status would apply to participant goods and services as well as Equipment

Modifications and Tech as our clients would otherwise be without a provider for these services. Does this dual status apply to these items as well as written in the current application or does this need to be further defined in it?
Action taken by SMA: No changes will be made to the renewed waiver application. Case management entities cannot furnish goods and services but can submit claims on behalf of an approved provider.
Comment: For new Consumer Direction clients, the timeline between the home assessment and initiation and completion of the plan of care is often missed because of the delay with the client completing the consumer direction training. For instance, if we get a new client who expresses interest in consumer direction at the beginning of one month but cannot complete this training that month we must wait until the next available training the following month before we can move to the POC completion. Can the time frames be adjusted for this, or can these training courses be recorded so that there is more flexibility for completing them?
Action taken by SMA: No changes will be made to the renewed application. Consumer direction training is required before the waiver participant can use that service option. Training sessions will be offered or made available to the application upon a new referral. Annual refresher training will be made available on-demand.
Comment: Had I known it was to help with input to secure our funding with advanced questions. The time period allowed would have been more productive in what we would be losing without the renewal and how it would affect us and how we felt about it. I am truly grateful to everyone and their time, the power point presentation was informative. It didn't express the purpose and needs we require to further the renewal process. Our supplier loss, equipment loss and upgrades needed. The loss of having a caregiver, assistance for many other valuable assists that we all require throughout our daily lives. I don't know what I would do with my assistance. As many who attend would agree.
Action taken by SMA: No changes to the renewed waiver application will be made.
Comment: I'm a live-in aide for my family member who is currently on the program, and this is not only convenient for me and her but absolutely a blessing! We get the best of both worlds because she wants to remain at home, and I can be confident she is getting the quality care she needs so yes, I'm grateful for the opportunity to be of service though CAPDA.
Action taken by SMA: No change will be made to the renewed waiver application.
Comment: I think a raise in pay for the caregivers is critical to retaining the workers. Turnover is high.
Action taken by SMA: No change will be made to the renewed waiver application.
Comment: CAP Is being a blessing for me and for my mom , also a huge helping to assist my mom’s needs. understand her health issues and take care of what she is needing.
Action taken by SMA: No change will be made to the renewed waiver application.
Comment: I have to disagree with Medicaid regarding generators that only beneficiaries using ventilators will receive assistance. There are many other diagnoses that require power for medical equipment. My son needs his breathing treatments with his Respironics machine for his asthma. My son is a quadriplegic who needs assistance with transfers which a patient lift is used. He's not able to be lifted manually due to his rods in his back from the sacrum to cranial & plates on both hips. In order for him to have bowel movements, he needs to use his ceiling patient lift onto an open seat. When changing his foley, he needs to be in a reclining position which is another transfer from chair to power bed. A patient lift is needed 100% of the time. In the last 11 months his ceiling lift has transferred to him 1,000 times. How I know this the lift has a counter.
Action taken by SMA: No change will be made to the renewed waiver application.
Comment: Recommend that CAP-DA providers be required to use the NC Incident Reporting System (IRIS) for all incident reporting.
Action taken by SMA: No change will be made to the renewed waiver application. The state will identify a process to transition to the new requirements of critical incident management.
Comment: On behalf of AARP, our members and their families, we appreciate the opportunity to provide comments on the proposed amendments to North Carolina’s 1915 (c) Community Alternatives Program for Disabled Adults (CAP/DA) waiver. AARP is the nation’s largest nonprofit, nonpartisan organization dedicated to empowering people to choose how they live as they age. With nearly 38 million members nationwide and more than 1.1 million members in North Carolina, AARP works to strengthen communities and advocate what matters most to families—with a focus on health security, financial resilience, and social connection.
AARP North Carolina (AARP NC) is grateful for the state’s many improvements to the CAP/DA waiver over the years, including its strong focus on participant-directed services. We applaud your current efforts to enhance the CAP/DA waiver for the North Carolinians it serves. We strongly support your proposed additions, including the higher level of certified nursing assistant services (Level II) and increased equipment, home modification, and technology budget allowances (i.e., utilization limits). Each of these enhancements will further support participants’ ability to remain in their homes and community as their care needs increase.
In addition to the proposed enhancements, AARP NC recommends that NC Medicaid consider adding the following three items to the current CAP/DA waiver renewal application in order to further facilitate North Carolinians’ ability to age at home:
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HCBS Presumptive Eligibility: Presumptive eligibility for home and community-based services (HCBS) allows individuals likely to be Medicaid eligible to receive HCBS immediately when a need develops, avoiding application and eligibility determination delays that can lead to unnecessary nursing home admissions that are hard to reverse. Several states have

presumptive eligibility for HCBS, supporting participants' preference to remain in the community and providing Medicaid saving through avoided institutional placements.

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Increased Financial Eligibility for HCBS: HCBS are unaffordable to a majority of Americans (a 2023 Harvard Joint Center for Housing Studies analysis found that only 14% of Americans can afford to pay privately for daily home care assistance). Expanding financial eligibility for Medicaid funded HCBS from North Carolina's current limit of 100% of the Federal Poverty Level (FLP) to the allowable 300% of Supplemental Security Income (SSI) standard will allow more people requiring long-term supports and services (LTSS) to obtain HCBS and remain at home, reducing Medicaid LTSS expenditures from unnecessary nursing home placements (a 2023 Journal of the American Geriatrics Society paper documents overall state Medicaid LTSS budget

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savings resulting from expanded access to Medicaid HCBS , see: https://pubmed.ncbi.nlm.nih.gov/37326313/).

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Increased Waiver Enrollment Obtaining the maximum participant benefits from the CAP/DA waiver requires eliminating current and future program waiting lists (currently 1,816 individuals). As noted in the Journal of the American Geriatrics Society study cited in the previous bullet, expanding access to HCBS also benefits the state's overall Medicaid LTSS budget. AARP NC recommends raising the unduplicated and point-in-time CAP/DA participant limits (14,078 and 11,648 respectively) to eliminate existing and anticipated CAP/DA waiting lists.

Action taken by SMA: No changes will be made to the renewed waiver application. The state has a new vendor and enrollment in the CAP/DA waiver is achieved within 30 days of the referral. The SMA is also evaluating applying institutional assessment of income and asset for this home and community-based program to reduce out of pocket costs due to payment liabilities.

Comment: I am writing to submit brief comments from Disability Rights North Carolina (DRNC) on the Proposed Waiver Renewal for the Community Alternatives Program for Disabled Adults (CAP/DA) waiver. First, we would like to express our support for the rate increases included for several of CAP/DA's services. Particularly, we are supportive of changes to the in-home aide service specifically recognizing Nurse Aide IIs as providers and including NA Level II tasks in the scope of the service, as well as providing a higher reimbursement rate for this expertise. We also respectfully submit the following A. Deductibles- North Carolina has failed to address an ongoing issue posed by the imposition of a high deductible for certain categories of Medicaid beneficiaries seeking enrollment into CAP/DA. Despite having incomes low enough to qualify for Medicaid, beneficiaries facing high deductibles often forgo enrollment into CAP/DA because paying it is financially unsustainable. For individuals with physical disabilities seeking integration into their communities, the high deductible can halt a successful transition. CAP/DA is the most robust option available to meet medical needs in the least restrictive setting, but a high deductible can constitute the sole barrier to enrollment and successful deinstitutionalization. The failure to have meaningful opportunities for otherwise qualifying beneficiaries to receive home and community-based services not only defeats the purpose of offering the waiver, but also violates the Supreme Court's mandate in the Olmstead decision. CMS has recently described reforming financial eligibility as a means of removing institutional bias and promoting community integration in the delivery of long-term services and supports.1 For example, unlike 43 other states, North Carolina has not opted to offer eligibility to The State must address this issue through the CAP/DA waiver or other Medicaid reform to ensure individuals otherwise qualifying for CAP/DA receive services in the most integrated setting of their choice.

B. Addition of "Missed Schedules" as Level I Critical Incident (Appendix G-1).

In Appendix G-1, the State has added "missed schedules for CAP in-home aide and personal assistant services" as a Level I critical incident. The definition and parameters of including "missed schedules" as a Level I critical incident is unclear. For example, this section does not specify specific circumstances where this applies, such as whether a "missed schedule" outside of the control of the beneficiary is still reported. The section requires more clarification prior to including "missed schedules" as a critical incident.

Action taken by SMA: No changes will be made to the renewed waiver application. The SMA is also evaluating applying institutional assessment of income and asset for this home and community-based program to reduce out of pocket costs due to payment liabilities. Training and education will be provided on critical incident reporting on all level incidents. A new SOP has been created for the management of incidents.

Comment: Will there be any policy listing that there are no limitations to the number of IHA hrs worked within a week and that IHA hrs are determined based on care needs discussed in the assessment? Also, will it apply to live-in and out-of-the-home aides?

Action taken by SMA: cri.

Comment: Many home care agencies providing CAP/DA In home aide services may not also be licensed for nursing services like they most likely would be for agencies providing CAP/C services who provide NAII PNA level of care. My understanding is that for agencies with the scope of NAII level care, the agencies need to be licensed for nursing by DHSR in order to provide the nursing oversight of a medical task, rather than just providing nursing for supervision. I would ask that you have a caveat written in the policy regarding NAII level of care that states agencies follow their DHSR home care licensure rule requirements for scope of service allowed for their agency

Action taken by SMA: No changes will be made to the renewed waiver application. The CAP/DA waiver does not offer nursing

services as one of its home and community-based services.
Comment: A new service will be included in the CAP/DA Waiver starting in Waiver Year 1 to reimburse direct care workers for providing CNA II-level care to qualifying beneficiaries. The estimated utilization and unit cost for this service was based on SFY 2023 claims data and trended forward at the same 3% annual utilization trend and 1% annual unit cost trend listed above for Waiver Years 2-5. The users accessing CNA II-level care will no longer be accessing CAP In-Home Aide or Personal Assistant Services. The user estimates for these services have decreased accordingly. Many home care agencies providing CAP/DA In home aide services may not also be licensed for nursing services like they most likely would be for agencies providing CAP/C services who provide NAII PNA level of care. My understanding is that for agencies with the scope of NAII level care, the agencies need to be licensed for nursing by DHSR in order to provide the nursing oversight of a medical task, rather than just providing nursing for supervision. I would ask that you have a caveat written in the policy regarding NAII level of care that states for agencies to follow their DHSR home care licensure rule requirements for scope of service allowed for their agency.

Comment: The North Carolina Coalition on Aging (NC COA) is a 501(c)(3) organization that works to improve the quality of life for older adults in North Carolina through collective advocacy education, and public policy work. We have a broad-based membership of advocacy organizations, service providers, trade associations, people who rely on services and family caregivers.
We fully support NC Medicaid's efforts to effectively meet the higher acuity needs of older adults and individuals with disabilities on the CAP DA waiver. Doing so builds our state's capacity to support individuals to remain in and return to their own homes and communities.
We also applaud NC Medicaid for developing a fee structure that supports the CNA Level II service. This is both responsive to the acuity trends in our LTSS population and reflects a policy commitment to support them effectively.
We also recognize that a CAP DA recipient's acuity level may increase over time, creating potential care disruption as the individual requires support from aides with additional clinical skillsets. We strongly encourage NC Medicaid's continued work with the NC Division of Health Services Regulation (DHSR) and the NC Board of Nursing to create training pathways that enable a direct care worker to remain with a person as the person's needs increase while also building the competencies necessary to support the person appropriately. Such Continuity is essential to person-centered care.
We also encourage efforts to build and expand the capacity of the existing CAP DA provider network to better meet this current and growing need.

Action taken by SMA: No changes will be made to the renewed waiver application. Emphases will Be placed on person-centered training to achieve some of the suggestions in this comment.

Comment: On behalf of Careforth, we appreciate the opportunity to provide feedback as the Division finalizes the stakeholder process for North Carolina's proposed renewal of the Community Alternatives Program for Disabled Adults (CAP/DA) 1915(c) Waiver. Careforth1 was the first approved provider of Coordinated Caregiving which enables individuals with disabilities and older adults to receive care at home from qualified live-in family caregivers of their choosing, and for caregivers to receive education, oversight, and financial support from provider organizations like ours. Providing live-in family caregivers consistent and ongoing support to relieve the stress and strain associated with their caregiving role is a primary goal of Coordinated Caregiving. We applaud the Division's continued commitment to exploring opportunities to expand the utilization of Coordinated Caregiving. We have reviewed the recently proposed Waiver application and compared it to the previous version released at the beginning of the stakeholder process. We extend our thanks for the changes made as a result of the recommendations made earlier in the process. Specifically, we support:
1. Replacing "supportive worker" with "live-in caregiver"; we note, however, that the updated terminology is not yet used consistently throughout the Waiver application, including within the service definition in C-1. We respectfully request that these updates occur before the application is submitted to CMS.
2. The allowance of the use of respite when receiving Coordinated Caregiving at both service levels.
3. The addition of the requirement that provider applicants demonstrate prior LTSS experience; we appreciate the Division's efforts to move progressively to a high-quality HCBS provider network.
4. The extension of payments to caregivers who are Legally Responsible Individuals when they otherwise meet applicable requirements.
5. The remaining technical issues we would like to bring to your attention for review prior to the submission of the application are:
Appendix C - Participant Services - Coordinated Caregiving

a. Revise the check box to indicate that the service is included in the current Waiver, currently the “not included” box is checked (see page 80).

b. As indicated on pages 81-82 of the application, legally responsible individuals, relatives, and guardians can/will be paid caregivers in Coordinated Caregiving. Accordingly, we question whether the following sentence found on page 81 needs revision?
An individual serving as the waiver participant’s power of attorney, guardian, or representative may not be a provider of coordinated caregiving.
Should the “not” be removed and the sentence modified because this is intended to be a statement about the live-in caregiver rather than the Coordinated Caregiving provider?

c. In C-2 e. (page 125), we believe that coordinated caregiving should be addressed in the narrative here (for relatives/guardians) as it is in the section immediately above for legally responsible individuals.

Appendix E-1 (page 178) – after reviewing the HCBS Waiver Application Technical Guide, it is not clear to us what the box at the bottom of the page (re: information and assistance in support of participant direction) is intended to convey so we question but cannot comment on the inclusion of all services, including Coordinated Caregiving, in this section.
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Appendix J – Coordinated Caregiving levels are identified as Skilled and Low. The levels are currently known as “High” and “Low/Moderate”, and we recommend that the “Skilled” label be returned to “High” as that is the more appropriate term in this context, and there are no provisions within the Waiver to indicate skilled needs or corresponding rates as are seen in the CAP/C Waiver.
Finally, we continue to assert that Coordinated Caregiving utilization could be improved if the Division were to review and revise the rate methodology for the service to ensure rates are fair and adequate to ensure sufficient support for Waiver participants and their informal family caregivers.
Action taken by SMA: Changes will be made as identified.

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:

   Long-Term Services and Supports

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

   In accordance with 42 CFR § 431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available

through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency. When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the state Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the state. Thus, this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

The CAP Business system will function 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 function as the quality assurance system to provide real time reports and data for:
• Waiver participant enrollment.
• Waiver enrollment against approved limits.
• Waiver expenditures managed against approved limits.
• Level of care evaluation and determination.
• Waiver participant service plans.
Critical incident and grievance management
The contracted entity will also be responsible for the following:
•Real-time Dashboards: These dashboards provide real-time data concerning the waiver population, allowing the state to monitor performance measures.
• Service Request Form: An electronic form that captures the necessary information required to properly evaluate an applicant's initial consideration for enrollment in the waiver. This includes a signed consent form from the applicant or waiver participant indicating their desire to be considered for waiver enrollment and a worksheet from their primary physician that identifies a functioning level that is consistent with an individual in an institutional placement.
• Level of Care Assessment (LOC): This electronic assessment takes the information provided in the Service Request Form (SRF) to help the SMA to assess the applicant's ability to meet the level of care required for the CAP Waiver. Initial and annual assessments where the applicant does not meet the required level of care, are reviewed by Registered Nurses (RN) at the SMA to mitigate potential errors in the information entered in the SRF.
Assessment of Service Needs: This electronic assessment tool provides a platform for a comprehensive, person-centered assessment of the needs of each waiver participant. Additionally, as this assessment tool is hosted electronically, the state retains full access to both the assessment results and the information entered in the assessment tool.
•Electronic Service Plan: The results of the assessment provide direct input into the waiver participant's service plan, assuring that the waiver participant's service plan addresses the assessed needs.
•Automated Tracking of Assessment Dates: The CAP Business system automatically triggers a notice when each waiver participant approaches the anniversary of their previous assessment, assuring that each waiver participant is reassessed both for service needs and for LOC on an annual basis.
•Monthly and Quarterly Reporting: The CAP Business system vendor provides both monthly and quarterly reports in addition to the reports provided via the system dashboards. These reports provide the state with additional information to track program participation and identify issues, quickly.
•Critical Incident Report System and Complaint and Grievance Management: The CAP Business system provides access to the critical incident forms and workflow management to process the investigative steps.
The SMA is solely responsible for determining eligibility for all waiver participants; however, a contracted entity and local agencies assist the SMA with these administrative tasks. The contracted entity is a Comprehensive Independent Assessment Entity (CIAE). The CIAE will be responsible for gathering the health care information and coordinating with other health care professionals to assist the SMA to process and evaluate a decision for LOC with the sole decision of LOC being made by the SMA. Additional administrative tasks the CIAE will assist the SMA include:
- Validation of participant service plans completed by case management entity.
- Slot utilization management.
- Participant waiver enrollment.
- Waiver expenditures managed against approved limits.

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

The appointed CIAE's primary responsibilities are to perform initial assessments of the need for waiver participation and annual quality assurances of the service plan.
The CIAE will be required to:
1. Process a service request to assist the SMA in processing and evaluating a level of care.
2. Complete comprehensive assessments to ascertain medical, psychosocial, and functional needs to identify a reasonable indication of need for waiver participation.
3. Coordinate and collaborate in a multidisciplinary team approach to decide on a reasonable indication for at least one waiver service that may prevent an institutional placement, maintain community placement or community integration.
4. Provide quality overview of the completed person-centered service plan to validate the service are authorized and being provided in the amount, duration, and frequency of the approved service plan.

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

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

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

A qualified provider guideline is posted on the NC Medicaid website to ensure a provider network to perform case management for waiver participants. At any time, an agency can submit a proposal to become a CME. Each CME must meet a provider qualification threshold that demonstrates experience in HCBS. The provider must be enrolled as a Medicaid provider and approved to provide services under HCBS taxonomies. The agency must provide case management services by a nurse and social worker/human service professional. The CME must demonstrate through evidence of past experiences, policy implementation and financial solvency working with aged and disabled adult or medically fragile, complex individuals. The interested CME must have at least two consecutive years of providing services to aged or disabled adults or medically fragile-complex individuals; extensive knowledge of community resources to conduct case management activities; care coordination and qualified staff to ensure an appropriate case mix and caseload management. The CME must have access to web-based automation. The CME must show fiscal soundness of Medicaid funds and have financial reserves up to $60,000 per waiver year.

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

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

• Providing written authorization to the local Department of Social Services/equivalent programs operated by Federally Recognized Tribes and service providers for approval/participation in the waiver.

•Ensuring each waiver participant/primary caregiver has exercised their freedom of choice among waiver services/providers.

•Conducting monthly monitoring of the service plan with waiver participant to ensure safe community living.

•Initiating Due Process tasks, specific to the CME’s role, when an adverse decision is made and coordinate with waiver participant, providers, and due process vendor.

•Providing feedback, when requested, in verifying whether medical documentation supports nursing facility level of care.

•Mitigating risk when a referral is made to Adult Protective Services.

•Providing monthly and quarterly case management/care advisement to the waiver participant.

•Assessing the effectiveness of hands-on personal care provided to the waiver participant.

•Holding a quarterly multidisciplinary treatment team (MDT) meeting with providers listed in the POC to also include primary care treating physicians or their representatives to review the provision of and continued appropriateness of the service plan.

•Documenting, monthly, the status of medical, functional, and psychosocial changes in the e-CAP system to be eligible to receive reimbursement for case management services.

•Reviewing quality assurance reports monthly to remedy any identified issues.

•Contacting the waiver participant/responsible party following the construction/installation of home modifications to confirm the modifications safely meet the waiver participant’s needs.

•Contacting the waiver participant/responsible party within 48 hours of learned discharge from a hospital/rehabilitation/nursing facility to assess health status and changes in needs.

•Ensuring that services offered to a waiver participant do not duplicate other services.

•Assisting with coordinating informal resources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal supports.

•Ensuring that the policies/procedures of the waiver are upheld and executed to maintain the health/well-being

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

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 entities. The case management entities (hospitals, DSSs, local health departments, case management agencies, Home Care Agencies, or federally recognized Tribes) will be monitored monthly to ensure compliance with the six waiver assurances and their associated performance measures. Each case management entity must maintain a 90% compliance rate. The CAP Business system will provide the State Medicaid Agency monthly data reports on timeliness and compliance with policy in the areas of level of care, service plan, qualified provider, financial accountability, health and welfare, and administrative authority. Every quarter, the performance rates 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 rates. The representative sample consists of a .95 confidence interval with a margin of error of 5%. The monitoring of these entities will be achieved through the objectives and benchmarks described in the assurances and performance measures. The State Medicaid Agency will conduct a quarterly evaluation of the performance of each entity through data analysis and compliance 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, including enrollment and utilization and core case management outreach objectives.
Each appointed case management entity is required to maintain a compliance rate of 90% at each quarterly assessment. The State Medicaid Agency provides a monthly summary of performance through data reports to each case management entity, along with technical assistance based on the summary data. For those performing under the required compliance rate, the agency is closely monitored through corrective action plans until improvement is achieved or lack thereof resulting in rescinding their role as a case management entity. The SMA's commitment to quality improvement is further demonstrated by the provision of technical assistance to noncompliant performances. If after two quarters of technical support (corrective action plan), the performance has not improved, the SMA will notify the case management entity that within 60 days their case management entity appointment will be rescinded. A case management entity network assessment will be conducted to ensure continuous access to service by impacted waiver participants, thereby ensuring a smooth transition to an alternative case management entity. Close oversight will be provided for these types of transitions to ensure the health and safety of each impacted waiver participant.
A case management entity must submit a packet of information, including documented experience, qualified staff, and fiscal soundness, to be considered for case management services to be considered as a case management entity. This requirement offers a pre-assessment of ability to function in the role of a case management entity and carry out its required responsibilities. Entities can be approved if they meet the requirements for willing and qualified providers.
The State Medicaid Agency will monitor the accessibility and usability of the NC Medicaid MMIS system quarterly to ensure claims are processed per waiver business rules.

The SMA will monitor the performance and usability of the CAP Business System monthly. 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 areas are brought to the attention of the SMA through a corrective action plan or a Cure Letter to assist in remediating the issue quickly. Conference calls and work sessions are scheduled to discuss the issue and identify the steps of the quality improvement plan. Fines and penalties will be imposed if noncompliance areas cannot be remediated within three months. If the noncompliance area(s) spans over six months and cannot be remediated, a recommendation will be made to release the vendor of the contract.
The SMA will monitor the performance and usability of the Comprehensive Independent Assessment Entity (CIAE) monthly. A monthly assessment will be conducted to determine if the CIAE is meeting its service level agreements (SLAs) and contract performance measures in the areas of waiver eligibility, assessed needs, service plan development, and transition of care. The SMA addresses noncompliance areas through a corrective action plan to assist in remediating the issue quickly. Conference calls and work sessions are scheduled to discuss the issue and identify the steps of the quality improvement plan. Fines and penalties will be imposed if noncompliance areas cannot be remediated within three months of the implemented corrective action plan. If the noncompliance area(s) spans over six months and cannot be remediated, a recommendation will be made to release the approved vendor of the contract.

Appendix A: Waiver Administration and Operation

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

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

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

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

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

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

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

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

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

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

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

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

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

The State Medicaid Agency will monitor, quarterly, the accessibility and usability of the State’s MMIS system, NCTracks to ensure claims are processed per waiver business rules. When noncompliance issue(s) are identified, file maintenance records, service tickets and CSRs are generated as a remedy. When the issue is failure to follow the waiver or the Medicaid business rules, a corrective action plan is implemented. A root cause analysis will be performed to

identify causes and future preventive measures.
The CAP Business System will be monitored monthly to ensure accessibility and ease of use to the case manager and CIAE 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 will be monitored monthly 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 CIAE will be monitored monthly to ensure SLAs and performance measures outlined in the contract are met. Monitoring includes weekly service level conference calls to review identified program assurances and monthly data analysis sessions to review and discuss actual performance rate for each program assurance. Monthly and quarterly reports are required to be submitted to the SMA that describe performance and remediation efforts.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

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

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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 PM: Number and percent of contracted vendors that maintained a performance compliance score of 90% or better in carrying out the designated waiver administrative functions Numerator: contracted vendors that maintained a performance compliance score of 90% or better in carrying out the designated waiver administrative functions
Denominator: Total number of contracted vendors

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
AA-2 PM: Number and percent of case management entities that maintained a performance compliance score of 85% or better in carrying out the designated waiver administrative functions N: case management entities that maintained a performance compliance score of 85% or greater in carrying out the designated waiver administrative functions D: Number of case management entities reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*

☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System Claim Data from Data Warehouse	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System Claim Data from Data Warehouse	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **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 IT system is a business system employed by the State Medicaid Agency to manage the case management needs of each waiver participant, administrative responsibilities assigned to each designated entity, and the State Medicaid quality framework. This business system is integral in ensuring the administrative oversight of the waiver and delegated duties to contracted and non-government and non-state entities are consistently carried out and met. This system also assists in the discovery of non-compliant waiver practices through aggregate data from workflows. The state's process of discovery and problem identification will be performed quarterly to ensure compliance with this assurance.
The CAP IT system performs the following tasks to ensure compliance with waiver policies and procedures, which allows the State Medicaid Agency to discover areas of noncompliance quickly:

- No wrong door referral/request for services
- Service plans development
- Utilization management
- Level of care and need determination
- Notification letters
- Care coordination and management

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs 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, the State Medicaid Agency notifies the non-compliant entity within 30-days of the discovery; requests a corrective action plan to remediate the concerns. The State Medicaid Agency provides technical assistance and training on policies and procedures. A root cause analysis must be conducted by the entity and shared with the State Medicaid Agency. 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 throughout the duration of the plan. If the non-compliant issue continues, a freeze on accepting new waiver participants will be imposed on that entity until continuous quality is achieved. If, after 6 months of assistance and remediation strategies, and remediation strategies do not promote continuous quality, the administrative responsibilities assigned to that entity will be removed 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
CAP IT system	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Intellectual Disability			☐
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

•Disability of chronic medical condition or physical disabilities that require long-term care, or have an Alzheimer's Disease or Related Disorder; and
Have risk indicators identified in the comprehensive assessment that potentially place the individual in jeopardy of losing community placement. Risk factors may consist of stress on the informal support system, financial hardship, inability to attend required medical appointments due to transportation barriers, need for day support, and medication management. A description of the assessed areas that identified risk is in Appendix D-1-d); and
.Require in-home supportive services, support to perform activities of daily living, or assistance with community integration or maintaining community integration; and
•Have a supportive network to manage intensive health care needs when 24-hour care or supervision is required or when can assume risk using an approved risk agreement that mitigates health and safety concerns.

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:

This HCBS program serves individuals who are 18 years and older. When a waiver participant turns 65, his participation in this program remains constant; however, the Medicaid category changes to Medicaid for the Aged. There is no disruption in service provision or participation.

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:

An individual cost limit is not specified. However, through coordinated case management that includes monthly and quarterly structured engagement, health and welfare of the waiver participant is assured by linking to the most appropriate services and assuring the connection to a health home.

For applicants and current participants seeking initial and ongoing participation in this waiver program, the expected care needs for home and community-based services and other Medicaid approved services, the expected annual expenditure amount for care needs must not exceed the average cost in Column N as projected in Appendix J -1. A thorough analysis of the waiver applicant's assessed needs and identification of risk indicators conducted in a multidisciplinary format initially and annually assist with ensuring the health and welfare of the applicant and the care needs are met within the average ranges of the cost limit.
Upon the completion of the assessment, and all eligibility criteria were met, a composite score (Refer to Appendix D-1e) that identifies the complexity of need will be reviewed to assist to identify care needs in the type, amount, frequency and duration of need. Risk factors are carefully discussed and planned. The waiver applicant is linked to the most appropriate formal and informal services and supports to address risk factors and to support the caregiver. The waiver participant will also be linked to a health home to ensure efficient and effective management of health care needs.

A monthly expenditure report is run to evaluate the waiver and non-waiver expenses and compare total expenses against projections in Appendix J.

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:

A cost analysis of the total waiver budget and each waiver participant's cost expenditure are conducted quarterly. When the average per capita cost of waiver services are 75 percent over the average per capita cost of the institutional care, the SMA creates a cost analysis plan.
Upon a change in an enrolled participant status where the care needs exceed the projected limits and the care needs are significant, the participant will not be disenrolled from the waiver. A cost analysis of the total waiver cost limit for that year and each waiver participant's cost expenditure are conducted quarterly. When the average per capita cost of waiver services are 75 percent over the average per capita cost of the institutional care, the SMA will do the following:
a. Develop a cost utilization plan with a timeline of 90 calendar-days;
b. Implement a 60 calendar-day cost adjustment plan to align with the established budgetary limits for waiver participant over the 75% threshold limit; and
c. At end of the 90 calendar-days, a recommendation may be made to refer waiver participants with an average expenditure cost of 110% of the cost limit threshold to other formal supports when all attempts are made to cost adjustment impacted waiver participants' service plan within the established waiver cost limits. All attempts are made to align care expenditures by linking to other informal and formal, non-Medicaid services prior to an adverse decision. If an adverse decision is made, the impacted waiver participants are provided with a Fair Hearing.

☐ **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	14078
Year 2	14078
Year 3	14078
Year 4	14078
Year 5	14078

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	11648
Year 2	11648
Year 3	11648
Year 4	11648
Year 5	11648

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	
Alzheimer's Disease	
Reserve Capacity for Community Transition and Waitlist Prioritization	

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):*

Alzheimer's Disease

Purpose *(describe):*

Individuals with a diagnosis with Alzheimer's Disease and Related Disorders are granted priority waiver planning. This priority planning is a result of the following:
EXPAND SUPPORT FOR PATIENTS WITH ALZHEIMER'S DISEASE AND THEIR FAMILIES THROUGH COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS' WAIVER SLOTS
SECTION 12H.5.(a) The Department of Health and Human Services, Division of Medical Assistance, shall amend the North Carolina Community Alternatives Program for Disabled Adults (CAP/DA) waiver to increase the number of slots available under the waiver by a maximum of 320 slots. These additional slots shall be made available on January 1, 2017.
S.L. 2021-180 approved 114 slots to be added to the unduplicated participant count. One hundred fourteen slots will increase the reserve pool for Alzheimer's Disease and Related Disorders to serve more individuals. The One Hundred and fourteen additional slots for individuals with Alzheimer's Disease and Related Disorders were approved in 2022.

Describe how the amount of reserved capacity was determined:

The number of slots were determined by the General Assembly based on a study written by the Institute of Medicine (IMO) and data from NC Medicaid. S.L.2016-94, Section 12H.5(a) allocated a fixed 320 slots specifically to this population.

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

Waiver Year	Capacity Reserved
Year 1	434
Year 2	434
Year 3	434
Year 4	434
Year 5	434

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):*

Reserve Capacity for Community Transition and Waitlist Prioritization

Purpose *(describe):*

This HCBS waiver program has a maximum number of participants approved to access services at any given time. Access to waiver services are limited to each county. Each county is assigned a maximum number of participants to serve based on the average number of Aged, Blind and Disabled individuals in that county. Once the maximum waiver allotment, referred to as slots, are reached in a county, a waitlist is created. Individuals are placed on the waitlist based on the date of the initial application for consideration for waiver participation. Due to the demand, entry to this program is on a first-come, first-serve basis. Individual choosing to participate in this HCBS program have similar needs and functional level, if a waitlist is imposed per county, a prioritization method is used. The prioritization method enables priority of access to the waiver, moving an individual to the top of an existing waitlist to mitigate substantial risk factors for individuals in a priority category including the following:
•An individual age 18 and over who is currently participating in an approved HCBS managed by NC Medicaid and wants to make the transition to CAP/DA waiver;
•An individual with an active AIDS diagnosis with a T-Count of 200;
•Active individual who is currently participating in this HCBS waiver and needs to transition to another county or case management entity
•An individual in an inactive status because of a short-term, 90-day rehabilitation placement who is transitioning back to their home community;
•An individual approved to transition from an institution using Money Follows the Person demonstration, Division of Vocational Rehabilitation transition services or Vocational Opportunities of Cherokee Transition services;
•An individual transitioning to the community using the community transition waiver service;
•An individual identified as at risk by his or her local Department of Social Services or equivalent programs operated by Federally Recognized Tribes who has an order of protection by Adult Protective Services for abuse, neglect or exploitation.
•A Medicaid beneficiary with active Medicaid who is temporarily out of the State due to a military assignment of his or her spouse or legal guardian.
•An individual who is terminally ill and enrolled in the Hospice program and who is in jeopardy of entering a non-Hospice institution because care needs cannot be met with current supportive services. Individuals with an Alzheimer's Disease or related disorders will have a total of 320 reserve slots to meet an initiative of the State.
•An applicant who meets a level of care and who is in the covergae group under the Transitions to Community Living Initiative (TCLI).

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined through aggregate data of the number of MFP participants entering the waiver from SFY 2013-2018 as well as the number of priority slots assigned to waiver participants from SFY 2017-2018.

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

Waiver Year	Capacity Reserved
Year 1	75
Year 2	125
Year 3	150
Year 4	175
Year 5	200

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:

Waiver capacity is limited to each county and is managed and allocated by the State Medicaid Agency. Each of the State's 100 counties is assigned a maximum number of participants to serve through this HCBS waiver based on the average number of Aged, Blind, and Disabled populations in the county. This per-county allotment is initially evaluated at each waiver renewal. Every quarter, an analysis is conducted to identify capacity utilization per county to make decisions about temporary or permanent reassignments based on demand and underutilization of slots. The statewide allotment capacity for this HCBS waiver is 11,214 which the North Carolina General Assembly sets. A reserve capacity of 434 is used to target individuals with Alzheimer's Disease and Related Disorders. Of this total number, each county is assigned a designated allocation. The State Medicaid Agency manages the slots rather than the county entities. The State Medicaid Agency is also responsible for approving the assignment of an individual to a priority slot.

Entities involved in administering and overseeing this HCBS waiver dually assist in managing the allocation of waiver capacity.

The State Medicaid Agency is responsible for allocating the slots countywide and reallocating them when a county is not utilizing them to its maximum allotment. An analysis is performed quarterly to assess the usage of allocated slots per county. Utilization rates that are <74% of the max allotment per county and the county does not have a waitlist or pending referrals, the State Medicaid Agency will arrange for the slots to be assigned to other counties with a large waitlist and extended wait times on either a temporary reassignment or permanent basis. When that temporary-reassigned slot is vacated through attrition, the State Medicaid Agency will evaluate the permanency of that slot in that county for ongoing assignment or decide to reassign it to the original county.

The CAP IT system manages the approved slot allocation for each county. The system has the total capacity for each county programmed, and when an individual is approved for a slot or is disenrolled from the program for any reason, the slot count is automatically and immediately adjusted.

The CIAE and case management entity will enter the required documentation in the CAP IT system to inform the system of new applicants, waiver participants who may meet a priority group, and participants who require disenrollment from the HCBS waiver, allowing the electronic management of county waiver allotment.

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

Physically disabled or aged individuals interested in participating in this HCBS waiver who can meet a level of care and are assessed to have risk indicators that place them in jeopardy of losing their community placements (institutionalized) are eligible to enter this HCBS waiver. When waiver capacity is available, entrance into this HCBS waiver is available to all assessed individuals needing supplemental and supportive services of this waiver.
This HCBS waiver can serve a total of 11 648 unduplicated participants at any given time. When the capacity of the waiver is reached, clinically eligible individuals (determined to be eligible only for a level of care) are placed on a waitlist based on that county's capacity. As discussed in B-3e, waiver capacity is allotted by county, and the local county government determines Medicaid eligibility. If a level of care-eligible individual is placed on a waitlist, they are placed in the chronological order of their approved service request form (initial application). When their name reaches the top of the waitlist, an assessment of need is conducted to validate that the level of care continues to be met and that there is an indication of the need for supplemental and supportive services from this waiver. If a waitlist is imposed, each individualized SRF is analyzed to determine if eligible to be assigned to a priority category for quick entry into the waiver. If a level of care is approved for an individual who falls into one of these priority categories, they are prioritized to the top of a waitlist or immediately assigned an HCBS assessment determination slot to advance the evaluation of risk indicators. These priority categories include the following:
•An individual aged 18 and over who is currently participating in an approved HCBS managed by NC Medicaid wants to transition to a CAP/DA waiver.
•An individual with an active AIDS diagnosis with a T-Count of 200.
•Active individual who is currently participating in this HCBS waiver and needs to transition to another county or case management entity
•An individual in an inactive status because of a short-term, 90-day rehabilitation placement who is transitioning back to their home community.
•An individual approved to transition from an institution using the Money Follows the Person demonstration or Division of Vocational Rehabilitation transition services.
•An individual transitioning to community using the community transition waiver service.
•An individual identified at risk by their local Department of Social Services who has an order of protection by an adult Protective Services for abuse, neglect, or exploitation.
•An individual with Alzheimer' Disease or Related Disorder.
•A Medicaid beneficiary with active Medicaid who is temporarily out of the State due to a military assignment of their spouse or legal guardian.
•An individual who is terminally ill, enrolled in the Hospice program, and who is in jeopardy of entering a non-hospice institution because care needs cannot be met with current supportive services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

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

- (●) **No**
- ( ) **Yes**

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

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

§435.217)

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

☒ **SSI recipients**

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

☒ **Optional state supplement recipients**

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

Select one:

◉ **100% of the Federal poverty level (FPL)**

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

Specify percentage:

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

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

☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA 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:

Individuals receiving under 42 CFR 435.135 (Passalong)

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: 1

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

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

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

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

- (●) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By an entity under contract with the Medicaid agency.**

Specify the entity:

- ( ) **Other**

Specify:

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.

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

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

An initial LOC is established using a Service Request Form (SRF). This form is consistent with the Medicaid State Plan nursing facility LOC criteria. The SRF has identifying mandatory fields that capture demographic information, diagnoses, medications, nursing interventions, dietary concerns, ancillary therapies, behavioral concerns, falls and other related medical needs to analyze health care information to yield a LOC decision. This form screens three core areas: targeted population, level of care and priority group. If the responses to the questions align with the target population and level of care, the SRF is approved which is a clear indication that nursing facility level of care has be meet. During an annual review for LOC, the comprehensive assessment verifies the level of care continues to be met. When the comprehensive assessment cannot clearly validate LOC is met, a SRF is initiated to establish or re-establish the LOC.

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

1. Need for services, by physician judgment, requiring:

A. supervision of a registered nurse (RN) or licensed practical nurse LPN); and

B. other personnel working under the direct supervision of a registered nurse or licensed practical nurse.

2. Observation and assessment of participant needs by a registered nurse or licensed practical nurse. The nursing services must be intensive and directed to an acute episode or a change in the treatment plan that requires such concentrated monitoring.

3. Restorative nursing measures once a participant's medical condition becomes stable as noted in the treatment plan. Restorative nursing measures are used to maintain or restore maximum function or to prevent advancement of progressive disability as much as possible. Restorative nursing measures are:

A. A coordinated plan that assist a participant to achieve independence in activities of daily living (bathing, eating, toileting, dressing, transfer, and ambulation).

B. Use of preventive measures or devices to prevent or delay the development of contractures, such as positioning, alignment, range of motion, and use of pillows.

C. Ambulation and gait training with or without assistive devices; or

D. Assistance with or supervision of transfer so, the participant would not necessarily require skilled nursing care.

4. Dialysis (hemodialysis or peritoneal dialysis) as part of a maintenance treatment plan.

5. Treatment for a specialized therapeutic diet (physician prescribed). Documentation must address the specific plan of treatment such as the use of dietary supplements, therapeutic diets, and frequent recording of the participant's nutritional status.

6. Administration or control of medication as required by state law to be the exclusive responsibility of licensed nurses:

A. Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration.

B. Drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgment on a continuous basis; or

C. Frequent injections requiring nursing skills or professional judgment.

7. Nasogastric or gastrostomy feedings requiring supervision and observation by an RN or LPN:

A. Primary source of nutrition by daily bolus or continuous feedings.

B. Medications per tube when participant on dysphagia diet, pureed diet, or soft diet with thickening liquids; and

C. Per tube with flushes.

8. Respiratory therapy: oxygen as a temporary or intermittent therapy or for a participant who receives oxygen continuously as a component to a stable treatment plan:

A. Nebulizer usage.

B. Nasopharyngeal or tracheal suctioning.

C. Oral suctioning; and

D. Pulse oximetry.

9. Isolation: when medically necessary as a limited measure because of a contagious or infectious disease.

10. Wound care of decubitus ulcers or open areas.
11. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan; or
12. HCBS Nursing Facility LOC may be established by having two (2) or more conditions in Category I OR one (1) or more conditions from both Category I and II below.

b. Conditions that must be present in combination as listed above may justify HCBS nursing facility level of care:

1. Category I: (Two or more, or at least one in combination with one from Category II)

A. Ancillary therapies: supervision of participant's performance of procedures taught by a physical, occupational, or speech therapist, consisting of care of braces or prostheses and general care of plaster casts.
B. Chronic recurrent medical problems that require daily observation by licensed personnel or other personnel for prevention and treatment.
C. Blindness
D. Injections: requiring administration or professional judgment by an RN or LPN or a trained personal assistance.
E. Diabetes: when daily observation of dietary intake or medication administration is required for proper physiological control:

i. Vision, dexterity, and cognitive deficiencies; or
ii. Frequent hypoglycemic and diabetic ketoacidosis (DKA) (high blood sugar) episodes with documentation requiring intravenous or intramuscular (IV or IM) or oral intervention.

F. Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction as prescribed by a primary care physician.
G. Frequent falls due to physical disability or medical diagnosis.
H. Behavioral problems symptoms due to cognitive impairment and depressive disorders such as:

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

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

A. Need for teaching and counseling related to a disease process, disability, diet, or medication.
B. Adaptive programs: re-training the participant to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the participant's participation in the program and document the participant's progress.
C. Factors to consider along with the participant's medical needs are psychosocial determinants of health such as:

i. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders and progress notes or by nursing or therapy notes).
ii. Age.
iii. Length of stay in current placement.
iv. Location and condition of spouse or primary caregiver.
v. Proximity and availability of social support; or
vi. Effect of transfer on individual, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning helps alleviate the fear and worry of transfer).

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

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

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

a. Personal health information;
b. Caregiver information;
c. Medical diagnoses;
d. Medication and precautions;
e. Skin;
f. Neurological;

g. Sensory and communication;
h. Pain;
i. Musculoskeletal;
j. Cardio-Respiratory;
k. Nutritional;
l. Elimination;
m. Education
n. Mental Health;
o. Informal support; and
p. Housing and finances.

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

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

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

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

This HCBS program uses a different instrument from that of the State Medicaid Plan and has been using this instrument since 2013. This instrument has been proven to be reliable and valid. This LOC instrument is called a Service Request Form (SRF). The LOC instrument is a comparable to the FL-2 form the State uses for nursing facilities. The SRF is robust and versatile to allow a better assessment of the needs of individuals living in the community. This instrument assesses for mental illness and substance abuse to promote holistic, comprehensive whole person planning. The instrument is automatic and provides a real-time decision of eligibility using scoring algorithms.

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:

The annual SRF is not completed. The ongoing LOC is established through an annual assessment of need. During the annual assessment, a comprehensive assessment is completed to determine if a level of care continues to be met. Within each assessment modular, assessment areas contain components of the level of care criteria for this waiver. Upon entering the responses in the waiver business management system by the assessment evaluator and attesting to the completeness and accuracy of the information, the business system analyzes the assessment using the programmed level of care algorithms (logic to evaluate the waiver participant level of care through entries of medical, functional, behavioral, and psychosocial conditions) to validate LOC continues to be met. Further, an assessment reviewer also reviews the assessment to confirm LOC continues to be met along with the level of risk and needs. All final determinations of annual LOCs are made by the SMA.
This reevaluation of need is conducted annually, which is referred to as the continued need review (CNR). The annual reevaluation is conducted each year in the month the waiver participant was initially approved to participate in this HCBS program. The CAP Business system is primarily responsible for notifying all parties of the annual review to ensure the timely reevaluation of the 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 continued need review (CNR) paperwork to the assigned assessment entity to initiate the revaluation of level of care and needs. The reevaluation must be completed by the last day of the month in which the anniversary occurs to maintain continuous eligibility for level of care.

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, which is referred to as the continued need review (CNR). The annual reevaluation is conducted each year in the month the waiver participant was initially approved to participate in the waiver. The CAP IT system is primarily responsible for ensuring the timely reevaluation of the level of care. The CAP IT system releases the CNR two months before the anniversary date of each waiver participant's level of care determination. Paperwork is transmitted to the assigned assessment entity to reevaluate the level of care and needs. The reevaluation must be completed by the last day of the month the anniversary occurs to maintain ongoing eligibility for the level of care.

A reevaluation notification alert is transmitted to the case management entity two months before—thirty days before 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 in a timely manner, a corrective action is issued with a timeline to complete the reevaluation. For circumstances beyond control, such as a significant change in the participant‘s status where the reevaluation cannot be conducted, a decision may be made to postpone the reevaluation and suspend services until the reevaluation is performed. The waiver participant signs a rights and responsibilities form that addresses the requirement for the level of care reevaluation and the potential need to suspend services when the level of care cannot be established within a reasonable amount of time during the annual review.

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 IT 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 Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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 PM: Number and percent of applicants who received a LOC evaluation N: Number applicants who received a LOC evaluation D: Number applicants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **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 PM: #/% of enrollees who received a LOC evaluation using processes/instrument in the approved waiver that are applied appropriately & according to the approved description. N: Number of enrollees who received a LOC evaluation using processes/instrument in the approved waiver that are applied appropriately and according to the approved description D: Total number of applicants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
LOC-C2: #/% of participant who received an annual LOC evaluation using processes/instrument in the approved waiver that are applied appropriately & according to the approved description N: #of participants who received an annual LOC evaluation using processes/instrument in the approved waiver that are applied appropriately & according to the approved description D: total # of 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **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 IT 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 discovery of non-compliant LOC practices through aggregating and analyzing LOC workflow. The state's process of discovery and problem identification will be performed quarterly to ensure compliance with this assurance.
The CAP IT system performs the following tasks to ensure compliance with LOC policies and procedures, which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- No wrong door referral
- 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 Stateâs method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Upon discovering noncompliant LOC waiver workflows, the State Medicaid Agency notifies the noncompliant entity within 30 days of the discovery and requests a corrective action plan to remediate the concerns and a summary of the root cause. The State Medicaid Agency provides technical assistance and training on policies and procedures in the noncompliant area(s). The State Medicaid Agency approves the corrective action plan and follows up with the noncompliant entity to ensure the corrective action plan is being followed through the duration of the action plan. If the noncompliant issue continues, a freeze on performing LOC activities for waiver participants is imposed 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system NCTracks	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

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).

For individuals seeking Medicaid services and having an indication to meet the eligibility criteria of the waiver, a service provider, a case management entity, the county department of social services, or a Tribal Nation may provide general information about the waiver and a referral can be made for waiver enrollment consideration. Individuals interested in home and community-based services are offered and provided information on the freedom of choice for choosing institutional or home and community-based services prior to enrollment into the waiver program. The case management entity, the independent assessment entity, and the SMA are responsible for informing the individual or their legal representative about their freedom of choice between waiver and institutional services. A CAP Waiver Enrollment Notice is mailed to each waiver participant initially and annually by the SMA to confirm their freedom of choice decision to enroll in the waiver. The waiver participant must sign and return the enrollment notice to the SMA acknowledging their agreement/choice to enroll in the waiver to receive waiver services.
Each waiver participant is informed of the case management entities in their catchment area and their roles and responsibilities. Upon the approval of waiver entry and at the approval of the annual reevaluation, each waiver participant is mailed a CAP Disclosure Notice that outlines the purpose of the waiver, services available through the waiver, what freedom of choice is, and how to exercise their choice of services, providers, and participation in the waiver. This notice also includes information about abuse, neglect, and exploitation. During the assessment and planning phases of initial and annual waiver enrollment, the waiver participant must select an agency of their choice to perform the four core functions of case management (assessing, care planning, monitoring, linking, and follow-up) monthly. During the assessment phase, the waiver participant is informed of their rights and responsibilities as a waiver participant and their right to select any provider (freedom of choice) at any time, including another case management entity, to render approved waiver and non-waiver services.

NC Medicaid plays a crucial role in ensuring the availability of case management entities. There are at least two case management entities per county to enable choice for the waiver participant. If a designated case management entity in a county is not able to provide case management services for any reason, to offer choice, another case management entity, within a 30-60 miles radius, will be permitted to serve that service area. If needed, 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. This proactive approach ensures that the waiver participant always has a choice of case management entities, enhancing the flexibility and reliability of the system.

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

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

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.

Written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of five years.
Waiver Freedom of Choice forms are maintained in the CAP IT systems and at the offices of the case management entities in a beneficiary file.
Provider(s) shall comply with the following in effect at the time the service is rendered:
All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

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):

The State Medicaid Agency complies with ADA requirements and Title VI, Section 1557for the provision of reasonable accommodation for individuals requesting entry into or who are current participants of this HCBS program. Accommodations made available include, but are not limited to providing individuals who are deaf, deaf-blind, or hard of hearing with auxiliary aids and services, such as sign language interpreters and services for the blind. The State Medicaid Agency uses services from sister Divisions to make these accommodations available.
The State Medicaid Agency has language interpreters available to interpret for potential participant and current participant when requested or determine to be a need.
The State Medicaid Agency also translates vital documents (documents used to gather or communicate critical information for obtaining federal and state services/benefits) according to the Title VI of the Civil Rights Act of 1964. Examples of the vital documents that may be translated include the following:

1. Applications for waiver entry
2. Consents forms
3. Notices of rights
4. Notice advising of free language assistance
5. Letters or notices that require a response from the waiver participant or primary caregiver

These types of accommodation are no-cost language services that are available or assessible for the waiver participant.
In accordance with Title VI, each provider of waiver services including case management entities shall establish a plan to adequately provide services to non-English speaking waiver participants. The provider shall identify the necessary resources and individuals to implement the plan. Identification of necessary resources may include referring the waiver participant to other services provider agency or businesses with staff available to meet the language needs of the waiver participant.

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	**Adult Day Health**		
Statutory Service	**CAP In-Home Aide**		
Statutory Service	**Coordination of care - case management and care advisement**		
Supports for Participant Direction	**Financial Management Services**		
Other Service	**Chore Service-Declutter/Garbage Disposal**		
Other Service	**Community Integration Services**		
Other Service	**Community Transition**		
Other Service	**Coordinated Caregiving**		
Other Service	**Equipment, Modification and Technology**		
Other Service	**Individual Directed Goods and Services**		

Service Type	Service		
Other Service	Meal Preparation and Delivery		
Other Service	Non-Medical Transportation Services		
Other Service	Nutritional Services		
Other Service	Participant Goods and Services		
Other Service	Personal Assistant Services		
Other Service	Personal Emergency Response Services		
Other Service	Pest Eradication		
Other Service	Respite Services		
Other Service	Specialized Medical Supplies		
Other Service	Training/Education and Consultative Services		

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:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service for a waiver participant to attend a certified Adult Day Health Care Facility. The service cares for persons who do not have other appropriate day supports and/or who need a structured day program of activities and services with nursing or other supervision. It is an organized program of services during the day in a non-institutional community group setting. The program supports the waiver participant's independence and promotes social, physical, nutritional needs (meals are provided as part but shall not constitute a "full nutritional regimen" (3 meals per day); and emotional well-being.
Physical, occupational and /or speech therapies are not components of this service.
Transportation is not provided as a component of this service. Transportation is provided through non-emergency medical transportation.

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

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

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Adult Day Health Center
Agency	Federally Recognized Tribes

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License *(specify):*

10A NCAC 06R and 10A NCAC 06S
Meet Medicare requirements for federally recognized Tribal Governments or Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Certified by the North Carolina Division of Aging and Adult Services, according to NC General Statute 131-D-6. Certification process is conducted by NC Division of Aging under NC Administrative Code Title 10, Chapter 42, Subchapter 42E and 42Z. As provided under Subchapter 42S, local departments of social services are responsible for ongoing monitoring and annual recertification.
Meet Medicare requirements for federally recognized Tribal Governments or Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

1.NC Division of Aging and Adult Services
2.DHHS fiscal agent and MMIS (GDIT/NCTracks)

Frequency of Verification:

Initially and annually- NC Division of Aging and Adult Services
Initially and every five years- State Medicaid Agency; DHHS fiscal agent and MMIS (GDIT/NCTracks)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Federally Recognized Tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the 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.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and every five years thereafter by State Medicaid Agency; DHHS fiscal agent and MMIS (GDIT/NCTracks)

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):

CAP In-Home Aide

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

CAP In-home aide service is a range of assistance to enable a CAP/DA beneficiary 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 beneficiary to perform a task or supervision or monitoring of a task. CAP In-Home aide services may be provided on an episodic or on a continuing basis. CAP In-home aide services help with Activities of Daily Living (ADLs), Instrumental activities of daily living (IADLs), and basic home management tasks. The assessed in-home care needs of the beneficiary must be rated at an acuity level of NA I scope of nursing practice or greater. The need for assistance is identified through a comprehensive assessment that evaluates physical, social, environmental, and functional condition. Assistance is provided for seven keys ADLs: bathing, dressing, eating, toileting, hygiene, mobility and transfer, and key Instrumental Activities of Daily Living (IADLs) to include: light housework (sweeping, vacuuming, dusting, mopping and washing dishes), laundry, meal preparation, transportation, essential shopping, using smart devices, the computer and telephone, medication, paying bills and money management). Such assistance also may include the supervision, monitoring, companionship and emotional support of a beneficiary as provided in the service plan.
CAP In-Home aide services must be at an acuity level of tasks at Nurse Aide I scope of nursing practice or greater.
CAP In-Home aide services may be provided in the community, home, workplace, or educational settings at the discretion of the Home Care Agency. CAP In-Home aide services can be provided in the workplace for a CAP/DA beneficiary who meets the specified qualifications.
CAP In-Home Aide services can be provided by a CNA I or CNA II as identified by their assessed needs. Due to the acuity needs of this population, a CNA II certification is required to carry out tasks such as 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.
CAP In-home aide services under the waiver differ in scope, nature, supervision, and provider type (including provider training and qualifications) from personal care services in the State plan.
A relative, paid staff, and when approved, a legal guardian may be paid overtime for hours worked greater than 40 hours per week. However, a legal guardian may not exceed more than 40 hours per week when approved to be the direct care worker.
Assurance: The CAP In-home aide services under the waiver are limited to additional activities of daily living and instrumental activities daily living not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Because this service is different than state plan personal care services in the scope, nature, and supervision requirements, all waiver participants are included to receive this service. This services under the waiver are limited to additional services not otherwise covered under the state plan, including EPDST, but consistent with waiver objectives of avoiding institutionalization.

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

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

The number of hours of this CAP service is authorized based on person-centered needs.
A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide CAP In-Home Aide to a waiver participant unless the extraordinary conditions are met as described in Appendix C-2. The legal guardian referenced in this waiver is a person who has been appointed by the court. A paid primary caregiving living with the waiver participant or how is a legal guardian, Power of Attorney, Health Power of Attorney may not be approved to work more than 40 hours per week.
The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Homecare Agency Licensed by the State of North Carolina
Individual	Home Care Agency and Federally Recognized Tribes

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: CAP In-Home Aide

Provider Category:

Agency

Provider Type:

Homecare Agency Licensed by the State of North Carolina

Provider Qualifications

License *(specify):*

NC General Statute 131E-135 through 142 in accordance with Title 10 of the North Carolina Administrative Code
(10 NCAC 31.0900 - .1400)
Meet Medicare requirements for federally recognized Tribal Governments or Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

Workers providing Level II and Level III tasks must be certified as a Nurse Aide by the NC Board of Nursing and possess a certification.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

1.NC Board of Nursing
2.NC Division of Medical Assistance.
3. Federally recognized Tribal Governments

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: CAP In-Home Aide

Provider Category:

Individual

Provider Type:

Home Care Agency and Federally Recognized Tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the 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.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation
NC DHHS fiscal agent and MMIS (GDIT/NCTracks)
State Medicaid Agency
NC Board of Nursing

Frequency of Verification:

Initially and every five years
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).

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:	**Sub-Category 1:**
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service that directs and manages the special health care, social, environmental, financial, and emotional needs of a waiver participant to maintain the waiver participant's health, safety, and well-being and for continual community integration. Case management services are available to assist waiver participants in gaining access to needed medical, social, educational, and other services. Case management includes the following principal components: assessing, care planning, referring or linking and monitoring and following 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 meets 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;
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 CIAE 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 have changed for potential assessment of need.
Care Planning includes 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 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 to medical, behavioral, social, and other programs, services, and supports to address identified needs and achieve goals specified in the plan of care.

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 following up include:
- Activities and contacts with the waiver participant, responsible party, and service providers that are necessary to

ensure that the plan of care is effectively implemented and adequately addresses the needs of the waiver participant.
Monitoring and following 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 including care advisement services shall not exceed one unit per month, unless otherwise approved. 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.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.

The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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 adults 18 years and older with medical-complexities or physical disabilities;
c. Policies and procedures that align with the CAP/DA 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 or sooner, based upon the needs of the individuals, of submission of the service authorization;
i. Ability to make home visits as required and requested. Provider enrollment and recertification and claim submission training provided by NCTracks (GDIT);
j. Knowledgeable about the resources, rules,and activities for tribal members enrolled in the waiver:
k. Demonstrate fiscal soundness by having financial reserves on-hand ($60,000)
Participate in initial and annual refresher trainings to include:
a. Person-centered training;
b. Abuse, neglect, exploitation;
c. Program integrity (PI);
d. Conflict resolution;
e. Mental Health First Aid;
f. Critical incident reporting;
g. Health, Safety and Well-being and Individual Risk Agreement;
h. Medicaid Due Process Appeal Rights and EPSDT;
i. Consumer-Direction;
j. Quality Assurance and Performance Outcomes
k. Cultural Awareness; and
l. Motivation interviewing or a similar training

In addition, the case manager or care advisor shall complete other required trainings sponsored by their organization annually:
a. Bloodborne Pathogens and Infection Control;
b. Health Insurance Portability Accountability Act (HIPAA)
c. End of Life planning;

Verification of Provider Qualifications

Entity Responsible for Verification:

Case managers are qualified providers for case management and responsible for the development of the service plan. Case managers are required to have at a minimum a 4-year degree in social work or a human service profession or be a registered nurse at an RN or LPN level, licensed to practice in the state. Additional qualification information is described in Appendix D-1. All case managers must be knowledgeable of both tribal and county activities. 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:

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 Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service provided for a waiver participant who is directing their care to ensure that consumer-directed funds outlined in the service plan are managed and distributed as intended. Financial managers provide education and training to orient the waiver participant, employer of record and employees to the roles and requirements of the consumer-directed model of care. Financial managers facilitate the employment of the personal assistant" employee and the requirements of the consumer-directed model by completing the following tasks:

- Serving as the participant's Power of Attorney for Internal Revenue Service's (IRS) processes;
- Submitting payment of payroll to employees hired to provide 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:

When financial management services are being shared due to a waiver participant transferring from one FM provider to another in one planning month, half of the published rate is allotted per each FM provider, for that planning month.
This service does not offer co-employer services.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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 Services

Provider Category:

Agency

Provider Type:

Fiscal management agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Must comply with the 21st Century Cures Act for EVV for all qualified direct care workers and waiver participants.
The FMS must have experience and knowledge of the following:
- Automated standard application of payment;
- Check Claims;
- Electronic Fund Transfer;
- Electronic Fund Account;
- Invoice processing platform;
- Judgment Fund;
- Payment Application Modernization;
- Prompt Payment;
- Automated Clearing House;
- Cash Management Improvement Act;
- GFRS/FACTS I;
- Government wide Accounting;
- Intergovernmental Reconciliation;
- Standard General Ledger;
- Tax Payer Identification Number
- 3 years of experience in developing, implementing, and maintaining a record management process for establishing and maintaining current and archived participant, attendant, and service vendors files;
- 3 years of financial management experience;
- 3 years of basic accounting and payroll experience;

The FMS provider must meet statutory guidelines to include:
- Approved as a NC Medicaid provider;
- Authorized to transact business in North Carolina (pursuant to all State laws and regulations);
- Be approved by the IRS to act as an employer agent Section 3504 of the IRS Code and IRS Revenue Procedure 70-6;
- Bonded;
- Knowledge of laws and rules that regulate expenditure of public funds;
- Ability to utilize an accounting system that operates effectively on a large scale;
- Ability to effectively track individual budgets;
- Ability to develop, implement, and maintain an effective payroll system that adheres to all applicable tax requirements;
- Ability to conduct required criminal history and health care registry checks;
- Ability to develop, implement, and maintain a record management process for establishing and maintaining current and archived participant, attendant, and service vendors files;
- Ability to maintain all files in a secure and confidential manner for the prescribed time as required by the Federal and State rules and regulations, including HIPAA requirements;
- Ability to develop policy and procedures to indicate how all processes will be implemented and maintained; and
- Ability to provider FMS through multiple self-direction models including: Agency with Choice and Fiscal/Employer Agent models.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC DHHS fiscal agent and MMIS (GDIT/NCTracks

Federally recognized 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:

Other Service

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

Service Title:

Chore Service-Declutter/Garbage Disposal

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08060 chore
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Chore services covered by this waiver is used specifically for decluttering the home to restore the home or premises around the home to a clean, sanitary and safe environment as a result of pest infestation, storm or weather damage, removal of items as result of hoarding as requested by a city/county official, and long-term neglect of home maintenance/cleaning. This service includes heavy household chores such as washing floors and walls, moving heavy items of furniture in order to assist in cleaning and ridding of pest after a pest eradication treatment (a separate and distinct service) and disposing of garbage or debris. These services are provided only when neither the waiver participant nor anyone else in the household is capable of performing or is financially able, and where no other relative, caregiver, landlord, community/volunteer agency, or third-party payor is capable of or responsible for providing this service. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, is examined prior to any authorization of service.

The services under the chores service-declutter 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:

Maximum of $60.00/hour (rate covers all workers, equipment and material). The maximum number of hours is 13 hours per fiscal year or $800.00. The maximum approved amounts for Chore Service-Declutter/Garbage Disposal, nutritional services, non-medical transportation and other goods and services shall not exceed $800.00 total per each fiscal year (July 1-June 30).
A work order must be provided to describe the chore tasks, material and equipment needed, number of workers to complete the work and number of hours needed to complete the job.
The following services are coverable:
• Yard maintenance fee to ensure safe entry in the home, when pathway into the home poses a hazard as result of storm or weather event;
• Removal of excessive amount of garbage in the home or yard that poses a health hazard for the waiver participants; and
• Service to declutter the home to assist with ridding pest from eating, sitting and sleeping surfaces
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 Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	retail vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Chore Service-Declutter/Garbage Disposal

Provider Category:
Individual
Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The individual demonstrate capacity to urnish 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 individual 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: Chore Service-Declutter/Garbage Disposal

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

Service Title:

Community Integration Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

This service is for a waiver participant who has been enrolled in the waiver for more than 30 days and is in jeopardy of losing their community placement due to tenancy-related issues. This service may be used in any duration or type, up to the maximum allotted amount through the duration of the waiver approval cycle, to pay for necessary and documented tenancy-related expenses for the waiver participant. The following are allowable activities for Community Integration:
Community Integration service enables waiver participants to maintain their housing as outlined in the participant's approved plan of care (POC).
Services must be provided in the home or a community setting. The service includes the following components:
1. Authorizing a community-based organization, housing authority agency, or a legal aide representative to assist the waiver participant in developing a housing plan that identifies preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and the associated support needed to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).
2. Authorizing a community-based organization or a legal aide representative to assist the waiver participant in developing an individualized community integration plan that includes securing supporting documents/records, completing/submitting applications, arranging to identify resources to assist with securing deposits, and locating furnishings for the home.
3. Authorizing a community-based organization or a legal aide representative to assist with crisis intervention by engaging property housing managers and landlords for eviction risk mitigation efforts related to a waiver participant's disability.
Items and services must be of sufficient quality and appropriate to the needs of the waiver participant. To seek reimbursement, the service vendor shall provide an invoice for each service intervention as described in the service definition.

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

This service does not provide any room or board items such as deposits, housing costs or household furnishings. Room and board fees are excluded
• Ongoing payment for rent is excluded
• Not to exceed $2500 per waiver participant for the life of the waiver cycle

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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 Managers
Agency	Retail Suppliers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

Property Managers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

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 provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

As provided in 42 CFR Â§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:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

○ **Service is included in approved waiver. There is no change in service specifications.**

◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Community Transition services are for prospective waiver participants transitioning from an institutional setting to a community setting. 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 non-recurring set-up expenses for individuals who are transitioning from a Medicaid-funded institution to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. These expenses are necessary and documented for the waiver participant to establish or maintain a basic living arrangement within one year of the transition to community.
Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community transition services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.
Community transition services may cover the following:
• Essential furnishings, and household products including furniture for the bedroom or living room, window coverings, food preparation items, and bed/bath linens
• Residential application fees
• Security deposits required to obtain a lease on an apartment or home
• Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating)
• Environmental health and safety assurances, such as pest eradication; allergen control; one-time cleaning prior to occupancy
This service may be used for housing safety and quality inspection by a certified professional, including the assessment of potential home-based health and safety risks to ensure the living environment is not adversely affecting occupants' health and safety, when applicable.

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

• 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 Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Independent Contractors

Provider Category	Provider Type Title
Agency	Property Management Agencies
Agency	Retail Suppliers

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 the service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Property Management Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community 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: 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 Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Coordinated Caregiving

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Coordinated Caregiving includes supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community which includes such supports as adaptive skill development, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), linkage to local resources such as adult educational opportunities, social and leisure skill development, protective oversight and supervision. The setting for this service is the home in which the waiver participant resides.
This service is intended to promote the waiver participant's independence and provides in-home supportive services for in-home care and basic home management tasks due to the waiver participant's inability to perform these tasks independently as result of a disabling condition. Coordinated caregiving integrates the waiver participant into the usual activities of family and community life. In addition, there will be opportunities for learning, developing and maintaining skills in the areas of social and recreational activities and personal enrichment.
Coordinated caregiving is provided by a live-in caregiver who resides in the primary home of the waiver participant. The primary home may be owned, rented, or leased by the waiver participant or is the official residence of the waiver participant, as documented by their local Department of Social Services (DSS). Coordinated caregiving is provided in a private residence and affords all the rights, dignity, and qualities of living in a private residence, including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences.

Primary, private residences are not excluded from the requirements of the HCBS setting requirements but rather are deemed to meet the HCB settings requirements and should be reviewed with the waiver participant to ensure that all qualities of home and community are being met. The review tool used includes all the HCBS settings requirements.
The coordinated caregiver provider must develop an individualized, coordinated caregiving care plan within 30 days following the approved service plan to ensure the live-in caregiver is fully aware of care needs, how to meet those care needs, and how to request support and educational information.
The Coordinated Caregiving care plan shall be revised as needed based on further assessments of the waiver participant and caregiver.
The Coordinated Caregiving care plan shall include the following:
A statement of the daily care or service to be provided to the waiver participant based on the assessment or reassessment.
A statement about the education and coaching to be provided to the live-in caregiver
The Coordinated Caregiving care plan is signed by the waiver participant, case manager, live-in caregiver, and coordinated caregiver provider to acknowledge agreement to the terms of the care plan.

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

The provider receives a daily rate for the waiver participant based on their assessed acuity need which can be low or moderate/high. The live-in caregiver is paid a stipend to provide the oversight and supervision needed to maintain community placement. The stipend must be at least 50% of the published coordinated caregiver rate. An individual serving as the waiver participant's power of attorney, guardian, or representative may be a live-in caregiver and receive a stipend. The reimbursement rate does not include room and board. Settings such as a foster care setting, an alternative family living setting, or a provider owned home are prohibited from being the live-in caregiver for the receipt of a stipend.
To reduce duplication of services and effort, some services offered through this waiver may be limited or not able to be approved.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCBS Agency approved by NC Medicaid
Agency	Federally Recognized Tribes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Coordinated Caregiving

Provider Category:

Agency

Provider Type:

HCBS Agency approved by NC Medicaid

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Caregiver Qualifications:
Must be at least 18 years of age, in good health and able to follow written and verbal instruction;
Must pass criminal and registry background check
Provider Qualifications:
Agency providers must be enrolled as an NC Medicaid Provider
Agency providers must demonstrate 3 years of delivering HCBS to elders and adults with disabilities and their caregivers.
Agency providers must develop, implement and provide ongoing management and support of a person-centered service plan that addresses the waiver participant's level of service needs which includes an agreement with caregivers describing their roles and responsibilities for the care and support provided to the waiver participant.
Agency providers must conduct home visits based on the waiver participant's assessed needs and caregiver coaching needs.
Agency providers must provide to the caregiver a minimum of 8 hours of annual training that reflects the waiver participant's and caregiver's assessed needs. Training may be delivered during home visits, through secure electronic communication methods or in another manner that is flexible and meaningful for the caregiver.
Agency providers must provide education and coaching to lay caregivers that is based on the participant's and caregivers' assessed needs, including managing health-related needs; in-home care; cognitive, behavioral and social needs of waiver participants and, including interventions to reduce behavioral problems for waiver participants with mental disabilities and who need restorative services. Training, coaching and guidance must occur at a minimal monthly.
Agency providers must work with waiver participant and caregiver to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care and ensure that caregivers understand how to manage medical and other incidents and emergencies as they may occur and report such situations to the provider agency, as soon as possible.
Must have the ability to perform competency evaluation on hired staff
Must perform background checks to include on all hired supportive caregivers to validate no finding entered the registry or convictions that are outlined on the HCBS banned list.
Must assure the health and safety needs of the waiver participant are met in conjunction with the case manager.
Must ensure that coaching to the supportive caregiver includes the importance of providing nutritionally balanced meals and healthy snacks each day to the waiver participant, as dictated by their medical/nutritional needs.
Must engage in regular review of caregiver notes to understand and respond to changes in the waiver participant's health status and identify potential new issues to better assist with the coordination of care to avoid unnecessary hospitalizations or emergency room use

Competency Validation of Caregivers
Provider agency shall assure that each caregiver has the demonstrated competency to perform the in-home care activities specified in the CAP service authorization.
Documentation Requirement -Documentation to support service rendered that includes:
Electronic caregiver notes that record and track the participant's status, and updates or significant changes in their health status or behaviors and participation in community-based activities and other notable or reportable events
Medication management records, when applicable
Critical incidents
Grievances and complaints
Home visits conducted by provider agency
Education, skills training and coaching conducted with the caregiver
Multidisciplinary team meetings demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers and other caregivers or individuals important to the waiver participant regarding changes in the participant's health status and reportable events.
Qualified caregivers
Least Restrictive Environment Requirements
The provider agency must assure that the participants access to common areas and supports available as

part of living in the community. A participant's access may be restricted only when the participant's service plan determines the need to assure the participant's safety as documented in the comprehensive assessment.
Transportation. The provider must assure, whenever possible, the provision of transportation by the supportive caregiver for the waiver participants to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, equivalent programs operated by Federally Recognized Tribes shopping and recreational facilities, and religious activities of the waiver participant's choice. The waiver participant is not to be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members and transportation, medical and non-medical.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC DHHS fiscal agent and MMIS (GDIT/NCTracks)
State Medicaid Agency

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Coordinated Caregiving

Provider Category:

Agency

Provider Type:

Federally Recognized Tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the 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.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

Caregiver Qualifications:
Must be at least 18 years of age, in good health and able to follow written and verbal instruction;
Must pass criminal and registry background check
Provider Qualifications:
Agency providers must be enrolled as an NC Medicaid Provider
Agency providers must demonstrate 3 years of delivering HCBS to elders and adults with disabilities and their caregivers.
Agency providers must develop, implement and provide ongoing management and support of a person-centered service plan that addresses the waiver participant's level of service needs which includes an agreement with caregivers describing their roles and responsibilities for the care and support provided to the waiver participant.
Agency providers must conduct monthly home visits based on the waiver participant's assessed needs and caregiver coaching needs.
Agency providers must provide to the caregiver a minimum of 8 hours of annual training that reflects the waiver participant's and caregiver's assessed needs. Training may be delivered during monthly home visits, through secure electronic communication methods or in another manner that is flexible and meaningful for the caregiver.
Agency providers must provide education and coaching to lay caregivers that is based on the participant's and caregivers' assessed needs, including managing health-related needs; personal care; cognitive, behavioral and social needs of waiver participants and, including interventions to reduce behavioral problems for waiver participants with mental disabilities and who need restorative services. Training and coaching must occur at a minimal monthly.
Agency providers must work with waiver participant and caregiver to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care and ensure that caregivers understand how to manage medical and other incidents and emergencies as they may occur and report such situations to the provider agency, as soon as possible.
Must have the ability to perform competency evaluation on hired staff
Must perform background checks to include on all hired supportive caregivers to validate no finding entered the registry or convictions that are outlined on the HCBS banned list.
Must assure the health and safety needs of the waiver participant are met in conjunction with the case manager.
Must ensure that coaching to the supportive caregiver includes the importance of providing nutritionally balanced meals and healthy snacks each day to the waiver participant, as dictated by their medical/nutritional needs.
Must engage in regular review of caregiver notes to understand and respond to changes in the waiver participant's health status and identify potential new issues to better assist with the coordination of care to avoid unnecessary hospitalizations or emergency room use

Competency Validation of Caregivers
Provider agency shall assure that each caregiver has the demonstrated competency to perform the personal care activities specified in the CAP service authorization.
Documentation Requirement -Documentation to support service rendered that includes:
Electronic caregiver notes that record and track the participant's status, and updates or significant changes in their health status or behaviors and participation in community-based activities and other notable or reportable events
Medication management records, when applicable
Critical incidents
Grievances and complaints
Home visits conducted by provider agency
Education, skills training and coaching conducted with the caregiver
Multidisciplinary team meetings demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers and other caregivers or individuals important to the waiver participant regarding changes in the participant's health status and reportable events.
Qualified caregivers
Least Restrictive Environment Requirements
The provider agency must assure that the participants access to common areas and supports available as

part of living in the community. A participant's access may be restricted only when the participant's service plan determines the need to assure the participant's safety as documented in the comprehensive assessment.
Transportation. The provider must assure, whenever possible, the provision of transportation by the supportive caregiver for the waiver participants to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the waiver participant's choice. The waiver participant is not to be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members and transportation, medical and non-medical.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and every five years thereafter, verified by MMIS

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Equipment, Modification and Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

This service may cover home modification type services to include:

- Installation, maintenance, and repairs of ramps; grab bars; and handrails
- Widening of doorways/passages for wheelchair or walker accessibility
- Modification of bathroom facilities to improve accessibility for a disabled individual, including toilet, shower/tub (including hand-held showers), and sink fixtures or modifications; water faucet controls; floor urinal adaptations; plumbing modifications; and modification for turnaround space
- Bedroom modifications to accommodate hospital beds and/or wheelchairs
- Kitchen Modifications to improve accessibility for an individual living independently with a disability including cabinets, sink fixtures or modifications, water faucet controls, related plumbing modifications, and modifications for turnaround
- Floor coverings for ease of ambulation
- Hydraulic, manual, or electronic lifts, including portable lifts or lift systems that can be removed and taken to a new location and are used primarily inside the participant's home
- Non-skid surfaces
- Lift chairs
- Door handle replacements;
- Door modifications
- Installation of raised roof or related alterations to existing raised roof system to approve head clearance;
- Lifting devices;
- Handrails and grab bars;

Approval of minor plumbing and electrical work when determined necessary during the modification, but not to repair or fix plumbing or electrical problems.

The replacement of storage spaces when original storage place was used to widen an area or modify the area.

This service may cover car modification type services to include:

- Adapted steering, acceleration, signaling and breaking devices only when recommended by physician and a certified
- driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel
- Devices for securing wheelchairs or scooter
- Lifting devices
- Non-skid surfaces
- Seating modifications- car;
- Lowering of the floor of the vehicle when the vehicle is not pre-manufactured with a lowered floor;
- Transfer assistances
- 4-point wheelchair tie-down;
- Wheelchair/scooter hoist;
- Cushions- car or home when not covered by State Plan;
- Wheelchair or scooter lift;
- Ramp
- Devices for securing oxygen tank

•Necessary home and car modifications, not otherwise identified by this list and that were identified during as assessment will prevent an out of home placement. These types of modifications must align with one of the listed items under this definition, but not currently expressed because of unfamiliarity of need/modification requirements. These types of modifications can only be approved by the State Medicaid Agency.

This service may cover assistive technology to include

- lift systems
- Smart home devices when the waiver participant will live alone. These smart devices will control light switches, thermostatic, smart bulbs, controllers for televisions and entryways, clocks and other small appliances as identified in an assessment due to the disability of the waiver participant.
- 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;
- specialized monitoring systems;
- specialized accessibility and safety adaptations or additions;

- ceiling track system for the purpose of transfers;
- an Environmental Control Unit (ECU) or Electronic Aid to Daily Living (EADL) that allows a beneficiary with a disability to control aspects of their environment that are operated by electricity (such as lights, door strikes and openers Heating and Ventilating Contractors Association (HVAC), television, telephone, hospital bed, computer, small appliances). An ECU or EADL can range from a single function device to a whole house computed-based system

Approval of minor plumbing and electrical work when determined necessary during the modification, but not to repair or fix plumbing or electrical problems.
The replacement of storage spaces when original storage place was used to widen an area or modify the area.

This service does not duplicate State Plan Services. Assurance: The services under the waiver's Equipment, Modification, and Technology 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:

- Addition of square footage to the home;
- Home renovations;
- A dwelling where the owner refuses portable modification;
- The modification in a rented residence that is not portable;
- Purchase of locks;
- Modification during new construction;
- Roof repair or roof replacement,
- Central air conditioning,
- Swimming pools, hot tubs; spas, saunas
- Items that meet the definition exclusions for general utility to non-disabled individuals;
- Replacement of equipment that has not been properly used, has been lost or purposely damaged per written documentation or through observation;
- Computer desk and other furniture; and
- items that meet the definition exclusions for recreational in nature

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

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Durable medical equipment provider
Agency	Independent Contractor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Equipment, Modification and Technology

Provider Category:

Agency

Provider Type:

Durable medical equipment provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DME vendor must hold an applicable state and or business license and demonstrate the capacity to make the needed modifications and install equipment according to applicable local and state building codes and be an enrolled NC Medicaid Durable Medical Equipment and Supplies provider. Providers must have the ability to install items according to the manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and federally recognized 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:

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: Other Service
Service Name: Equipment, Modification and Technology

Provider Category:

Agency

Provider Type:

Independent Contractor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Independent Contractor must hold an applicable state and or business license and demonstrate the capacity to make the needed modifications and install equipment according to applicable local and state building codes and be an enrolled NC Medicaid Durable Medical Equipment and Supplies provider. Providers must have the ability to install items according to the manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Individual Directed Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service for the waiver participant directing care that provides services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan, and the waiver participant does not have the funds to purchase the item, or the item 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 need.
Types of coverable goods and services are 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.
Coverable items:
Long handle sponges, Long handle brushes, Long handle shoe horns, Elastic shoelaces, Bath tap turners, Button aids, Zipper pulls, Socks aids, Reacher and grasping aids, Door knob grippers, Key turners, Wheelchair or walker baskets/bags/caddy, Safety aid, Magnifying glass or magnifier, Writing aids, Large number clock, Bedside table, Emergency hand cranked radio, Flashlight, Arthritic utensils and adaptive utensils, No spill cups straw holder, two-handle mug, Scooper bowls and plates, one pull can opener, Plate guards, Jar openers, Bibs, Bottom wipers, Bedside commode cushion, Incontinence disposal system, Protectants for a mattress, chair or car seat to protect against incontinence accidents, Standing aid, Bed raisers, Orthopedic pillows, Wheelchair canopy, Repair to broken eyeglasses frames, hypoallergenic pillows and blinds, when determined to be necessary consistent with a medical condition, and Medication dispensing box.
The services 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:

The maximum approved amounts for Individual Directed Goods and Services et al. shall not exceed $800.00 total per each fiscal year (July 1-June 30).
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.

• 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
• 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 Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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 Provider
Agency	Retail Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Directed Goods and Services

Provider Category:
Individual
Provider Type:

Individual

Provider Qualifications

License *(specify):*

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.

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: Individual Directed Goods and Services

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License *(specify):*

meet all applicable licensure requirements per NC Medicaid Provider Enrollment requirements

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
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:

Other Service

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

Service Title:

Meal Preparation and Delivery

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service for a waiver participant who requires special assistance with nutritional planning per an assessment of needs. This service is often referred to as “Meals on Wheels” and provides for the preparation and delivery to the waiver participant’s home for one or more nutritious meal per day. 10A NCAC 06K.0101
Meals provided as part of this service does not constitute a full nutritional regimen.

A waiver participant must have at least one of the conditions listed below to receive meal preparation and delivery services.
Waiver participant living alone
Waiver participant does not have a caregiver living in the home
Waiver participant support services are before or after the required meal
Waiver participant can not prepare their own meal
Waiver participant needs a specialized diet that can only be provided by meal preparation and delivery
Quarterly multidisciplinary team meetings and post-payment reviews ensure compliance with this service to prevent duplication and unnecessary services.

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

Oral nutritional supplements are excluded
No more than up to 2 meals per day may be provided.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Nutrition
Agency	Federally recognized tribes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meal Preparation and Delivery

Provider Category:
Agency
Provider Type:

Nutrition

Provider Qualifications

License *(specify):*

Certificate *(specify):*

10A NCAC 06K.0101
Meet Medicare requirements for federally recognized Tribal Governments

Other Standard *(specify):*

Agencies/organizations that meet Division of Aging and Adult Services requirements for home delivered meals.
Meet Medicare requirements for federally recognized Tribal Governments

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Aging and Adult Services
Federally recognized Tribal Governments

Frequency of Verification:

Annually and five years thereafter by MMIS

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meal Preparation and Delivery

Provider Category:

Agency

Provider Type:

Federally recognized tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the 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.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and as required and five years thereafter by MMIS.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Non-Medical Transportation Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Transportation covered by this waiver is intended to allow waiver participants to gain access to 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. The maximum approved amounts for Non-Medical Transportation Services et al. shall not exceed $800.00 total per each fiscal year (July 1-June 30). Items that exceed $200.00 may require approved by a NC Medicaid.

- Mile reimbursement - .67 per mile. The maximum allowable per trip is $25.00. 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 $25.00. The maximum allowable trips per month is three (3).
- Gas Vouchers - .67 per mile. The maximum allowable for one gas voucher per trip is $25.00. 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 Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☒ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	retail vendor
Individual	Individual

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Medical Transportation Services

Provider Category:

Agency

Provider Type:

retail vendor

Provider Qualifications

License *(specify):*

Employees must have a valid driver's license and the company must have liability insurance coverage

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 federally recognized 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 Services

Provider Category:

Individual

Provider Type:

Individual

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 federally recognized 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 Â§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:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service for a waiver participant that provides coverage for physician ordered health supplements, vitamin or mineral supplements, herbal preparations and over-the-counter medications (OTC) that are directly related to the primary physical medical condition and are determined medically necessary but are not available under the State Plan. These nutritional services are necessary to assist the 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 Services 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 maximum approved amounts for Nutritional Services, non-medical transportation and other goods and services. shall not exceed $800.00 total per each fiscal year (July 1-June 30).
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 over-the-counter medications (OTC) and these nutritional services are not available through another source.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	The Specialized Medical Goods Suppliers
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:

The Specialized Medical Goods Suppliers

Provider Qualifications

License *(specify):*

The Specialized Medical Goods Suppliers must hold an applicable state and or business license or tribal business license or be an IHS/638 Compact Facility.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

The Supplier must demonstrate the capacity to render the service according to the service plan and according to the manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and federally recognized 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:

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: Other Service
Service Name: Nutritional Services

Provider Category:

Agency

Provider Type:

DME

Provider Qualifications

License *(specify):*

The DME vendor must hold an applicable state and or business license or tribal business license or be an IHS/638 Compact Facility.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

The DME vendor must demonstrate the capacity to provide the service according to the service plan and manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and federally recognized 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:

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 Â§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:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service for the waiver participant who is not directing his or her 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 services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.
- 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 specific coverable items are approvable using this service:
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,Long handle shoe horns,Elastic shoelaces,Bath tap turners, Button aids, Zipper pulls,
Socks aids, Reacher and grasping aids, Door knob grippers, Key turners, Wheelchair or walker baskets/bags/caddy, Safety aid, Magnifying glass or magnifier, Writing aids, Large number clock, Bedside table, Emergency hand cranked radio, Flashlight, Arthritic utensils and adaptive utensils, No spill cups straw holder, two-handle mug, Scooper bowls and plates, one pull can opener, Plate guards, Jar openers, Bibs, Bottom wipers, Bedside commode cushion, Incontinence disposal system, Protectants for a mattress, chair or car seat to protect against incontinence accidents, Standing aid, Bed raisers, Orthopedic pillows, Wheelchair canopy
Repair to broken eyeglasses frames.

hypoallergenic pillows and blinds, when determined to be necessary consistent with a medical condition.
Medication dispensing box provides assistance to the CAP beneficiary in knowing when to take their medication .

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

The maximum approved amounts for participants goods and services et al. shall not exceed $800.00 total per each 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
• Outdoor monitoring systems that are not approved in the service plan and are included in the recreational in nature or general utility definition
The Waiver Service Fee Schedule can be accessed using this link: https://medicaid.ncdhhs.gov/providers/fee-schedule/community-alternatives-programs-cap-fee-schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies

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 Provider
Agency	Retail Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Goods and Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual provider of transportation shall have a valid drivers' license, car insurance that covers liability and his or her own.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Frequency of Verification:

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

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Goods and Services

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

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 delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Goods and Services

Provider Category:

Agency

Provider Type:

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 federally recognized 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 Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Assistant Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Personal assistant service is a range of assistance to enable a waiver participant 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 to perform a task. Personal assistant services may be provided on an episodic or on a continuous basis. Personal assistant services provide hands-on assistance with ADLs, IADLs, 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 (sweeping, vacuuming, dusting, mopping and washing dishes), laundry, meal preparation, transportation, essential shopping, using smart devices, computers and telephone, medication, paying bills and money management). Such assistance also may include supervision, monitoring, companionship, and emotional support of participants as provided in the service plan.
Personal assistant services may be provided in the community, home, workplace, or educational settings at the discretion of the participant or designated representative.
Personal Assistant Services is authorized when using consumer-directed care. Consumer-directed care allows eligible beneficiaries to hire the provider of their preference. The eligible beneficiary is the employer of record, hence requiring a fiscal intermediary (FI) to file Medicaid claims on their behalf. Financial Management Service (FMS) is an enrolled qualified Medicaid provider. This entity files claims on behalf of the eligible beneficiary and then reimburses the hired personal assistant or vendor of other waiver services.

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

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

The number of hours of this CAP service is authorized based on person-centered needs. A relative, paid staff, and when approved, a legal guardian may be paid overtime for hours worked greater than 40 hours per week. A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide personal assistant services unless one of the extraordinary conditions described in this Appendix is met. When qualifying conditions are met for a legally responsible person to become the paid caregiver, that person cannot work more than 40 hours per week. A legally responsible person referenced in this waiver is a person who has a legal obligation under the provisions of state law to care for another person.
An individual hired to perform these tasks must have a criminal background check and assessed competencies.

Tasks, amount, frequency and duration must be clearly outlined in job duties.
A personal assistant is restricted for hire when:
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.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Personal assistance

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Assistant Services

Provider Category:

Individual

Provider Type:

Personal assistance

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual provider of personal assistant services must meet the following qualifications:
- At least 18 years of age
- Not a representative, guardian, Power of Attorney, or legally responsible person to the participant
- Deemed competent to provide assistance with the tasks indicated on the participant's comprehensive assessment by the participant or by the designed representative as indicated on the self-assessment questionnaire
- Have a criminal history and health care registry check free from the following findings:
  - 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.

A potential personal assistant with offenses that are not outside of Medicaid guidelines nor related to abuse, neglect, criminal sexual conduct, or exploitation may qualify for an exemption and be eligible for employment under the direction of the participant or designated representative if the offense occurred 10 years or more prior. A potential personal assistant who has findings from the health care registry checks that prevents him or her from working in the health care field is permanently banned from providing services to a waiver participant.
Comply with the 21st Century Cures Act for Electronic Visit Verification (EVV).

Verification of Provider Qualifications

Entity Responsible for Verification:

Employment application reviewed and accepted by the FMS provider when all qualifications are met

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Services

HCBS Taxonomy:

Category 1: 14 Equipment, Technology, and Modifications

Sub-Category 1: 14010 personal emergency response system (PERS)

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.
A service that pays the monthly service charges or monthly rental charges for a system used to alert a central monitoring facility of medical emergencies that may threaten the waiver participant's health, safety, and well-being. The emergency response provider must have the capability to provide a 24-hour monitoring system in accordance with the service definition.
This service may also be used for management of smart devices to alert emergency personnel and for the purpose of medication management.

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

Installation and maintenance are not covered.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Emergency Response Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Services

Provider Category:

Agency

Provider Type:

Emergency Response Agencies

Provider Qualifications

License *(specify):*

UL/ETL Approved Devices
Emergency care providers
Alarm system contractor
Meet Medicare requirements for federally recognized Tribal Governments or Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

Provider must have the capability to provide a 24-hour monitoring system in accordance with service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management entity
DHHS Fiscal Agent
Federally recognized Tribal Governments

Frequency of Verification:

Initial 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:

Other Service

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

Service Title:

Pest Eradication

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service for waiver participants that provides a one-time pest eradication treatment. This service is coverable when the waiver participant is living in his or her own home, when not already included in a lease, and when the eradication is for the management of health and safety as identified in the person-centered service plan. The eradication procedure is limited to one time per year.
Assurance: The service under the waiver's Pest Eradication is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

This service is not intended for monthly, routine or ongoing pest treatments.
The cost of this service shall not exceed $1600.00 per waiver participant over the course of two State fiscal years (July-June); $800.00 maximum for each fiscal year. The maximum approved amounts for Pest Eradication shall not exceed $800.00 total per each fiscal year (July 1-June 30).
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 Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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 federally recognized 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 Â§440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Respite Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

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

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

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

Institutional and In-home Respite Services 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 CAP In-Home Aide to 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 Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Federally recognized tribes
Agency	Home Care Providers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Services

Provider Category:

Agency

Provider Type:

Federally recognized tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the 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.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

Comply with the 21st Century Cures Act EVV requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and five years thereafter by MMIS

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Services

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 or Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

Comply with the 21st Century Cures Act EVV requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

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

Other Service

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

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supplies that are necessary to avoid institutionalization and promote continuous community integration often prescribed by a physician.

- Oral Nutritional Supplement: Provided to promote the health and well-being by increasing the ability to perform ADLs and IADLs.
- Incontinence Supplies: These supplies assist with bowel and bladder management and skin integrity.

Assurance: The services under the waiver's Specialized Medical Equipment are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Federally recognized Tribes may render this service all qualifying conditions are met - 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.

When a CME qualifies as a DME vender, because of conflict of interest protections, the case management entity is not authorized to provide specialized medical supplies unless that entity meets the threshold for rural service regions as described in Appendix D-2. Case management entity is only authorized to assist with the development of the service plan and to provide the selected service provider a written service authorization. This information will be included in the waiver application.

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

A signed physician's order certifying medical need.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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	Specialized Medical Goods Supplier
Agency	Durable Medical Equipment Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Specialized Medical Goods Supplier

Provider Qualifications

License *(specify):*

The Specialized Medical Goods Suppliers must hold an applicable state and or business license or tribal business license or be an IHS/638 Compact Facility.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

The Supplier must demonstrate the capacity to render the service according to the service plan and according to the manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and federally recognized 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:

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: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Vendors

Provider Qualifications

License *(specify):*

The DME vendor must hold an applicable state and or business license.
Tribal Home Health/Care agencies may be licensed by the state or be Medicare/CMS certified or other equivalent federally recognized Tribal code.

Certificate *(specify):*

Other Standard *(specify):*

The DME vendor must demonstrate the capacity to provide the service according to the service plan and manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and federally recognized 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:

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 Â§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:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**
- ( ) **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service that provides supportive services to the waiver participant, the waiver participant's unpaid primary caregiver, or unpaid support system. The purpose of the supportive service is to enhance the decision-making ability of the waiver participant, enhance the ability of the waiver participant to independently care for him or herself, or enhance the ability of the primary caregiver in caring for the waiver participant. These service activities which include training and counseling services for individuals who provide unpaid support, training, companionship or supervision to waiver participants. All training and education services must be documented in the participant's person-centered care plan as a goal with the expected outcomes. This service may cover conference registration and enrollment fees for classes and trainings to build competency of direct care worker. Coverage of on-line training in PPE/Safety data, Bloodborne pathogens and CPR Certification.

This service may cover violence intervention training/educational services, when not covered through the State Plan.

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.

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. Payment for ongoing training for a paid worker must be provided by the provider agency or through a saving plan from the budget of individuals directing their care. Paying for continuing education training will ensure the non-certified worker, who an agency is not supervising, maintains the essential training needed to continue to protect the health and well-being of the waiver participant.
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 on-line training and certification must be obtained within 30-days of the worker employment agreement.

The Waiver Service Fee Schedule can be accessed using this link:
https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link:
https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **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	Trainers and Educators

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:

Individual

Provider Type:

Trainers and Educators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

1) Universities, Colleges, and Community Colleges
2) An organization with a training/class curriculum approved by the Division of Medical Assistance.
3) Meet requirements for Qualified Tribal entities or IHS/638 Compact agencies.

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Tribal Governments
Case Management entities

Frequency of Verification:

Prior to class or training

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:

Case Management Entities

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 History and/or Background Investigations specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who are providing personal care type services in the capacity of a CAP in-home aide or a personal assistant. This HCBS waiver offers a waiver participant to direct their care using the consumer-directed model of care. The waiver participant has the autonomy to select the direct support staff (personal assistants) of their choice. The selected support worker (personal assistants) must undergo a criminal history record check prior to being hired to render the supplemental and supportive services. This HCBS waiver offers the services of a financial management entity to conduct the criminal history record check of all direct support (personal assistants) staff under the consumer-direction option. During the recruitment and employment verification phase for consumer direction, a state criminal history record check is conducted only in North Carolina if residency is verified for 5 years or more. A national criminal history record check is conducted if residency in North Carolina is for less than 5 years. The standards of obtaining a national criminal history record checks are from a public or private entity that regularly conducts criminal history record checks utilizing public records from a state agency. The standards of obtaining a state criminal history record checks are from a N.C. County that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank or a public or private entity that regularly conducts criminal history record checks utilizing public records from a state agency. In-home aides who are hired by an agency, a criminal record check and registry check must be completed by that agency prior to hire. The agency follows the guidelines determined by their regulatory agency, Department of Health Services Regulations for administering background checks. The agency follows the guidelines determined by their regulatory agency, Department of Health Services Regulations or the governing agency for tribal providers or IHS/638 Compact Facilities for administering background checks.

To ensure that mandatory background checks are completed as required, the financial management entity obtains consent from the selected direct worker (personal assistant) to conduct the criminal history record checks during the application process. The following information is obtained to assist with conducting the required checks: full legal name, date of birth, social security number, street address, city, state, driver’s license information, gender, previous names used, length of stay in the NC, and city and state of residence within the last five years. The selected direct worker may not render HCBS until the background check is completed and there is no indication of crimes that fall into the hiring ban.
In-Home Aide service providers must include in their personnel files the date the background check was completed for each hired in-home aide. A listing of findings shall be documented in the record if a criminal record exists and how those findings are within the requirements of this waiver program.

To mitigate risk of abuse, neglect, exploitation to a waiver participant, the State Medicaid Agency has implemented a hiring ban for selected direct workers (personal assistant). If any one of the following convicted criminal acts is listed on a background check, the direct worker will not be able to provide hands-on care. The ban provides exclusions when the criminal act is over a ten (10) year period with no same or similar criminal act. The hiring ban include the following:

- Felony or misdemeanor related to manufacture, distribution, prescription or dispensing of a controlled substance;
- Felony or misdemeanor health care fraud;
- More than one felony conviction;
- Felony or misdemeanor for 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;
- Felony or misdemeanor for abuse, neglect, or exploitation of a minor or vulnerable adult;
- Substantiated allegation of abuse, neglect, or exploitation listed with the NC Health Care Registry or Office of Inspector General (OIG) U.S. Department of Health and Human Services Exclusion Database; or
- Any substantiated allegation listed with the NC Health Care Registry or OIG U.S. Department of Health and Human Services Exclusion Database that would prohibit an individual from working in the health care field.

A direct worker (personal assistant) with offenses that are not outside of Medicaid guidelines nor related to abuse, neglect or exploitation may qualify for an exemption and be eligible for employment under the direction of the participant or designated representative if the offense occurred 10 years or more prior. The Financial management entity shall inform the waiver participant or designated representative when an offense is within the 10-year exemption rule. A direct worker (personal assistant) who has findings from the health care registry checks that prevents him or her from working in the health care field are permanently banned from providing services to a waiver participant.

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)or the governing agency for tribal providers or IHS/638 Compact Facilities is responsible for maintaining the nurse aide registry. DHSR or the governing agency for tribal providers or IHS/638 Compact Facilities 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 or the governing agency for tribal providers or IHS/638 Compact Facilities conducts a criminal background check on entities monitored by that division. The licensed entities monitored by DHRS 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, the governing agency for tribal providers or IHS/638 Compact Facilities 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 HCBS IT 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)

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services**

when they are qualified to provide the services.

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

This section outlines when it is in the best interest of the waiver participant to have a legally responsible individual to provide in-home aide services. The case manager in collaboration with the physician (when applicable) and the MDT to identify 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 MDT and physician (as applicable), 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.
Payment to a legal guardian to provide CAP in-home aide services or personal assistant services to a waiver participant may be made when any one of the following extraordinary circumstances is met:

1. There are no available CNAs in the waiver participant's county or adjunct counties through a Home Care 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 to 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.

This waiver allows a spouse or legally responsible individual of a waiver participant to perform in-home care services and receive payment when any one of the following extraordinary circumstances occur: 1. The waiver participant is experiencing a cognitive limitation such as dementia or Alzheimer's Disease or a related disorder and the present of an unfamiliar individual is more disruptive than productive and the waiver participant requires additional assistance with ADLs than ordinary as identified in a service plan.
2. The waiver participant is in an area with limited access to service providers and the assessment of needs identifies that the waiver participant requires five or more hours per day of uninterrupted in-home care.
3. The waiver participant has a secondary diagnosis of mental illness and the behavior, because of this illness, poses harm to an unfamiliar person or past behaviors have alienated service providers.

A legally responsible individual can only be authorized for 40 or less hours per week when approved to be the direct care worker. The approved hours are based primarily on the assessed needs identified in the assessment.

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 in-home care tasks.

The assigned case management entity will perform bi-monthly 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 in-home care services and receive payment because of an unjustified unwillingness to work with Home Health Agencies/In-Home Aide Agencies. A legal guardian will not be approved to provide in-home care services and receive payment if there are other providers available to render in-home care services when the waiver participant has been discharged from a Home Health Agency/In-Home Aide Agency due to non-complaint or violent behavior exhibited by the waiver participant or the legal guardian.

A 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.

The CME is required to closely monitor the provision of services through monthly contact with the beneficiary and quarterly observation of hands-on tasks.

☒ **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.

Relatives of all kinds and a guardian as appointed by a Court can provide CAP In-Home Aide, Respite, coordinated caregiving, and personal assistant services. A relative and guardian may be employed by a Home Care Agency, consumer-directed services or live in the same home as the waiver participant. A relative and a guardian cannot provide non-institutional respite services.
The relative or guardian must:
a. Be at least 18 years of age;
b. Meets the hiring criteria as established by the care needs of the waiver participant; and
c. Not having other employment that interferes with the needs of waiver participants regarding time and days.
The CMEs and provider entities play a significant role in assessing and determining the need for In-home aides, personal assistants, and coordinated caregiving services. The CME and provider entities also assist in monitoring the service plan, tasks, and time records to ensure appropriate provision and utilization of waiver services.
The provider agencies also play a critical role in ensuring payments are made for services rendered. Providers must create a care plan that aligns with care needs and cross reference the task and time sheets against EVV data and other supportive data to validate the service rendered in the amount, frequency, and duration listed in the approved POC. Additional safeguards include post-payment reviews conducted by the State Medicaid Agency.
Payment is made directly to a relative or legal guardian by the provider entity upon the submittal of a timesheet that is signed and verified for authentication of the service being rendered.
A guardian must be approved under one of the categories of extraordinary care. The case manager must obtain supporting documentation from the physician or other professional that a guardian is the best individual to provide care and upload that supporting evidence in the case file. Due to the waiver participant's behavioral or cognitive needs, permitting a guardian to be the paid caregiver is the best option to ensure special needs are appropriately met and addressed. This decision is made by exercising one of the categories under extraordinary conditions. Upon the approval of meeting one of the extraordinary conditions, guardian performs those tasks and activities as identified in the comprehensive assessment or recommendation from the multidisciplinary team as needing assistance.
A relative or guardian living in the same home as the waiver participant may not be assigned to perform tasks as a direct care worker for more than 40 hours per week. The identification of support needed daily is consistent with the acuity of care needs identified through a comprehensive assessment.

○ **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 CIAE 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 service.

Providers interested in providing case management and financial management services and coordinated caregiving must complete a packet of information demonstrating their experience in long-term services and supports and offering management and oversight services to individuals enrolled in a community-based program such as a 1915(c) HCBS waiver. All qualifying requirements must be met before approval is granted to render these three core waiver services. Case management entities will be assigned to serve a county when all qualification requirements are met and when there is a service need in that county.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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-A2 PM: #/% of waiver providers who met the required licensure and /or certification standards and /or adhere to other standards prior to their furnishing waiver services. N: number waiver providers who met who met the required licensure and /or certification standards and /or adhere to other standards prior to their furnishing waiver services D: number of waiver providers reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =

		95% 5% margin of error
☒ **Other** Specify: MMIS CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 PM: Number/percent of all non-licensed/non-certified providers who received a quarterly eval to confirm adherence with hiring requirements N: Number of non-licensed/non-certified providers who received a quarterly eval to confirm adherence with hiring requirements D: Number of non-licensed/non-certified providers who were evaluated

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **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 #/% of waiver participants enrolled in consumer-directed care (CD), for the 1st time, who completed the CD training modules before hiring staff N: # of waiver participants enrolled in consumer-directed care (CD), for the 1st time, who completed the CD training modules before hiring staff D: # of waiver participants enrolled in the consumer-directed care for the 1st time that were reviewed

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
CAP IT System	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-C2 Number and percent of local agencies that uploaded evidence of completed required training outlined in the waiver CCP Numerator: Number of local agencies that uploaded evidence of completed required training outlined in the waiver CCP Denominator: Total number of local agencies

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT System CME	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
QP-C3 Number and percent of HCBS providers who uploaded evidence of completed training before rendering waiver services for each waiver participation year N: Number of HCBS providers who uploaded evidence of completed training before rendering waiver services for each waiver participation year D: Total number of HCBS providers reviewed

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

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 IT system is a business system employed by the State Medicaid Agency to assist in managing qualification of providers in conjunction with the MMIS entity (GDIT/NCTracks). This system assists in the discovery of provider qualifications through aggregating and analyzing National Provider Identifiers, training requirements and assessment of needs. The state's process of discovery and problem identification will be performed quarterly to ensure compliance with this assurance.
The CAP IT system performs the following tasks to ensure compliance to qualified provides policies and procedures which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- Service authorizations
- CAP IT system user identification using MMIS NPI information
- Prior approval segments
- Workflow timelines and alerts
- Communication logs
- Supporting documentation queues
- Knowledge and educational materials
- Training modules

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs 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 qualified provider, the State Medicaid Agency notifies the non-compliant provider immediately upon discovery. If the non-compliant area can be remediated, a corrective action plan is requested to remediate the concerns and technical assistance and training on policies and procedures are provided. The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant provider to ensure the corrective action plan is being followed through the duration of the action plan. If the non-compliant issue continues for a duration of 3 months of technical assistance and remediation strategies and quality cannot be achieved, the entity will be terminated indefinitely.
If the provider loses Medicaid enrollment status or is placed on an Office of Inspector General list, termination as a waiver provider is initiated immediately.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
CAP IT System, CME, GDIT/NCTracks	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

a) How initial settings compliance was determined along with a brief description of the services being provided in each setting.

To comply with the home setting rule, an assessment was conducted on all the waiver services in the CAP/DA waiver. The only service identified to fall within the home setting rule was Adult Day Health (ADH). AHD service is for a waiver participant to attend a certified Adult Day Health Care Facility. The service cares for persons who do not have other appropriate day supports and who need a structured day program of activities and services with nursing or other supervision. It is an organized program of services during the day in a non-institutional community group setting. The program supports the waiver participant's independence and promotes social, physical, and nutritional needs (meals are provided as part but shall not constitute a "full nutritional regimen" (3 meals per day); and emotional well-being. An evaluation was completed by all ADH providers to assess their compliance with the home setting rule and determine the level of compliance and strategies to align when all requirements weren't met. A beneficiary survey was conducted with waiver participants to assess their satisfaction with the service and whether they were provided services in a person-centered engagement aligned with the home-setting rule. Every AHD was assessed, and representatives from the state and the assigned case management entity worked with them until compliance was met. Each quarter, an assessment was conducted to ensure ongoing compliance.
Validation can begin once the assessment is marked fully integrated/fully compliant. The case manager's role in the validation process is to conduct on-site monitoring and notification to NC Medicaid should there be areas that do not align with the HCBS requirements. Validation efforts begin as soon as case managers/care coordinators meet with individuals in the community and complete the HCBS Monitoring Tool. As Case Managers/Care Coordinators complete onsite monitoring, if they identify areas that do not align with HCBS, it is important that they notify the assigned NC Medicaid CAP/DA consultant, as this may be a place where remediation may need to be completed.

NC Medicaid conducted a desk review or intensive on-site review, if deemed necessary determine if remediation is needed, and finalize the site validation.
The intent of validation is not to look for something wrong, rather support a more effective system. If a case manager/care coordinator submits information from the HCBS Monitoring Tool that is not aligned with information provided in the Provider Self-Assessment, CAP DA staff consultant work with the provider to remediate the identified HCBS compliance issue or concern.

The case management entity was responsible for ensuring compliance with the setting rule. NC Medicaid requires a monthly checklist from local Case Management Entities for their monthly compliance monitoring strategies. The monthly checklist covered 17 questions regarding:
setting,
surrounding neighborhood,
home location,
staff communication in a respectful manner,
not required to sit in assigned seating and may choose with whom to eat,
visitors aren't restricted to hours or area privacy in living space,
staff required to always knock before entering,
individual has a key to the home or room when applicable,
no medical appointments or medications are posted in general areas,
furniture arranged per the desire of the individual,
personal preference is noted for the kind of work and activities the individual should participate in,
determining individual is in an integrated setting,
unrestricted access to settings,
furniture is appropriate in size to allow individual access, and
technology to include the telephone is in the individual's room.

b) If the state is adding a new setting type to the waiver, that was not in the HCBS delivery system prior to March 17, 2014 and therefore not included in the STP, the state is required to describe the process used to ensure that the setting is compliant prior to its use in the waiver.
A new service was not added to the waiver that must comply with setting rule.
c) A description of how ongoing compliance is monitored (with frequency of monitoring activities) including how individuals' private homes are also monitored for compliance with the settings criteria. The case manager is required to conduct at least two in-person face-to-face visits in which observation is made to ensure compliance with the home setting rules.
NC Medicaid ongoing compliance consist of the case manager in the validation process is to conduct the on-site review and to notify NC Medicaid should there be any areas that do not align with the HCBS requirements. Once the on-site visit HCBS Validation Tool has been completed, the case manager uploads the document into the knowledge exchange and notifies the CAP/DA consultant that the on-site visit is complete, indicating any areas of concern noted during the on-site visit. Some Case

managers fax the document directly to NC Medicaid staff.

NC Medicaid completes the remaining steps in the validation process.
This includes a desk review or intense onsite review, if either is deemed necessary to verify that the site is meeting HCBS compliance. If issues are identified during the validation process, a remediation step may be required by the site to correct issues in order to receive validation. Once a site is validated, it will NOT have to be validated again.

The site enters into what is called Ongoing Monitoring.
Quarterly Case Management monitoring will continue at Adult Day Health sites and coordinated caregiving arrangements, ensuring that participants are receiving services consistent with their person-centered plan and CMS requirements. HCBS elements will be added into the existing Case Management monitoring tool. As the questions for validation and ongoing monitoring are the same, case managers will continue to utilize HCBS Validation Tool during the quarterly monitoring. This will deliver a continuous monitoring and oversight system to ensure that providers are offering services and supports that are consistent with HCBS.
Any concerns noted with HCBS compliance will be reported to the CMEs/CAP-DA consultant for follow up.
MIE Surveys
If concerns are noted on the MIE surveys, LME-MCO or CAP DA staff may use information to determine if remediation efforts may be required and follow up accordingly

During quarterly in-person face-to-face visits, the case manager ensures the private home compliance with the setting criteria. As listed below, assessment questions are asked of the waiver participant or primary caregiver and observed by the case manager to ensure compliance with the setting rule.
These questions are: While living in your private home, are you able to:
interact with neighbors when desired
receive respectful communication from caregivers of all types
sit and sleep when want to
have visitors
have privacy
has a key to the home or room, when applicable
know the dates of medical appointments
know where medications are stored
has furniture arranged per the desire of the individual and is appropriate in size of the,
can participate in the kind of work and activities of preference
has unrestricted access to the home,
has access to technology, including telephone and television

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-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:

4-year Bachelor Social Work Degree with minimum of 2-3 years of direct experience in long-term care or home and community services; or 4-year Bachelor Human Services Degree with minimum of 2-3 years of direct experience in long-term care or home and community services; or registered nurse who holds a current NC license with 1 year of case management experience in long-term care or home and community services.
Must complete the following annual mandatory initial and refresher trainings:
a. Person-centered thinking and planning 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. Fair hearing and EPSDT;
i. Consumer-Direction;
j. Quality Assurance and Performance Outcomes
k. Cultural Awareness;
l. Motivation interviewing or a similar training; and
n. How to use and navigate e-CAP
o. Knowledge on State Plan Medicaid Services

☐ **Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

An assessment is conducted to initially assess needs and risk indicators to validate eligibility to receive this level of care and HCBS planning. Upon the approval of waiver participation, the waiver participant is required to select a case management entity to assist with the development of a person-centered service plan. The person-centered service plan is individualized and is designated to address risk indicators that were identified. The CME arranges an appointment with the waiver participant and encourages the waiver participant's support system to attend. Prior to the first appointment, the waiver participant is encouraged to identify goals/objectives to address social/health needs. The CME reviews those goals with the waiver participant and relates them to the identified risk indicators to begin the discussion of the person-centered service plan. The CME is also responsible for providing monthly case management to ensure each waiver participant's health/welfare is maintained. The CME may also be approved by SMA to render other waiver services when there is no other qualified entity available, and the CME is the only willing and qualified entity. Safeguards are put in place to mitigate conflict and bias. To prevent conflict of interest and to promote freedom of choice, the SMA has instituted firewalls to safeguard the waiver participant. Two firewalls: 1. Clearly defined definition for conflict of Interest (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, when the CIAE cannot perform the initial assessment, can't have direct or indirect affiliation with the waiver participant. The CIAE will be responsible for performing a quality validation of the completed plan of care to ensure the service plan is interest free and the waiver participant could fully exercise freedom of choice. As a means of documenting choice was provided to the waiver participant, the case management entity must review and have the waiver participant to acknowledge and sign an agency disclosure form that provides information about COI, free choice of providers or lack of specific service providers in that service region. Disclosure about freedom of choice and interest free case management is provided in four written formats-Participant Disclosure Form, Introductory Letter, Welcome Letter, and a reassessment anniversary letter. Each of these letters is generated in the CAP Business system and mailed by the CIAE. Yet another safeguard is the Rights and Responsibilities form. This form clearly outlines the responsibilities of the waiver participant. The form must be signed and dated by the waiver participant and uploaded in the CAP Business system prior to the approval of the service plan. The e-CAP Business system performs a quality check of the service plan to validate COI protections were practiced by the CME with all waiver participants. When CME acts in a dual role, safeguards are in place to assure the CME administratively separates the plan development function from the direct service provider functions. Two safeguards are in place to manage potential COI. 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. The case management entity is also required to assess adequacy of provider network quarterly. The SMA identifies in advance the potential agencies that will fall in this threshold through a quarterly network analysis. When an agency is approved to function in this dual role, the SMA monitors those agencies closely by the initial service plan, paid claims, revisions to service plans, monitoring of monthly and quarterly visit summary reports, incident reports and annual surveys. The CME is also required to assess provider network in the service region routinely for available providers and discuss free choice of provider (disclosure form) with the waiver participant quarterly. Entities can only provide both case management services and other waiver services when prior approved by the SMA. The state CAP unit will assist the waiver participant to select different direct service provider when COI is evident. The waiver participant will be offered a dispute resolution process to dispute any state assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan. 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 waiver service, the utilization limits and how the services may prevent institutional placement.

•Person-centered planning – information to describe the definition of person-centered planning and how the participant is entitled to determine who should be involved in decision-making and who may attend planning meetings. The participant is also provided information about how to ensure his or her likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity are included in the plan. The participant is also informed about assumed risk when choosing to participate in a home and community-based program.

•Freedom of Choice – information is provided to describe what freedom of choice is and how the participant can exercise his or her freedom of choice when selecting to participate in the waiver, how to select waiver services and providers to provide services which also includes the case management agency for management of the day-to-day oversight during waiver participation. A participant may select a different provider at any time, for any reason.

•Fair hearing- information is provided on how to request an appeal when an adverse decision is made, and the timeline granted to file an appeal.

•Complaints and Grievances- information is provided that describes what is a complaint and a grievance and how to voice a complaint and a grievance. The timeline is provided on how the complaint and 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 providers 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 in completing 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 support and social support, 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 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 days 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 at-risk of institutionalization based on functional needs and psychosocial factors identified in a comprehensive assessment. At-Risk of institutionalization is defined as participants who meet nursing facility level of care (LOC) criteria 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 being at-risk of institutionalization leads to the last step of eligibility, the service plan development. Breakdown of each step:

The 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 CIAE initiates the second steps of eligibility which is the comprehensive assessment that assesses the following functional areas:

• 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.

If the individual needs indicate gaps in service provisions or the individual is assessed to be at-risk of community displacement (institutionalized), and there is an indication there are 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 the service plan worksheet, for consideration and planning. The CAP IT system will not allow a service plan to be completed until there is a plan for each identified risk indicator 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 participants 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 their primary residence, to initiate the interdisciplinary 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 IT 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 IT 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 IT 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.
Individuals transitioning from an institution or a similar 1915(c)HCBS waiver may use a previously approved service plan while a more comprehensive assessment of needs of community placement can be conducted to ensure community needs are adequately addressed. The service plan must be completed within 60 days.
The service plan development consists of:
a. An interdisciplinary 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 re-assessment is called a Continued Need Review (CNR) assessment. The CAP IT system tracks all Continued Need Review and reassessments. The CAP IT system provides monthly alerts to CME or CIAE, 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 IT system within 30-days of identified needs and approved within five (5) business days or sooner based upon the needs of the individuals. 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 IT system places prior approval limits on all authorized waiver services to ensure accurate reimbursement. The assigned case manager monitors the services monthly with the waiver participant and authorized waiver providers to identify deviations of services and review provision of care. If there are consistent deviations and the service is authorized on the service plan, the case manager must review this with the waiver participant and discuss a possible change in providers. If the waiver participant's needs

may be maintained at the deviated service level, a service plan revision must be completed.
The Case management entity shall send a written adverse notice in accordance with State Medicaid Agency Due Process policy to the waiver participant or responsible party if a service is denied, reduced, terminated, or if the waiver participant is disenrolled from the program. The service plan will be active on the date of the effective date and all approved services will be rendered regardless of 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 is provided a participation letter to acknowledge approval of receipt of other Medicaid services.
The CAP IT 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 an annual assessment is performed on all active waiver participants. Upon the completion of the assessment, the CAP IT 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 IT 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 support 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 responsibility for his or her personal choices through surrogate decision making or through planning team consensus. This agreement outlines the risks and course of action. The IRA is primarily used to manage behavioral concerns, non-compliance of the service plan and other well-being concerns that can't be mitigated by a formal service. The individual risk agreement is in conjunction with the service plan and does not replace the service plan. The individual risk agreement is instrumental in creating a think-tank for the case manager and the waiver participant to process risks and identify ways to minimize them and to assume responsibility and accountability of decisions.

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 support system is 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 into an Individual Risk Agreement (IRA) to assume responsibility and accountability of decisions. A risk agreement permits a 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, with or without a Personal Emergency Response System;

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 well-being 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 an Adult Protective Services assessment or care plan, or the parent or responsible party refused to comply with Adult Protective Services where there is a high-risk factor of existing conditions of abuse, neglect, or exploitation.
For new individuals with any of the listed conditions addressed above, an acknowledgement agreement for a 90-day conditional waiver participation period may be implemented. During this 90-day period, an evaluation can be made to determine waiver participation is an option for that individual and risks can 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 the Risk Assessment and Mitigation Plan, each waiver participant will be required to have an emergency back-up 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 in-home 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 IT system generates letters at each step to inform the waiver participant about freedom of choice. This information describes 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 independent assessment entity (auditing of the independent assessment entity 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. An independent assessment entity will complete the initial eligibility phases of waiver consideration and validation of the developed service plan to ensure conflict of interest protection 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 on 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 or sooner based on the needs of the waiver beneficiary 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 or sooner based on the waiver beneficiary's needs 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 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 IT system provides 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 analysis 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, an adult with moderate to high risk indicator scores as identified in a completed assessment must have an in-person 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 assurance 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 support.

Case Manager should complete monthly contact via telephone or other secure means of contact with the participant. Case Managers shall make sufficient (more than quarterly) face-to-face contact contingent on 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, Microsoft Team, Zoom, and 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 an in-person face-to-face visit. The second and third quarterly visits may be conducted through technology when there is no evidence of a critical incident between the two monitoring periods. The fourth quarterly visit must be performed by an in-person 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 include completion of critical incident reports, completion of monthly and quarterly monitoring templates, upload of information in a communication log and technical assistance support from SMA. Each case manager is required to complete a critical incident report for both Level I and II incidents within the specified timeframe. Completed reports are automatically transmitted to the SMA for monitoring health, safety and well-being. The monthly and quarterly monitoring tools are programmed with risk indicators algorithms that provide 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 implemented to mitigate the identified risk factors.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

As a quality assurance to manage the monitoring of the service plan and to reduce conflict of interest for a case management entity that may be considered a dual agency, provider of case management and other Medicaid and waiver services, a clearly defined definition for COI is in place and is a requirement of the CME to follow and adhere and specific restrictive assurances are carefully monitored by State Medicaid Agency. These restrictive assurances include an analysis of network adequacy in that service region and a phone or mail questionnaire by representatives from the State Medicaid Agency to the waiver participant regarding access to his or her freedom of choice and engagement with the case management entity. As a means of documenting monitoring requirements and ensuring the waiver participant's needs are adequately met, the case management entity must review with the waiver participant information about disclosure of potential conflict of interest. The waiver participant must voice an agreement or provide written information that the person-centered plan continues to meet current health and social status. The CAP IT 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 in 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 is 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 Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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 participantsâ 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 PM: #/% of waiver participants who had a signed/approved SP that identified PC goals/strategies to meet identified needs through the provision of waiver

services/other resources N: # Waiver participants who had a signed/approved SP that identified PC goals/strategies to meet identified needs through the provision of waiver services/other resources D: # Waiver participants reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system CME	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	Frequency of data aggregation and analysis*(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-A2 PM: Number and Percent of waiver participants who had SP that addressed needs N: Number of waiver participants who had who had SP that addressed needs D: Number of waiver participants reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

	Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participantâs 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 PM: #/% of service plans that are revised/updated when warranted by change in the waiver participant's needs. N: number of service plans that are revised/updated when warranted by change in the waiver participants needs D: number of service

plans reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-C2 PM: Number/percent of service plans that re updated/revised at least annually N: number of service plans that are updated/revised at least annually D: number of service plans that were reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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 PM: Number and percent of waiver participants whose services were delivered in accordance with the service plan, including type and scope N: Number of waiver participants whose services were delivered in accordance with the service plan, including type and scope D: #Waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CME CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
SP-D2 #/% of waiver participants whose files were transmitted to the MMIS with PA service limits in the amount, frequency, and duration authorized in the service plan.
N: Number of waiver participants whose files were transmitted to the MMIS with PA service limits in the amount, frequency, and duration authorized in the service plan
D: number of waiver participants' files 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):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other**	☐ **Annually**	☐ **Stratified**

Specify: CSRA/NCTracks CAP IT System		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CSRA/NCTracks CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 PM: #/% of waiver participants who were afforded choice between/among waiver services and providers N: # waiver participants who were afforded choice between/among waiver services and providers D: # waiver participants' records reviewed

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

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

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
CAP IT system	
	☒ **Continuously and Ongoing**
	☐ **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 IT system is a business system employed by the State Medicaid Agency to manage the service plan development and to ensure assessed needs are adequately planned in the type, scope, duration and frequency, initially, annually and as needed. This system assists in the discovery of non-compliant service plan development practices through aggregating and analyzing waiver activities workflow. The state's process of discovery and problem identification will be performed quarterly to ensure compliance with this assurance.
The CAP IT system performs the following tasks to ensure compliance to service plan development policies and procedures which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- Completion of a comprehensive assessment, initially and annually
- Risk indicators based on assessed needs
- RN exception reviews to reassess health care information, when applicable
- Person-centered service plan
- Notification letters to providers and waiver participants
- Individual risks agreements
- Service authorization
- Prior approval segments
- Workflow timelines and alerts

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs 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 service plan development, the State Medicaid Agency notifies the non-compliant entity within 30-days of the discovery; requests a corrective action plan and a root cause analysis to remediate the concerns. The State Medicaid Agency provides technical assistance and training on policies and procedures. 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 throughout the duration of the action plan. If the non-compliant issue continues, a freeze on performing service plan development activities for waiver participants is imposed on that entity until continuous quality is achieved. If, after 3 months of assistance and remediation strategies are not productive and quality cannot be achieved, the entity assigned to complete service plan development responsibilities will be placed on a probationary status for 3 months (removed from the freedom of choice list until compliance is achieved during the probationary period). If after 6 months of probationary technical guidance and quality in the area of service plan is not achieved, the entity 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system CME	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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.

The participant direction opportunities afforded to waiver participants:
This HCBS program allows a waiver participant to direct his or her care using a consumer-directed model of care using both the employer authority and budget authority. When a request is made to enter this HCBS program, a Participant Disclosure Form is provided to the interested individuals. Within this form information is provided about the service options of this HCBS program and the right to direct care once demonstrated competencies are confirmed to assume the role of employer or designation of a representative who can demonstrate the required competencies. An approved waiver participant may select this option of care at the onset of waiver entry or at any point in time during their waiver participation. To initiate enrollment in this model of care, each waiver participant must complete a self- assessment questionnaire and an orientation training before exercising their right to select this model of care. The self-assessment questionnaire identifies areas of strengths, weaknesses and opportunities for skill building to assume the role of employer while the orientation training introduces the waiver participant to consumer-directed policies and procedures, State Plan Medicaid terms, Internal Revenue Service requirements, Department of Labor laws and program integrity compromises. Upon the completion of the self-assessment questionnaire and orientation training, a waiver participant is placed on a path to direct their care. This path may be direct enrollment into this model of care once all administrative requirements are met or a transitional phase-in upon the completion of identified skill-building techniques as identified through the self-assessment questionnaire.
The process by which participants may access these participant direction opportunities:
During the comprehensive assessment phase of waiver enrollment, quarterly multidisciplinary team meetings or annual reassessment, the HCBS participant is asked of their interest in directing care using the consumer-directed model. If the response is yes, the waiver participant is provided a self-assessment questionnaire to complete to allow the assessment of strengths, weaknesses and opportunities for skill-building in assuming the role of employer. The assessment areas of the self-assessment questionnaire include: Is Consumer-directed care right for me; What are my health care needs; What areas do I need help; Thinking Like an Employer, Findings the right Employee to meet my Care Needs; and Competency Validation of direct care staff. Upon the expressed interest to direct care using the consumer-directed model of care, the SMA and assigned case management entity conduct an orientation training and provide consumer-directed educational materials to ensure an informed decision to participate in this model of care is made. A requirement initial and refresher training is required before enrollment in consumer-directed care can be approved.
Upon the demonstration of competencies to direct care, the waiver participant signs an enrollment agreement that states their willingness and capability to direct their care as evidenced by their expressed understanding of the rights and responsibilities of directing one's own care; agreement to collaborate with entities that play a role in supporting participants who direct their care; agreement to validate all direct care workers prior to hiring and participation in annual consumer-direction education and training session.
The entities involved in supporting participant direction and types of supports by each entity:
There are three specific entities that support the waiver participant to successfully participate in this model of care. These entities are State Medicaid Agency, Case Management Entity and Financial Management Services (FMS) providers.
The Medicaid State Agency:
Support is provided by the State Medicaid Agency through:
1. Development of policies and procedures for the administration of this option of care.
2. Administrative oversight to designated entities providing support to waiver participants.
3. Management of a grievance and complaint system to respond to grievances and complaints.
4. Management of a critical incident management system for the management of critical incidents while participating in this model of care; and
5. Quality improvement initiatives to remediate non-compliance discoveries for continuous quality improvement
6. Mandatory initial and annual training on consumer-directed care
The Case Management Entity:
Support is provided by the Case Management Entity through:
1. Direct contact with the waiver participant on a monthly, quarterly, and as needed basis to monitor health care needs and progression towards person-centered goals.
2. Regularly scheduled multidisciplinary team meeting to assess benchmarks, achievements, access to care concerns and other topics as identified.
3. Approval of the service plan to assist with authorizing providers of services as listed in the plan of care.
4. Arranging alternative care in the event natural support network is unavailable.
5. Assisting the waiver participant with grievances or complaints or filing an appeal, when applicable; or
6. Troubleshooting payment issues when there is a system error or payment failure.
7. Discussing the results of the self-assessment questionnaire.
8. Ensuring all qualifying requirements are met before enrollment in consumer-directed care.
The Financial Management Entity:

Support is provided by the Financial Management Entity through the completion of:
1. A consumer-direction orientation comprising of employer rules and labor laws to waiver participant, employer of record, and employees.
2. IRS forms for employer and employee.
3. Background and registry checks and age verification on all interested employees.
4. Budget analysis based on negotiated hiring rates.
5. Expenditure reports to manage budget; and
6. Payroll to include tax withholding.
This entity provides customer service support to 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

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case management entity is responsible for providing waiver participant/primary caregivers/legally responsible party sufficient information to ensure informed decision-making and understanding of the consumer-directed service option and the provider-led service delivery option. The information includes the responsibilities and choices individuals may make with the election of the consumer-directed service option. The Disclosure Notice and the Welcome letter include information about consumer-directed care. The assigned case manager also reviews the consumer-directed services option at program enrollment, at least annually, or upon request. This information is provided orally and in writing to the waiver participant, and the legally authorized representative by the case management entity.
The information that is provided includes:
• An overview of the consumer-directed services option;
• Explanation of responsibilities of the individual or individual's legally authorized representative and the consumer-directed service agency in the consumer-directed service option;
• Explanation of benefits and risks of participating in the consumer-directed services option;
• Self-assessment questionnaire requirement for participation in the consumer-directed services option;
• Explanation of required minimum qualifications of service providers through the consumer-directed services option; and
• Explanation of employee/employer relationships, that prohibit employment under the consumer-directed services option.

During the initial enrollment in the consumer-directed option, a Financial Management Services (FMS) agency performs financial intermediary (FI) services as listed below:
• Information, training and outreach to waiver participant, EOR, and employee;
• 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, EOR, and employee?
• 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 in-home 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 consumer-directed 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 in-home care assistants;
• Maintaining monthly contact with the care advisor and other essential members of the MDT;
• Ensuring all required paperwork is received before approving the EOR or direct care worker; and
• Assuring accessibility to customer service for waiver participants to submit claims and seek guidance for technical problems or concerns.
The FI and the case management entity will monitor the compliance of all self-assessment tools to ensure appropriateness of directing care.
The care advisor will inform roles and responsibilities associated with a consumer-directed care, explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual/representative to modify individual budget. The care advisor will also provide:
• Assessment of individual risk;
• Assessment of health, safety, and well-being of the person as well as the continued appropriateness of services and supports;
• Identification of the need for a representative for the waiver participant, who desires to direct his/her own services and supports, and ensures that the representative, meets established criteria to assist the participant to self-direct their supports/services;
• Quality assurance of the person-centered plan, identifies how emergency back-up services will be furnished for workers employed by the individual, and authorizes the provision of on-call emergency back-up services;
• Report critical incidents; and
• Addresses complaints, grievances, and appeals.

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:

This HCBS program permits the appointment of a legal representative to direct care on behalf of the waiver participant. A legal representative is appointed when the waiver participant or the participant's responsible party requests assistance or has demonstrated a need for assistance. The case management entity assists the waiver participant in identifying a legal representative and assure the representative meets the specified criteria. The legal representative must:
• be at least 18 years of age;
• be approved by the waiver participant to act in this capacity;
• agree to a predetermined level of contact with the participant;
• demonstrate knowledge and understanding of the participant's needs and preferences;
• use sound judgment to follow the participant's needs and preferences; and
• comply with all program requirements.

The representative is not reimbursed for providing representative tasks. The case management entity is responsible to monitor activities to ensure the appointed representative acts in the best interest of the waiver participant. If a representative is identified, the representative will be asked to sign the "Representative Agreement" provided by the case management entity. The 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 case management entity monitors the delivery of services monthly and reports any concerns to the FM and the State Medicaid Agency.

The representative may not be the personal assistant for the participant or provide any other paid waiver services.

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
Coordination of care - case management and care advisement	☒	☒
Individual Directed Goods and Services	☒	☒
Respite Services	☒	☒
Financial Management Services	☒	☒

Waiver Service	Employer Authority	Budget Authority
Personal Assistant Services	☒	☒
Training/Education and Consultative Services	☒	☒

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 that meet the required credentials may enroll as a Medicaid provider of financial management services. The entity must have the following credentials:
• A minimum of three years of financial management services experience with other departments or divisions of state government, county government, municipal governments, or large corporation employers;
• Experience and knowledge of the following: automated standard application of payment, check claims, electronic fund transfer, electronic fund account, invoice processing platform, judgement fund, payment application modernization, prompt payment, automated clearing house, Cash management Improvement Act, Governmentwide Financial Report System (GFRS), governmentwide accounting, intergovernmental reconciliation, standard general ledger, and tax payer identification number processes;
• Have the capacity to provide financial management services through the Budget and Employer Authority models of consumer-directed care; and
• Authorized to transact business in North Carolina.

Because these entities are private entities, 45 CFR § 92.42 are adhered. The approval process is a request for information (RFI) to render FMS. The receipt of the information is reviewed to determine ability to render this type of service. Multiple entities may be selected to furnish FMS.
The provider must meet all the qualifying conditions listed in Appendix C-1/C-3 and all other Medicaid enrollment requirements. A managed change request is submitted to MMIS for provider enrollment to request consideration to render FMS and approved by the member of the waiver unit.

A managed change request is submitted to MMIS for provider enrollment to request consideration and approval to render FMS.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS provider is enrolled as a Medicaid provider approved to render financial management service which is an approved home and community-based services of this HCBS program. This service is called financial management and is reimbursed as a fee-for-service rate methodology. The maximum utilization per month is one unit. The FMS provider is compensated a one-time fee for the enrollment activities completed and a monthly fee for ongoing FMS provided to the participant. This service utilization is included in the service plan in the amount, frequency and duration. Claims are made to the MMIS for reimbursement of start-up and monthly management fees.

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:

The FMS provider completes criminal history record and health care registry checks on the personal assistant(s) and assist the waiver participant or designated representative in understanding the findings of the reports. The FMS provider educates the waiver participant/EOR on protocol in the event a report returns with results that are not in compliance with the State Agency's criteria for personal assistant in the consumer-directed model of care.
The FMS provider provides education to the waiver participant/EOR on responsibilities of being an employer and information on appropriate employee/employer relationships.

Ongoing customer service support is provided to assist the waiver participant/EOR or designated representative with any questions or concerns related to services provided by the FMS provider.

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:

The FMS provider issues guidance to the waiver participant/EOR or designated representative on appropriate spending practices to ensure spending is within budgetary limitations (i.e. discussion of overtime payment to employees, factors that may affect pay rates, such as tax factor changes).

The FMS does not act in the role as a co-employer.

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.

As a Medicaid provider, the FMS provider must complete recertification as determined based on their enrollment status. The State's Medicaid fiscal agent oversees provider enrollment and recertification to ensure the FMs continues to meet the requirements for a Medicaid provider.

The State Medicaid and the case management entity monitor the execution of the FMS to ensure compliance with waiver policies and procedures. Expenditure reports are reviewed regularly to ensure consumer-directed services are managed appropriately by the FMS provider.

The CAP IT system in conjunction with the case management entity generate prior approval notices to the FMS provider and the State's Medicaid fiscal agent that identify the type, amount, frequency, and duration of approved services to provide. The State's Medicaid fiscal agent monitors the prior approval notices monthly to ensure financial transactions are within the established allowable limits.

The State Medicaid agency conducts monthly monitoring reviews with the FMS provider to address performance, incidents, and provisions of financial management services.

The FMS provider shall provide quarterly reports to the State Medicaid Agency to include detailed payroll budget utilization reports (per waiver participant) that includes:
• Vendor name
• Vendor number
• Case management entity name
• Care advisor name
• Participant name
• Participant identification #
• Authorization date: From___ To____ for participant
• Service code(s) for authorized services
• Annual authorization $ amount for participant
• Amount of FUTA, SUTA, and FICA taxes withheld within current quarter
• Payroll period(s): From ___ To ___ within current quarter
• Participant's total expenditure for pay period(s) within current quarter
• Name, number of hours worked and rate of pay for each participant's personal assistant designated personal assistant hours per week within current quarter
• Total number of hours worked, gross wages, net wages, FICA taxes, and other deductions for each personal assistant within current quarter
• Authorization budget balance carried forward for waiver participant
• Amount remaining on annual authorization for waiver participant
• Annual authorized amount for participant for other consumer-directed services
• Budget balance carried forward for participant for other consumer-directed services
• Expenditure amount for pay period for participant for other consumer-directed services
• Workers Compensation policy date: From_____ To_____ for participant
• Workers Compensation annual policy premium rate for participant
• Workers Compensation bi-weekly amount for participant

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

☒ **Waiver 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
Coordination of care - case management and care advisement	☒
Nutritional Services	☐
Individual Directed Goods and Services	☐
Respite Services	☐
Pest Eradication	☐
Chore Service- Declutter/Garbage Disposal	☐
Personal Emergency Response Services	☐
Financial Management Services	☐
Non-Medical Transportation Services	☐
Participant Goods and Services	☐
Specialized Medical Supplies	☐
Meal Preparation and Delivery	☐
Coordinated Caregiving	☐
Adult Day Health	☐
Personal Assistant Services	☐
Community Integration Services	☐
Equipment, Modification and Technology	☐
CAP In-Home Aide	☐
Training/Education and Consultative Services	☐
Community Transition	☐

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- ○ **No. Arrangements have not been made for independent advocacy.**
- ◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Waiver participants are provided with information on opportunities to access independent advocacy. This information is provided by the case management entity and the financial managers during initial enrollment, anniversary and upon a request. Independent advocacy may be obtained through by the following agencies: Community Resource Connection program sponsored by the Division of Aging Services (DAS), NC 211, the Department of Health and Human Services (DHHS) Call Center, NC360Cares, and Legal Aid of North Carolina.
The DAS provides counseling, training, and technical assistance in how to live independently and how to arrange and access resources in the community. North Carolina has various DAS offices located throughout the state and accessible Monday-Friday from 8am-5pm for in person, in writing, or telephone assistance.
The NC 211, NC360 Cares, and DHHS Call Center provides information, referrals, education and outreach to individuals requesting assistance. The NC 211, NC360 Cares, and DHHS Customer Service Center is available 24-hours, 7-days per week and includes interpretive services for non-English speaking callers.
Legal Aid of North Carolina offers free legal services in civil matters to low-income individuals. Legal Aide offices are located throughout the state and accessible Monday-Friday from 8am-5pm.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A waiver participant enrolled in consumer-directed services may elect to withdraw from this option of care at any time. A transition plan is created immediately upon the expressed desire to transition to provider-led model of care. The transition date is planned for the last day of the transition month to allow the alternative service delivery method to occur the first day of the month following the transition month. The following steps are followed to complete a waiver participant requested to transition from the consumer-directed model of care:
1. The waiver participant or designated representative informs the assigned case management entity of their desire to transition from the consumer-directed model of care.
2. The case management entity provides the waiver participant or designated representative with a freedom of choice form to select a service provider agency to provide in-home care services.
3. The case management entity collaborates with the waiver participant or designated representative to update the person-centered service plan to reflect the transition from consumer-directed model of care. The waiver participant or designated representative confirms their agreement to transition by signing the service plan.
4. The case management entity submits the updated person-centered plan of care into the CAP IT system.
5. The CAP IT system analyzes the person-centered plan of care to ensure accuracy of performance measures to allow for approval and sign off by the local approval.
6. The CAP IT system generates the new program participation letter, and the case management entity sends a letter to the waiver participant. Newly selected providers are provided service authorization letters.
7. The waiver participant or the designated representative and the FMS provider notify the personal assistant(s) of the transition to provider-led services.

The waiver participant's services are uninterpreted as well as the preservation of health, safety, and well-being for the duration of the transition. The case management entity increases the oversight and monitoring of the beneficiary to a weekly basis to mitigate any unplanned or unforeseen risks.

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.

The State Medicaid Agency will involuntarily remove a waiver participant from the consumer-directed model of care and require the participant to receive provider-led services when the following concerns cannot be managed despite agreements and support:
• Immediate health, safety, and well-being concerns
• Utilization of funds exceeding planned expenditure levels for consumer-directed care when the overage cannot be managed through corrective actions and measures
• Substantiated fraud, waste, and abuse from the waiver participant or designated representative
• Substantiated abuse, neglect, or exploitation from a personal assistant and the inability to select a new personal assistance
• Demonstrates inability to consumer-direct as evidenced by consistent non-adherence to program rules despite corrective actions and measures
• Confirmed misuse of waiver funds and services
• Repeated use of unapproved expenditures that cause the budget to be over maximum limits
• Conflict of interest by the waiver participant's responsible party which ultimately places the waiver participant at greater risk
• Inability or unwillingness to select an approved representative when the need for a representative has been identified by the State Medicaid Agency, Financial Management entity or case management entity
• Refusal to accept training or arrange training for hired workers
• Refusal to allow case management entity to monitor services
• Refusal to participate in mandatory monthly and quarterly monitoring requirements
• Non-compliance with supportive entities to include the State Medicaid agency, case management entity, or FMS provider
• Non-compliance with an established corrective action or quality assurance plan issued to the participant or designated representative
• Inability to implement the approved plan of care or comply with waiver requirements

The State Medicaid Agency will remove a waiver participant from the consumer-directed model of care if any of the above items occur three times or more in a 12-month period as documented by a completed participant corrective action plan. Immediate termination from consumer-directed model of care may occur if there is blatant misuse of waiver funds or the participant's health, safety, and well-being is in jeopardy. Prior to considering initiating a termination from consumer-directed care, the case management entity will report the concern or allegation to the State Medicaid Agency. The State Medicaid Agency will investigate the concern or allegation. The State Medicaid Agency will review all available documentation related to the concern or allegation. Upon review of all information, the State Medicaid Agency will make a determination of immediate removal from the consumer-directed model of care. The State Medicaid Agency will coordinate with the case management entity to complete processes for the removal.

The participant will receive written notification on the involuntary termination and the timeline of the transition. All supportive entities: State Medicaid Agency, case management entity, and FMS provider will coordinate to establish a timeline and effective date of the termination. The participant will be allowed the opportunity to select provider-led model of care to receive services. The FMS provider and participant will inform the personal assistant(s) of the transition and the impact the transition will have on their employment.
To ensure continuity of care and the waiver participant's health, safety, and well-being, the waiver participant will continue to receive services as listed on the current person-centered plan of care until consumer-directed model of care is terminated. If this termination required immediate removal from this model of care, the State Medicaid Agency will arrange for the waiver participant to select a provider who is able to submit claims for consumer-directed services until the program changes are made.

The participant has the option to file an appeal regarding the concerns resulting in the termination from this model of care. Upon the change to the new model of care, the waiver participant will be provided a change of program notice at which time he or she may request an appeal. If an appeal is requested and the waiver participant is not in immediate jeopardy, consumer-directed service will continue through the duration of the appeal through maintenance of service.

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		3404
Year 2		3744
Year 3		4118
Year 4		4529
Year 5		4981

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 participant will have a maximum budget limit to negotiate a pay rate for hired employees. This limit is the Medicaid maximum listed on a published fee schedule for the service approved in the service plan. The approved negotiated rate is included on the plan of care which is developed based on the methodology currently in place as listed in Appendix C-4. The process involves the completion of an assessment to identify needs; development of goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. A completed assessment identifies the composite score for complexity of need of the waiver participant to ensure appropriate planning of care needs and resources. All formal services are listed in the plan of care to identify an estimated monthly cost of care for all waiver service to ensure the cost does not exceed the estimated monthly cost of an individual in an institution. During the enrollment into consumer-directed care, the FMS provider provides information to the waiver participant regarding how to set a rate of pay including flexibility for pay increases, unexpected changes, maximum utilization of waiver services, Department of Labor overtime and minimum wage requirements. Information shared include how the pay rate must budget for wages for the personal assistant(s), applicable taxes, insurances overtime payment and Workman's Comp. To provide the waiver participant with an overview of monthly expenditures under the consumer-directed model of care, the FMS provider creates a consumer-directed budget. The FMS provides information to the waiver participant or designated representative to ensure understanding and agreement about how to establish and manage a personal assistance budget. An example of a completed budget is shared with waiver participant to build competencies. The negotiated pay rate is added to the plan of care to ensure the rate does not exceed the State Medicaid Agency approved reimbursement limits including applicable taxes, insurances overtime payment and Workman's Comp. An assessment of the service plan is reviewed with the waiver participant monthly to determine any changes in the participant's status that may warrant a modification of the budget.

The SMA posts publicly a Fee Schedule that lists the maximum reimbursement for waiver services that can be directed by the waiver participant. One other training document is used that is publicly available to the waiver participant and other stakeholder is a budgeting resource tool. This tool provides information about the budget and how to create a budget. The waiver participant is informed of the maximum limit. Through training and education by the SMA and the FMS, the waiver participant is taught how to create a range of pay within the maximum limit and DOL guidelines that is consistent with their budget

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.

The waiver participant/EOR is informed of the amount of the consumer-directed budget during initial enrollment, quarterly monitoring periods and during the annual reassessment and as requested by the waiver participant. The FM provides the waiver participant/EOR or designated representative with a monthly report to show his or her current budget and utilization trends. The waiver participant/EOR may request and view information about his or her utilization trends upon request from the FM.

To request an adjustment in the budget amount; the waiver participant must request a change of status assessment through the case management entity to initiate this process. The case management entity will complete an assessment and the information is entered into the CAP IT system to determine the complexity of need and budgetary limit.

To request an adjustment in the budget related to negotiated pay rates; the waiver participant must request the change from the FM; in coordination with the assigned case management entity. Any requested changes must correspond with established budgetary limits. The FM will review the requested changes with the waiver participant and correspond with the case management entity to determine if the budget amount can accommodate the pay rate changes based on the State Medicaid Agency maximum reimbursement limits.

A waiver participant whose request is denied for a budget adjustment or when a budget is reduced, is granted the opportunity for a Fair Hearing as outlined in Appendix F, when a service request is denied, reduced or terminated.

Prior to the denial of the request or the reduction of the budget, information is provided to the waiver participant/EOR by the case manager or financial manager about why the request approved or why the budget must be reduced. The CM and FM work closely with the waiver participant to determine strategies to adjust the budget or prevent a reduction in the services. When no other alternatives are available, the waiver participant is provided an adverse notice with appeal rights.

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:

The waiver participant/EOR may request modifications to the budget amount at any time to the case management entity. A request to the waiver participant-directed budget requires the completion of a change of status assessment. The change of status assessment is initiated in CAP IT system and completed by the case management entity. The CAP IT system will determine the updated budgetary limits based upon the participant's composite score for complexity of need. Modifications to the participant-directed budget are documented in the service plan by the case management entity. The updated participant-directed budget information is forwarded to the FMS to ensure utilization is consistent with budget modifications.

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:

The FMS provider tracks the usage of the participant-directed budget monthly. The FMS provider generates expenditure reports that illustrates utilization of the waiver participant's budget. The waiver participant, Medicaid State Agency, and case management entity have access to review the budget reports. The FMS shall report any identified "red flag" cases to the State Medicaid agency. Red flag cases are cases that illustrate over utilization of the consumer-directed budget or cases that have the potential to exceed the consumer-directed budget. The Case management entity conducts monthly and quarterly monitoring the waiver participant which include a review of the participant's budget report. Reports that indicate budget concerns (over-utilization or under-utilization) are reviewed and discussed in detail with the waiver participant to develop an action plan to ensure utilization aligns with the established budgetary limits. Continued instances of over-utilization or under-utilization must be reported to the State Medicaid agency. The State Medicaid Agency will conduct a review to determine if consumer-directed care remains appropriate or if a transition to provider-managed waiver option is necessary.

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.

Each individual or currently enrolled waiver participant is granted a Fair Hearing when an adverse decision is made for initial waiver entry, ongoing waiver participation, denial of a provider or program choice or when a requested waiver service is reduced, denied, terminated or suspended or not honored. A Participant Disclosure form is a method used to inform interested individuals and active participants about the fair hearing process when accessing services through this HCBS program. This form is provided after the analysis of a submitted service request form that determines clinical eligibility for HCBS participation as well as during the annual reassessment for HCBS participation. The form clearly outlines the steps for eligibility for waiver entry and access to waiver services, rights to request a fair hearing when an adverse decision is made and how to request a fair hearing. Contact information such as telephone numbers and addresses are provided on the Participant Disclosure Form. In addition to the Participant Disclosure Form, when an adverse decision is made, each waiver participant is granted a letter of notice that clearly describes the original request and the reason(s) the request was denied, reduced or terminated. The notice letter also includes instructions on how to appeal this adverse decision. Included in the adverse letter notification is an appeal form with pre-populated identifying information to allow ease of filing. The notice letter also provides information on how services will be continued during the period while the appeal is under consideration in accordance with42 CFR §431.230. The waiver participant is instructed to mail in the letter within the prescribed time frame to continue to receive services through maintenance while the request goes through the fair hearing process.
The State Medicaid Agency manages all adverse hearing to ensure timelines were met, clear supporting information is provided for the adverse decision and service entitlements are maintained during the appeals process.
The Fair Hearing timelines are listed below and can be access through this link:
https://files.nc.gov/ncdma/documents/files/DueProcessRights050311.pdf

Information and instruction on how to request an expedited hearing.
The requirements of the appeals process must be consistent with the fair hearing established at 42 CFR Part 431, Subpart E, and NC Gen. Stat. § 108A-70.9A.

Appealing a Medicaid Adverse decision 30 days of the date the notice was mailed
Hearing resolution 90 days of the (Office of Administrative Hearing) OAH's receipt of the completed Recipient Hearing Request Form
Maintenance of Service (MOS)Appeal request submitted 10-30 days for the date the notice was mailed.

How notice is made, the entity or entities responsible for issuing the notice and where notices of adverse actions and the opportunity to request a Fair Hearing are kept:

The notice about the fair hearing is provided to the waiver participant by the entity performing the specific task of determining eligibility of a request. The Independent Assessors will provide the Participant Disclosure Form when an initial request to participate in this HCBS program is made. This notice provides the interested individual basic information about entry eligibility and steps to take if an adverse decision is made or when a request is not honored. This form is mailed to the individual in regular US Mail along with a consent form to gather pertinent health information. The case management entity or IAE also makes direct contact with the interested individual by telephone or in person to discuss this process and reasons adverse decision may be made.
The Case Management entity and Independent Assessment Entity are responsible for providing an adverse notice to a newly interested individual or an active HCBS participant if the assessment of need is denied for HCBS participation. This adverse notice is mailed. The case management entity or the IAE also makes direct contact with the interested individual by telephone or in person to discuss this process and reasons an adverse decision were made. The case management entity or IAE sends the notice by trackable mail to the individual using the State Medicaid address on file or the most recent address if the individual is not eligible for Medicaid. The mailing is tracked to ensure it was retrieved by or delivered to the individual within the established time line. An electronic copy of the letter is maintained in the IT system for reference as well as access for the assigned case manager to reference.

The case management entity (CME) will provide an adverse notice if a service plan or item(s) on a plan of care is denied, reduced, terminated or suspended. The case management entity is responsible for providing an adverse notice to an individual if service plan or plan of care is denied, reduced, suspended or terminated. The waiver participant may request a fair hearing if he/she feels a service request was not honored/acknowledged. This adverse notice is mailed. The CME also makes direct contact with the individual by telephone or in person to discuss this process and reasons adverse decision was made. The CME sends the notice by trackable mail to the individual using the State Medicaid address on file or the most resent address if the individual is not eligible for Medicaid. The mailing is tracked to ensure the notice is was retrieved by or delivered to the individual within the prescribed time line. An electronic copy of the letter is maintained in the IT system for reference.

Assistance (if any) that is provided to individuals in pursuing a Fair Hearing

The Participant Disclosure Form provides interested and active participant's contact information to the State Medicaid Agency, the case management entities in the catchment area, the IT contracted vendors and the customer support center/call center to request assistance when needed. The adverse notice and the appeal form also includes similar information. The interested or active participant may request assistance from anyone to assist to pursue a fair hearing. The CME also aid an active HCBS participant in pursuing a fair hearing.

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:

DHHS – State Medicaid Agency

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).

Types of grievances/complaints that participants may register
A HCBS participant may register a grievance or complaint regarding any subject matter pertaining to waiver participation or dissatisfaction with services or providers. Common grievances/complains may consist of the following:
• Program integrity concerns such as perceived exploitation of funds beneficiary/caregiver fraud, provider fraud
• Rights and responsibilities concerns such as perceived violation of privacy/rights unethical behavior
• Qualified provider concerns such as perceived unqualified personnel, unauthorized services, disregard for the plan of care, inadequate or inappropriate care or service delivery, no supervision, staff unreliable – late or doesn't keep schedule, customer service issue, constant staff turnover, staff not courteous or respectful of the beneficiary and or family
• Service provisions concerns such as delayed services, service limitations, non-covered service, placement on a wait list, and billing and reimbursement errors
Complaints can be reported by:
• Waiver participant or Representative
• Direct Service Provider
• Case Management Entity
• CAP IT System
• Independent Assessment Entity
• Stakeholders
Complaints may be submitted both verbally and in writing. Persons submitting verbal complaints will be encouraged to put the complaints in writing. Complaints can be received through mail, email or fax.
Anonymous complaints will be reviewed in situations that allege issues that are critical to the health and safety of an individual served. Complaints alleging abuse, neglect or exploitation will not be handled through this complaint protocol. A critical incident report will be completed by the case manager; and a referral made to Adult Protective Services.

(b) The process and timelines for addressing grievance/complaints
Complaints/Grievances/Inquiries come directly to State Medicaid Agency staff via telephone, email, mail or the IT Case management system called e-CAP. Complaints/Grievances/Inquiries may also come in as Constituent Request through the DHHS Director's Office, NC Governor's Office, DHHS Secretary's office of Government Affairs, NC General Assembly Members/Division Staff, US Congress Members. The grievance/complaint is assigned to a subject matter expert for research and analysis to formulate a response and identify the root cause.
Constituent Requests require that State Medicaid Agency staff to take appropriate action to resolve the request and compose a comprehensive response to the constituent or referral source in a business letter format referencing the Requestor name, referral source, Date of Inquiry, issue, State Medicaid Agency staff actions in chronological order to include dates and names of State Medicaid Agency staff and the external parties contacted. State Medicaid Agency staff must also indicate the resolution date and the outcome. Constituent Request responses must be approved by the Division prior to forwarding finale response to the constituent. Responses to Constituent Requests are due within 3 business days, but may require an extension due to data report generation or external collaboration. When Constituent Requests are assigned with an "Urgent" status they require same-day completion.
If it is determined that a Complaint/Grievance/Inquiry does not require a formal response to NC Governor's Office, DHHS Secretary's office of Government Affairs, NC General Assembly Members/Division Staff, US Congress Members, State Medicaid Agency staff will take appropriate action to resolve the Complaint/Grievance/Inquiry and will provide a resolution within 3 business days when possible. Depending on the need for external collaboration, a more extended resolution time may be required.
The following actions may be taken:
o No action needed
o Technical Assistance required
o Recoupment/Overpayment
o Recommendation for Termination
o Referral to Program Integrity
o Referral to Division of Health Service Regulation
o Referred/reported complaint to DHHS Division
o Development of a Quality Improvement Plan
o Recommend care giving training/teaching
o Recommend staff training/teaching
o Recommend change in treatment regimen
o Implementation of a Risk Agreement
o Implementation of a Corrective Action Plan

All Complaints/Grievances/Inquiries and Constituent Request are documented in e-CAP or in a shared drive and archived for trending.

The complainant is informed that filing a grievance or complaint does not substitute for a fair hearing.

(c) The mechanisms that are used to resolve grievance/complaints
Complaint investigations may include but is not limited to interviews with the beneficiary, formal and informal supports or other appropriate individuals, record reviews, staff interviews, site visits, documentation for billing and e-CAP monitoring system.

An official written response is provided to the complainant to address the grievance/complaint. A description of the concern is restated to ensure understanding and information is provided about the steps taken to research or invest the concerns and lately information is provided about the steps the Division will make or the complainant could take to resolve the identified issues. If there is discovery of non-complaint areas during the research or root cause analysis steps, the State Medicaid Agency identify areas for remediation and opportunities for continuous improvement. Changes are immediately made to workflow and training is provided.
Data collected will be aggregated and used to identify system-wide issues, for risk prevention and to improve the quality of services. The Quality Unit will direct an analysis of the compiled data. This will include trends in type and provider and effectiveness of district response. This analysis will be part of the quality management team activities and will be reviewed monthly.

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 incidents. 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 IT system. The CAP IT system will track receipt of all critical incident reports to assure a 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 incidents must be reported within 3 business days in the CAP IT system. These incidences include hospitalizations, ER visits, death by natural causes, failure to take medication as ordered, and missed schedules for CAP In-home aide and personal assistant services.

Level II incidents must be reported within 3 business days to the State Medicaid Agency. These incidences include, APS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, all types of falls and specifically 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, 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 l)

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 matter 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 in an area not generally vulnerable to trauma), or the number of injuries observed at one particular 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 is not limited to a device or garment that interferes with freedom of movement or withholding assistance or mobility device to a dependent participant for the purpose of interfering with the participant's free movement.
Chemical restraint means the administration of drugs with the intent of significantly curtailing the normal mobility or normal physical activity of a participant.
Involuntary seclusion means the separation of a participant from others such as in a locked room, or from the participant's room or against the participant's will or the will of the participant's guardian/representative. Involuntary seclusion does not mean separating the participant from other individuals on a temporary and monitored basis.
Suicide (combine with death) (LEVEL II)
Suicide is the act of taking one's own life voluntarily and intentionally.
Suicide Attempt (LEVEL II)
Suicide attempt is the act of deliberately harming oneself with the intention of causing death.
Treatment and Medication Errors (LEVEL II)
A treatment error involving medication is defined as any medication management event that results in a participant requiring medical services beyond first aid. This would include any preventable event that may cause or lead to inappropriate medication use 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 type 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 IT 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 a state Medicaid agency are reports of abuse, neglect and exploitation that are referred to the local DSS Adult Protective Services or equivalent programs operated by Federally Recognized Tribes. Article 6, Chapter 108A of the North Carolina General Statutes requires that county departments of social services perform certain activities for disabled adults 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.

Eastern Band of Cherokee Indian(EBCI)Tribal Code, Article II, Section 108 outlines requirements, inclusive of reporting for tribal members on trust lands.
The County Departments of Social Services or the Eastern Band of Cherokee Indian(EBCI) must accept all reports alleging abuse, neglect, or exploitation of a disabled adult who needs protective services. This includes anonymous reports.
North Carolina has a mandatory reporting law. Any incidents containing allegations of abuse, neglect or exploitation

must be immediately reported to the local Department of Social Services responsible or equivalent programs operated by Federally Recognized Tribes for investigation of abuse, neglect or exploitation allegations. Any person having reasonable cause to believe that a disabled adult needs protective services shall report such information to the director of the county Department of Social Services, or his representatives, or equivalent programs operated by Federally Recognized Tribes where the disabled adult 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 adult; the name and address of the disabled adult's caretaker; the age of the disabled adult; the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect; and other pertinent information. (G.S. 108A-102 or Article II, Section 108)

North Carolina conducts a comprehensive functional assessment (evaluation) to determine whether there is a need for protective services in situations where it is alleged that a disabled adult 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 adult from abuse, neglect, or exploitation. (G.S. 108A-101)or Article II, Section 108. North Carolina General Statutes require that any director or Tribal leader receiving a report that a disabled adult needs protective services shall make a prompt and thorough evaluation to determine whether the disabled adult needs protective services and what services are needed. The evaluation shall include a visit to the disabled adult 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 adult'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 workers/Tribal consult with one another about the facts of a particular 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 and 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 or equivalent programs operated by Federally Recognized Tribes for assistance with Adult Protective Services. You can also call your Case Management Entity or the Independent Assessment Entity” 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 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 high-level training Power Point on ANE in supporting waiver participants. The DHHS-Division of Aging Services provides semi-annual training in ANE that is accessible 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 for receiving the details of the event or incident to complete a critical incident report using the CAP IT 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, 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 IT system. The CAP IT system will track receipt of all critical incident reports to ensure 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 IT within 72 hours. The CAP IT 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 incidents must be reported within 3 business days the CAP IT system. These incidences include hospitalizations, ER visits, death by natural causes, failure to take medication as ordered, and missed scheduled CAP In-Home aide and personal assistant services.
Level II incidents must be reported within 3 business days to the State Medicaid Agency. These incidences include, APS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, all fall specifically 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 well-being of the waiver participant by refusing to comply with the terms of the plan of care, refusal to sign a rights and responsibility 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 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 identity 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 were 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 IT system is reviewed by the State Medicaid Agency on a quarterly basis and compared against the data query generated by DAS. These two reports are used to identify trends and strategies to mitigate future occurrences.

The case management entity shall initiate an investigation within 5 business days of a Level II incident report to ensure the health, safety and well-being of waiver participant. The waiver participant must be notified of the investigation within 15 business days of the incident. The waiver participant will receive a written letter from the case management entity detailing the investigation findings and results and the recommended mitigation/action plan to manage ongoing or future incidents within 30 business days of the incident. The case manager will arrange an in-person visit to review the letter detailing the results of the investigation with the waiver participant.

The Department of Social Service, APS section or Tribal APS program is responsible for evaluating all cases of abuse, neglect and exploitation. The Adult Protective Services unit has a prescribed timeframe of 24, 48 and 72 hours to investigate a report of ANE. The reporter is provided with 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 have specific guidelines for evaluating a case to determine if a waiver participant is at risk and needs protection. The assigned Adult Protective Service Worker evaluates the waiver participant cognitive skills to determine capacity to make decision and the need for supportive care. If a waiver participant is deemed not to be able to make appropriate cognitive decision, APS will provide an order of protection.

The state has an agreement with the state aging agency (Division of Aging Services-DAS) 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 or equivalent programs operated by Federally Recognized Tribes trains the APS workers in how to capture and complete the needed information for the report. A planning meeting is scheduled quarterly with the SMA staff and the DAS 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 IT 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 IT 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 the 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 in how to manage health conditions?
• 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 incidents. 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:

This HCBS program prohibits the use of restraints and restrictive interventions for all settings approved in this waiver. The care provided to these individuals must be non-invasive and free from restraints and seclusion, including personal restraints, drugs used as restraints or mechanical restraints.
Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to detect unauthorized use of restraints.
The case management entity is primarily responsible for detecting the unauthorized use of restraints through two required face-to-face visits and two other required visits that may be conducted using technology. However, if a concern is voiced or identified, the case management entity is required to make an unannounced visit to evaluate the concern and when necessary, call an ad-hoc multidisciplinary meeting to assess the unauthorized use of restraints. A critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery.
The case management entity will initiate referrals and investigatory steps within 2 business days of notification.
For this HCBS program, restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to a waiver participant's body that the waiver participant cannot remove easily, which restricts freedom of movement or normal access to one's body.
For this HCBS program, seclusion involves placing a waiver participant alone in a room or other area from which exit is prevented. This may or may not include the use of locking mechanism.
If a waiver participant is determined to be restrained or secluded, the case management entity or the service provider (if the service provider is not the offender) is required to contact law enforcement, adult protective services or the Department of Health Services Regulation (DHSR) to report the event.
Any known or observed use of restraints is referred to APS and Division of Health Services Regulation (DHSR), to investigate and report on their findings. The case management entity is responsible for monitoring the investigation and findings to assure the health, safety and well-being of the waiver participant. The State Medicaid Agency will also monitor the status of the report to ensure the critical reporting system is working as designed.
The use of restraints or seclusion with a waiver participant indicates an immediate need to reassess the waiver participant and his or her plan of care to determine if there are unmet medical or functional needs; whether the waiver participant's caregiver can appropriately deliver the required services while managing stress; and whether the HCBS program remains an appropriate choice for the waiver participant.
If a case management entity observes or learns that restraints, seclusion, or restrictive interventions are being used, a critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery.
The case management entity will initiate referrals and investigatory steps within 2 business days of notification.

○ **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:

The HCBS waiver does not permit, for all settings approved in this waiver, the use of interventions that restrict waiver participant movement; restrict a waiver participant's access to other individuals, locations, or activities; restrict a participant's basic freedoms or that employ aversive methods to modify behavior.
Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to detect unauthorized use of restrictive interventions.
The case management entity is primarily responsible for detecting the unauthorized use of restrictive interventions through two required face-to-face visits and two other required visits that may be conducted using technology. However, when a concerned is voiced or identified, the case management entity is required to make an unannounced visit to evaluate the concern and when necessary, call an ad-hoc multidisciplinary meeting to assess the unauthorized use of restrictive interventions. A critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery. The case management entity will initiate referrals and investigatory steps within 2 business days of notification.
•Waiver participant's basic freedom include sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, and use of bathroom facilities.
• Aversive methods or techniques are intended to cause pain or other unpleasant sensations such as contingent noxious stimulation, visual or facial screening (i.e., placing a cloth or other material over the face or eyes).
If SMA determines the use of the restrictive interventions is not in compliance with the requirements outlined above, the appropriate law enforcement and/or adult protective services will be contacted on the day of discovery to report the event. The SMA is responsible for monitoring investigations and findings to assure the health, safety and well-being of the waiver participant is being met.
The use of restrictive interventions with a waiver participant indicates an immediate need to reassess the waiver participant and their plan of care to determine if there are unmet medical or functional needs; whether the waiver participant's caregiver can appropriately deliver the required services while managing stress; and whether this HCBS program remains appropriate.
If a waiver provider or HCBS program consultant observes or learns restrictive interventions are being used, a critical incident report must be completed and submitted to SMA on the date of discovery. SMA will initiate referrals and investigatory steps within 2 business 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 dose not permit the use of seclusion including personal restraints and drugs for any waiver beneficiary for all settings approved in this waiver. Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to detect unauthorized use of seclusion.

The case management entity is primarily responsible for detecting the unauthorized use of seclusion through two required face-to-face visits and two other required visits that may be conducted using technology. However, when a concerned is voiced or identified, the case management entity is required to make an unannounced visit to evaluate the concern and when necessary call an ad-hoc multidisciplinary meeting to assess the unauthorized use of seclusion. A critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery. The case management entity will initiate referrals and investigatory steps within 2 business days of notification.

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 occurs, 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 business 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 Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs 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 instancesof 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 and percent of waiver participants who were screened for ANE where an appropriate action plan was implemented to address risk factors within 45-days of the report. N: Number of waiver participants who were screened for ANE where an appropriate action plan was implemented to address risk factors within 45-days of the report D: Number waiver participants screened for ANE

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
HW-A2: Number and percent of waiver participants who received SMA generated information on ANE, and how to report a concern of ANE N: Number of waiver participants who received SME generated information on ANE, and how to report a concern of ANE D: Number of waiver participants reviewed generated information

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin error
☐ **Other**	☐ **Annually**	☐ **Stratified**

Specify:		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW-B1 Number and percent of critical incident trends where systemic intervention was implemented Numerator: number of critical incident trends where systemic intervention was implemented Denominator: Total number of critical incidents reviewed

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system CMe	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW-B2 Number and percent of critical incidents where root cause was identified
Numerator: number of critical incident where root cause was identified
Denominator: number of critical incidents reviewed

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

CAP IT system CME		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW-B3 Number and percent of death incident reports for unexplained deaths that had a root-cause analysis narrative summation. Numerator: number of death incident reports for unexplained deaths that had a root-cause analysis narrative summation Denominator: number of death incident reports for unexplained deaths

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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 Number and Percent of providers with an approved policy by SMA prohibiting unauthorized restrictive interventions (restraints, seclusions) for waiver participants. Numerator: number of providers with an approved policy by the SMA prohibiting unauthorized restrictive interventions (restraints, seclusions) for waiver participants. Denominator: number of providers reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

		Interval = 95% 5% margin
☒ **Other** Specify: CAP IT system CME/HCBS providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
HW-C2 Number and percent of participants with a critical incident (CI) for

unauthorized restraints/restrictions that were mitigated in the required timeframe. N: Number of participants with a CI for unauthorized restraints/restrictions that were mitigated in the required timeframe. D: Total number of participants reviewed

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW-D1 Number and percent of waiver participants who reported completion of recommended annual preventative/wellness appointments. Numerator: number of waiver participants who reported completion recommended annual preventative/wellness appointments Denominator: number of waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☐ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*

Performance Measure:
HW-D2: Number and Percent of participants who had a quarterly MDT meeting with care providers to address overall health care needs to ensure needs were adequately met by the service provider N: # of participants who had a quarterly MDT meeting with care providers to address overall health care needs to ensure needs were adequately met by the service provider D: # of waiver participants reviewed

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **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 IT system is a business system employed by the State Medicaid Agency to manage the health and welfare for all waiver participants to ensure safety communication living and integration. This system assists in the discovery of non-compliant areas in health, safety and well-being workflows through aggregating and analyzing data. The state's process of discovery and problem identification will be performed quarterly to ensure compliance with this assurance.
The CAP IT system performs the following tasks to ensure compliance to health and welfare policies and procedures which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- Completion of a comprehensive assessment, initially and annually
- Risk indicators based on assessed needs
- Person-centered service plan
- Notification letters to providers and waiver participants
- Individual risks agreements
- Training
- Prior approval segments
- Workflow timelines and alerts
- Critical incident management
- Grievance and complaint management

b. Methods for Remediation/Fixing Individual Problems

i. Describe the Stateâs 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 health and welfare, the State Medicaid Agency notifies the non-compliant entity immediately upon discovery. If the non-compliant area can be remediated, a corrective action plan and a root cause analysis are requested to assist to remediate the concerns. The State Medicaid Agency provides technical assistance and training on policies and procedures within 5 days of discovery. The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant provider to ensure the corrective action plan is being followed throughout the duration of the action plan. If the non-compliant issue continues ongoing after 3 months of assistance, the entity 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):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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 IT, 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 IT system. The CAP IT system is the hub for all waiver activities. Information pertaining to all the waiver assurances is entered in the CAP IT system by the State Medicaid Agency (SMA), Case management entities (CMEs), Independent assessment entity and HCBS providers. The CAP IT system correlates this information to align with the waiver business workflows to allow the SMA the ability to aggregate and analyze trends and areas that may need remediation. The data elements in the system are real-time which promote immediate discovery and quick implementation of remediation steps. The CAP IT 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 IT 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. DMA 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 IT 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 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 CIAEs (by April 2020), 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 IT systems that displays the performance of the waiver. An announcement queue is used to communicate quality improvement information.

To validate the efficiency and capacity of each responsible entity, the CAP IT system measures their performance monthly. Each entity must maintain a 90% quality compliance rate.

The CAP IT 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 IT 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.

Stakeholders are notified quarterly through planned stakeholder engagement meetings about waiver trends and performances. Stakeholders are given the opportunity to voice concerns or provide recommendations on how the systems may be more efficient or methods to implement and manage waiver assurances and QIS.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☒ **Other** Specify: CAP IT system, CME and CIAE)	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

A quarterly assessment of the functionality of the CAP IT system is conducted to monitor the performance and wavier specification per the approved scope of work. A State Medicaid representative reviews data reports and conducts testing to assess the effectiveness of the waiver functionality and its reliability to design. One hundred percent of the data must be processed and made available to the State Medicaid Agency when requested. However, 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 than 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 ensures 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 includes 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 IT system vendor to generate daily reports on all workflows that are directly connected to the six waiver assurances. The CAP IT systems must also maintain historical files. On a quarterly basis, and when a concern arises, an analysis of the reports is performed to evaluate the system's performance. Data from this system is cross-referenced, when applicable, to MMIS to validate compliance or issues of concern. This analysis allows a whole system review to identify areas that are working as designed and areas that need improvement. System improvements are implemented when areas of 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):*

My Experience Survey to assess experience in ADH settings.

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 is performed by the SMA with data reports received from the CAP IT system 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)& contracted vendors, Public Consulting group that conducts post payment reviews & Carolinas for Medical Excellence that conducts pre-payment reviews of providers that deliver provider-led and consumer-directed services. Post-payment reviews are done by OCPI on complaints that enter the Business Intake Center. These complaints come from 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 Aides/beneficiaries are required to sign to confirm PCS services were provided. The OCPI uses the Fraud and Abuse Management System (FAMS), Java-Surveillance and Utilization Review System (JSURS), and Advantage Suite to detect over/underutilization of services, and improper/aberrant billing practices. FAMS and JSURS can identify providers' billing practices/behaviors outside the norm of peers. On a 90-day basis, post-payment review samples with a 95% confidence level & 5% margin of error are sent to the SMA from each of the assigned reviewers that were completed during the previous quarter. For the SMA, the post-payment review process occurs daily. 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. 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 & 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/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 3 consecutive months to successfully complete the program. Providers may stay on prepayment claims review for 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 6 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 CAP IT system 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 IT 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 wavier participant to develop the service plan. The CAP IT system also monitors services as listed on the service plan through monthly and quarterly documentation the case manager is required to complete in the CAP IT system. The case manager gathers information about waiver participation and health and welfare during contact with the wavier 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 analyzes if services are provided as planned and if these services are meeting needs in the amount, frequency and duration as identified. The CAP IT 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 CAP IT system 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 IT system. When the assessment is approved which determines the participant to be at-risk of institutionalization and appropriate to participate in this HCBS program, the CAP IT 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 IT 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 for ensuring the CAP IT 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 ensure claims adjudicated per the PA. The CAP IT system reviews 90% of 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 IT 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 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. Outliners/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 Stateâs quality improvement strategy, provide information in the following fields to detail the Stateâs methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
FA-A1 Number and percent all claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. Numerator: number of all claims coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered Denominator: number of claims reviewed

Data Source *(Select one):*
Financial 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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%* *5% margin of error*
☒ ***Other*** *Specify:* *CAP IT system GDIT/NCTracks*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
FA-B1: Number and percent of rates that remain consistent with the approved rate methodology Numerator: Number of rates that remain consistent with the approved rate methodology Denominator: number of rates reviewed

Data Source *(Select one):*
Financial 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):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%* *5% margin of error*
☒ ***Other*** *Specify:* *GDIT/NCTracks*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:*	☐ ***Annually***

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
GDIT/NCTracks	
	☒ ***Continuously and Ongoing***
	☐ ***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 IT system is a business system employed by the State Medicaid Agency to manage the financial accountability of the waiver in conjunction with the State's MMIS contracted entity. This system assists in the discovery of non-compliant reimbursement activities through aggregating and analyzing approved waiver services. The state's process of discovery and problem identification will be performed quarterly to ensure compliance with this assurance.
The CAP IT system performs the following tasks to ensure compliance to service plan development policies and procedures which allows the State Medicaid Agency to quickly discovery areas of noncompliance:

- *Linkage to approved Fee schedules*
- *Service authorization*
- *Prior approval segments*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the Stateâs 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 financial accountability, the State Medicaid Agency notifies the non-compliant entity within 15-days of the discovery and requests a self-referral to program integrity to remediate the concerns and for technical assistance and training. The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant service provider/entity to ensure the corrective action plan is being followed through the duration of the action plan. If the non-compliance issue continues, a pre-payment reimbursement plan is imposed on that provider until continuous quality improvement is achieved. If, after 3 months of assistance, and remediation strategies that promotes continuous quality is not achieved, the entity will be terminated as a waiver service provider.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:*	☐ ***Annually***

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
CWE, e-CAP *CSC/NCTracks*	
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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 SMA collaborates with an actuarial contractor to calculate an appropriate fee schedule based on the services and requirements outlined in Appendix C. The Provider Reimbursement Unit works collaboratively with the actuary to set all provider rates for waiver services and provides oversight for the rate determination method process. Rates are set based on demand for services, qualification of providers, and estimated provider service cost. The methodology used for rate determination for waiver participants directing their care is the same rate methodology used for provider managed services.

Generally, the State determines rates through a fee-for-service fee schedule methodology using market data and information specific to the State of North Carolina. For fee schedule rates, the State has historically solicited data from providers to inform the rate development process. The review of rates is ongoing and frequent based on feedback from stakeholders that is received during a formal quarterly meeting, legislative requests and approvals and overall program monitoring for the State Medicaid Agency. As part of the ongoing provider engagement and feedback process from the broader stakeholder community, the SMA reviews feedback, when supplied, on all rate components (e.g., transportation costs for in-home services) and on service limits in place for services paid based on invoices to ensure these limits continue to cover the intended offerings.

A formal review/rebase of all rates and rate setting assumptions was performed in SFY 2017-2018. The State Medicaid Agency more recently as part of their response to the public health emergency took steps to review and update their fee schedules.
The State Medicaid Agency completed stakeholder engagement, through a provider survey to understand current wage levels and received additional feedback from the provider community on reasonable wage levels for direct care workers. This was conducted most recently ahead of implementing the direct care wage increases with the funds available through ARPA 9817. The outcome of this rate review led to increases to many fee schedule rates offered through this waiver as authorized by the North Carolina Legislature. Additionally, provider feedback is accepted on an ongoing and frequent basis to ensure the adequacy of the rates
When reviewing the rates in SFY 2017-2018 as well as more recently as part of the 2022 and 2023 rate increases, the Provider Reimbursement utilized a fee schedule methodology based on the following components:
• 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 costs as defined in section 1861(v) of the Social Security Act. Service rates are developed using various information: 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 rate methodology for Individual Goods and Services, Nutritional Services and Pest Eradication were determined through a fee-for-service fee schedule methodology using market data and information specific to the State of North Carolina.
The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.
A CAP/DA Waiver Fee Schedule is posted to the SMA website and updated periodically. The Fee Schedule lists all the HCBS services in Appendix C and the utilization limits for reference by waiver participants and HCBS providers. The MMIS portal provides up-to-date information about rate changes and the claim submittal process. Local case management entities, at the direction of the SMA, provide waiver participants an HCBS informational sheet that lists the approved waiver services and the maximum utilization limits.
The rates and reimbursement for all services including consumer-directed services are uniformed for every provider and across geography. The utilization limits were set based on historical claim data and associated expenditures.
Review of rates are performed at the time of annual updates as required by SMA. During each waiver year, stakeholder meetings are held to listen to user and providers experiences. Information about rates is recorded and reviewed closely. Also, at the end of each waiver year, utilization data is analyzed to identify requests or approvals that minimally met or exceeded the maximum limits to assist in informing if the reimbursement rates are sufficient and to make a recommendation to Provider Reimbursement unit for a rate analysis review. A formal rebase will be conducted no later than the next waiver renewal cycle.
Rates changes are triggered by legislative mandates or stakeholder group interaction with economically or fiscally sound supporting information as well as CMS rate change methodology. Changes to the state rate methodology are triggered by the same factors as listed above.

Maximum reimbursement of rates is uniformed for every provider and across geography for the following services is the same instance rate and is reviewed at least annually by SMA:
• Equipment, modification and technology -- $28,000 for the waiver life cycle; billed in varies dollar increments up to the maximum limits.
•Participant Goods and Services - $800 per fiscal year; billed in various dollar increments up to the maximum limits of the total allotment for all goods and services.
•Individual-directed Goods and Services - $800 per fiscal year; billed in various dollar increments up to the maximum limits of the total allotment for all goods and services.
•Pest Eradication- $800 per fiscal year; billed in various dollar increments up to the maximum limits of the total allotment for all goods and services.
•Nutritional Services - $800 per fiscal year; billed in various dollar increments up to the maximum limits of the total allotment for all goods and services.
•Non-medical transportation- $800 per fiscal year; billed in various dollar increments up to the maximum limits of the total allotment for all goods and services.
•Community Transition - $2,500.00 per Waiver beneficiary waiver life cycle; billed in varies dollar increments up to the maximum limits.
•Community Integration Services - $2,500.00 per Waiver beneficiary waiver life cycle; billed in varies dollar increments up to the maximum limits.
•Training/Education and Consultative Services- $500.00 per state fiscal year; billed in varies dollar increments up to the maximum limits.
Maximum reimbursement of rates is uniformed for every provider and across geography for the following services is the same per month rate and is reviewed at least annually by SMA:
•Coordination of care- case management and care advisement –$377/month per calendar year
• Financial Management Services - $107.42 per month
Maximum reimbursement of rates is uniformed for every provider and across geography for the following services is the same per unit rate (one unit = 15 minutes) and is reviewed at least annually by SMA:
• Personal Assistant Services
• CAP In-Home Aide
• Respite Care (in-home)
• Specialized Medical supplies - units vary by item and are consistent with State Plan services
Maximum reimbursement of rates is uniformed for every provider and across geography for the following services is the same per day or per meal rate and is reviewed at least annually by SMA:
•Institutional respite - per day
• Adult Day Health – per day
• Coordinated caregiving – per day
• Personal emergency response services - paid per month
•Meal preparation and delivery – per meal
The rate methodology for non-medical transportation was created by using Internal Revenue Service (IRS) mileage rates, refer to Appendix C-1/C-3 for the specific rates.
The rate methodology for Chore Service-Declutter/Garbage Disposal was created by using Bureau of Labor to create marketplace rate, Appendix C-1/C-3 for the specific rates. The marketplace rate covers all workers, material and equipment.
Following the rate determination for this waiver renewal, the full waiver application was made available for public review and comment as described in Main Section-6-I.
The Waiver Service Fee Schedule can be accessed using this link: https://ncdhhs.servicenowservices.com/fee_schedules.
The corresponding clinical coverage policy for the waiver program may be accessed using this link: https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies.
SMA is in constant communication with providers and their associations through frequent meetings and stakeholder engagements. Consumers may submit complaints by phone, or in writing expressing rates insufficiency. These complaints are closely reviewed, and an analysis is conducted to review trends related to rates to aid in future recommendations and the rebase of rate during the waiver renewal cycle.

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 from provider-led and consumer-directed services are processed and adjudicated by the State's claims payment system.

NC Medicaid uses an open-vendor Electronic Visit Verification (EVV) model to collect and aggregate visit verification data to comply with the 21st Century Cures Act. The open vendor model permits providers to use it as their sole source verification system to capture electronic visits or send completed visits to the aggregator. All providers subject to the EVV mandate and rendering personal care type services in this waiver must register with the State's EVV solution to collect visits in the State's EVV system or send data to the State's aggregator. Upon registration, the provider signs up for self-paced training. Once the "Sign Up" process is completed, the provider is provided a welcome package. This welcome package permits the provider to set up their securities and identify roles for all staff members. This step allows the providers to collect or send visits to the State's EVV solution.

Each in-home visit must receive a validation of the core components of EVV as listed above. Each claim line complies with the EVV requirements; the "From (date of service)" and "To (date of service)" field on each claim line must be billed as a separate claim detail line, or the claim line will deny. The EVV system captures and stores all data elements. These data elements are transmitted to the MMIS, where the data is converted to validated visits for processing claims.

- *Beneficiary ID*
- *Date of Service*
- *Rendering Provider NPI*
- *Procedure Code/Modifier*
- *Start Time*
- *End Time*
- *Units*
- *Caregiver's ID*

Edits are in MMIS to pend or deny a claim if the required data elements are not present when a claim is submitted. Visit verification data is in MMIS for the provider to see visit confirmation data before processing their claim.

The CAP waiver is a comprehensive, wraparound program intended to support chronically ill Medicaid beneficiaries so they can live and integrate into their community like non-disabled individuals; flexibility is allowed for how the EVV mandates are reported for specific types of enrolled waiver participants. These types of participants are:

- *Waiver participants who have a paid live-in caregiver*
- *Waiver participants who are directing their care using consumer-directed services*

A subset of caregivers authorized to render personal care services in the waiver is exempted from the EVV visit capture mandate. These caregivers are referred to as paid live-in caregivers. When submitting a claim for services rendered by a paid live-in caregiver, the provider agency must select the place of service (POS) code 99. POS code 99 is designated by NC Medicaid as the paid live-in caregiver exemption code to bypass the EVV edits.

A paid live-in caregiver is defined as a person who lives in the same household as the waiver participant and is hired and paid by an in-home aide or home health agency or through the consumer direction program to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). An in-home aide, home health agency, or financial management entity does not have to report visits of a paid live-in caregiver in their EVV solution or the State's aggregator. The in-home aide, home health agency, and financial management entity must document in their records the confirmation the paid live-in caregiver shares the same address as the waiver participant. This documentation consists of an attestation statement of the paid live-in status to be included with the employment agreement and two supporting pieces of evidence, one of which must be a driver's license or another valid photo ID and the other a utility-type or credit card statement/bill, a residential lease agreement, school enrollment forms if enrolled in school or graduated from school within the past three months, or an acceptable piece of evidence approved by NC Medicaid at the request of the provider. These two supporting pieces of evidence must list the address of the paid live-in caregiver to be the same address as the waiver participant, which must be confirmed initially upon hire and annually during the CAP enrollment renewal period. These documents should be filed in your agency's personnel file or waiver participant's case file.

Self-directed care promotes flexibility in how services are planned and rendered; for a waiver participant who is directing their care using consumer-directed services, the only EVV requirements that must be reported are the approved in-home aide or pediatric nurse aide service listed on the point of contact and the person who has been hired to provide the in-home aide or pediatric nurse aide service. Because of the flexibility to use services based on a given day's specific needs, the reporting of the date and times the service begins and ends and the location the service was provided can be reported differently from what is listed in the service authorization.

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:*

GDIT is the fiscal agent (FA) and monitors the State MMIS for Medicaid claim processing and payment. It is the FA's responsibility to process valid Medicaid claims from enrolled providers in accordance with SMA policies, edits, audits, guidelines, and reimbursement methodologies.

Payments are made through the State 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 reimbursement of a waiver claim may occur. Once the provider is provided the authorization to render a waiver service, the provider then submits that claim to NCTracks for reimbursement.

Validation that services have been provided as billed is a function of quality assurance conducted by the IT 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 SMA's Accountability Team conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per sample of enrolled providers. This review includes monitoring of requirements that address staff qualifications, service authorizations, person centered plans, service documentation, and billing protocol. For the waiver, a billed event must meet the following requirements to be validate

1. Have the required signatures by or before when 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 IT system reviews 100% of its cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided.

•The reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, different LOC monthly to assure accuracy and 100% compliance of authorized services.

• The IT system conducts quality assurance reviews that include a review of the person-centered plan and service documentation for each waiver participant. The reviewer reviews the current service request form, the assessment and the approved person centered, service documentation, and paid claims to ensure that services were billed appropriately as according to the service plan.

• The IT system 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 participant for further validation.

The State Medicaid Agency/IT system will provide each case management entities with QI reports to validate all authorized services. The case management entities will contact the IT system/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; and

• Claim is paid per the published rates; and the participant was not institutionalized during the time covered.

Payments are made through MMIS and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers. Validation that services have been provided as billed is a function of quality assurance conducted by the IT system and 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.

CAP In-Home Aide, personal assistance and respite services are subject to EVV and must comply with EVV before

claiming. Billing validation is a prepayment activity. The provider must have evidence of an electronic visit transmitted to the MMIS prior to the adjudication of the claim. The visit confirms Medicaid eligibility for whom the billing was made on the date of service, the rendering provider, and the service provided was approved in the service plan. When an electronic visit or the EVV requirement is not confirmed in the MMIS, the claim is pended/denied.

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:

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:

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

- ○ ***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 section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used***

and how payments to these plans are made.

○ ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

◉ ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***

○ ***The following source(s) are used***

Check each that applies:

☐ ***Health care-related taxes or fees***

☐ ***Provider-related donations***

☐ ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

◉ ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***

○ ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- ◉ ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ○ ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing *(1 of 5)*

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor*

D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: 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	45919.90	12787.00	58706.90	84353.00	4266.00	88619.00	29912.10
2	47634.38	13303.00	60937.38	84092.00	4438.00	88530.00	27592.62
3	49520.88	13839.00	63359.88	88293.00	4617.00	92910.00	29550.12
4	51377.17	14396.00	65773.17	92711.00	4803.00	97514.00	31740.83
5	53310.85	14977.00	68287.85	97347.00	4997.00	102344.00	34056.15

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:
		Nursing Facility
Year 1	14078	14078
Year 2	14078	14078
Year 3	14078	14078
Year 4	14078	14078
Year 5	14078	14078

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 302 days. This figure is actual average length of stay for waiver participants from November 1, 2021, through October 31, 2022, as reported in the historical CMS 372. This figure was corroborated using state eligibility data with no notable differences identified. Note that the overall length of stay for the CAP/DA waiver is comparable to the average length of stay across the previous CAP/DA 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:*

The basis for Factor D was Medicaid FFS data for the July 1, 2022 – June 30, 2023 (SFY 2023) period for CAP/DA waiver users and reflect only CAP/DA waiver services. Medicaid FFS data for enrollment and expenditures for CAP/DA waiver users was compared to CMS 372 reports for the Waiver Year 3 overlapping time period and found to be reasonable and consistent.

Unit cost estimates were based on the state fee schedule effective July 1, 2023, and trended to Waiver Year 1 at an annual rate of 1.0%. For certain services, there is no state fee schedule due to reimbursement methodology (i.e., those services that are reimbursed based on vendor cost up to a cap). In these cases, the unit cost reflects SFY 2023 calculated unit cost, trended to Waiver Year 1 at an annual rate of 1.0%.

There was an additional adjustment made to increase the unit cost for Personal Emergency Response Services in Waiver Year 1. This is due to a planned increase in the state fee schedule to allow the beneficiary to purchase additional automation for safety and security.

There was also an additional adjustment made to increase the unit costs for both Assistive Technology and Home Accessibility and Adaptation services in Waiver Year 1. This is due to an increase in the limit of these two services from $13,000 to $28,000 that is being adjusted as part of this waiver renewal. The state estimates that this will not impact the number of users accessing these services but allow some existing users to access a higher level of these services.

For Waiver Years 2 – 5, the 1.0% annual unit cost trend was included as an estimate of potential future fee schedule unit cost growth during the prospective time period. It is included as consideration for cost of living/ inflationary growth to services, including those paid based on cost rather than a standardized preset fee (e.g., assistive technology, home accessibility and adaptation, etc.). The 1% annual growth trend was based on review of historical CMS 372 reports from Waiver Years 2 and 3 for the CAP/DA waiver and a review of monthly Medicaid FFS data on a rolling basis for the SFY 2022 and SFY 2023 time periods.
Utilization estimates (users and units per user) were based on Medicaid FFS utilization data for SFY 2023. Units per user values were trended to Waiver Years 1 - 5 at a rate of 3% annually. The 3% annual utilization trend was based on review of historical Waiver Years 2 and 3 CMS 372 reports for the CAP/DA waiver and a review of monthly Medicaid FFS data on a rolling basis for the SFY 2022 and SFY 2023 time periods.

The 3% annual utilization trend was not used for Care Advisor, Case Management, or Personal Emergency Response Services as those are monthly units that are already at the anticipated utilization level for these services, given the average length of stay on the waiver.

The 3% annual utilization trend and 1% annual unit cost trends were not applied to Non-Medical Transportation Service since the maximum utilization and unit cost were used for the estimates for all 5 years of the waiver. 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 based on utilization data.

A new service will be included in the CAP/DA Waiver starting in Waiver Year 1 to reimburse direct care workers for providing CNA II-level care to qualifying beneficiaries. The estimated utilization and unit cost for this service was based on SFY 2023 claims data and trended forward at the same 3% annual utilization trend and 1% annual unit cost trend listed above for Waiver Years 2-5. The users accessing CNA II-level care will no longer be accessing CAP In-Home Aide or Personal Assistant Services. The user estimates for these services have been decreased accordingly.

ii. ***Factor D' Derivation.*** *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Year 1 Factor D' Derivation is estimated based on actual Medicaid expenditures for all non-waiver services (i.e., acute medical, pharmacy and behavioral health) for CAP/DA recipients during SFY 2023. The data was trended forward to each waiver year using 4% annual growth in expenditures to align with utilization and unit cost trends observed for the CAP/DA waiver spending as summarized in the historical CMS 372 reports and a review of monthly Medicaid data on a rolling basis for the SFY 2022 and SFY 2023 time periods. This 4% trend also aligns with medical trends observed by the State in other projections of future medical expenses. Similar to the Factor D Derivation section above, SFY 2023 expenditure data for Factor D' was found to be consistent with CMS 372 information from overlapping Waiver Year 3 time periods.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Year 1 Factor G Derivation is estimated based on actual FFS Medicaid institutional claims expenditure data for adult non-CAP/DA Medicaid recipients residing in nursing facilities for over 90 days. These individuals were identified based on a detailed review of nursing facility claims and age criteria to proxy individuals who would otherwise be eligible for the CAP/DA waiver. The data was evaluated for SFY 2023 and was trended forward to each waiver year using 5% annual growth in expenditures. This trend factor was based on review of monthly institutional claims on a rolling basis for the identified Nursing Facility level of care population during the SFY 2022 and SFY 2023 time periods. In addition to a review of institutional claims, Mercer also reviewed Skilled Nursing Facility PPS trends for FY2023 and FY2024 as published by CMS and found them to be consistent with the institutional claims data.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Year 1 Factor G' Derivation is estimated based on actual Medicaid claims expenditure data for non-institutional services (i.e., acute medical and behavioral health) for adult non-CAP/DA Medicaid recipients residing in nursing facilities for over 90 days. These are the costs associated with non-nursing facility expenditures for the recipients identified and measured for Factor G derivation (see above). The data was evaluated for SFY 2023 and was trended forward to each waiver year using a 4% annual inflation factor to align with historical growth in utilization and unit cost for these services based on a review of monthly Medicaid data on a rolling basis for the SFY 2022 and SFY 2023 time periods.

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	
Adult Day Health	
CAP In-Home Aide	
Coordination of care - case management and care advisement	
Financial Management Services	
Chore Service-Declutter/Garbage Disposal	
Community Integration Services	
Community Transition	
Coordinated Caregiving	
Equipment, Modification and Technology	
Individual Directed Goods and Services	
Meal Preparation and Delivery	
Non-Medical Transportation Services	
Nutritional Services	

Waiver Services	
Participant Goods and Services	
Personal Assistant Services	
Personal Emergency Response Services	
Pest Eradication	
Respite Services	
Specialized Medical Supplies	
Training/Education and Consultative Services	

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
Adult Day Health Total:						**1449734.88**
Adult Day Health	Day	229	145.20	43.60	**1449734.88**	
CAP In-Home Aide Total:						**403747245.28**
CAP In-Home Aide II	15 mimutes	2520	6000.00	7.34	**110980800.00**	
CAP In-Home Aide I	15 minutes	7623	6369.10	6.03	**292766445.28**	
Coordination of care - case management and care advisement Total:						**50625933.49**
Care Advisor	Month	3945	10.00	381.79	**15061615.50**	
Case Management	Month	9507	9.80	381.72	**35564317.99**	
Financial Management Services Total:						**4821330.80**
Financial Management Services	month	4030	11.00	108.76	**4821330.80**	
Chore Service-Declutter/Garbage Disposal Total:						**1102.38**
Chore Service-Declutter/Garbage Disposal	Instance	2	1.10	501.08	**1102.38**	

GRAND TOTAL:	**646460368.76**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**45919.90**
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Services Total:						**13360.50**
Community Integration Services	instance	15	1.50	593.80	**13360.50**	
Community Transition Total:						**21229.12**
Community Transition	Instance	37	1.10	521.60	**21229.12**	
Coordinated Caregiving Total:						**666842.80**
Skilled Service Level	Day	15	247.60	65.43	**243007.02**	
Low Service Level	Day	39	249.60	43.54	**423835.78**	
Equipment, Modification and Technology Total:						**4546286.91**
Assistive Technology	Instance	67	1.30	3045.63	**265274.37**	
Home Accessibility and Adaptation	Instance	1151	12.60	282.90	**4102785.54**	
Vehicle Modification	Instance	50	12.60	282.90	**178227.00**	
Individual Directed Goods and Services Total:						**73638.25**
Individual Directed Goods and Services	Instance	350	14.50	14.51	**73638.25**	
Meal Preparation and Delivery Total:						**1045753.80**
Meal Preparation and Delivery	Meal	895	149.80	7.80	**1045753.80**	
Non-Medical Transportation Services Total:						**98400.00**
Non-Medical Transportation Services	Instance	123	1.00	800.00	**98400.00**	
Nutritional Services Total:						**700.02**
Nutritional Services	Instance	1	2.20	318.19	**700.02**	
Participant Goods and Services Total:						**184937.20**
Participant Goods and Services	Instance	879	14.50	14.51	**184937.20**	
Personal Assistant Services Total:						**149027146.39**
Personal Assistant					**149027146.39**	

GRAND TOTAL:	**646460368.76**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**45919.90**
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Services	15 minutes	3223	7668.10	6.03		
Personal Emergency Response Services Total:						**2143777.41**
Personal Emergency Response Services	Month	5465	9.30	42.18	**2143777.41**	
Pest Eradication Total:						**26343.20**
Pest Eradication	Instance	50	1.30	405.28	**26343.20**	
Respite Services Total:						**23160204.48**
In-Home	15 minutes	2843	1349.10	6.03	**23128012.54**	
Institutional	Day	4	36.20	222.32	**32191.94**	
Specialized Medical Supplies Total:						**4806362.49**
Resuable Incontinence supplies	per item	21	9.40	21.06	**4157.24**	
Disposal Liners	per item	2288	913.30	0.34	**710474.34**	
Nutritional Supplements	per item	4436	1002.60	0.92	**4091730.91**	
Training/Education and Consultative Services Total:						**39.37**
Training/Education and Consultative Services	Instance	1	1.10	35.79	**39.37**	

GRAND TOTAL:	**646460368.76**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**45919.90**
Average Length of Stay on the Waiver:	302

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
Adult Day Health Total:						**1508397.35**
Adult Day Health	Day	229	149.60	44.03	**1508397.35**	
CAP In-Home Aide Total:						**419946917.61**
CAP In-Home Aide II	15 minutes	2520	6180.00	7.41	**115400376.00**	
CAP In-Home Aide I	15 minutes	7623	6560.10	6.09	**304546541.61**	
Coordination of care - case management and care advisement Total:						**50853030.74**
Care Advisor	Month	3945	10.00	385.61	**15212314.50**	
Case Management	Month	9507	9.80	382.54	**35640716.24**	
Financial Management Services Total:						**5046728.70**
Financial Management Services	month	4030	11.40	109.85	**5046728.70**	
Chore Service-Declutter/Garbage Disposal Total:						**1113.40**
Chore Service-Declutter/Garbage Disposal	instance	2	1.10	506.09	**1113.40**	
Community Integration Services Total:						**13494.15**
Community Integration Services	instance	15	1.50	599.74	**13494.15**	
Community Transition Total:						**21441.17**
Community Transition	Instance	37	1.10	526.81	**21441.17**	
Coordinated Caregiving Total:						**693737.91**
Skilled Service Level	Day	15	255.10	66.08	**252855.12**	
Low Service Level	Day	39	257.10	43.97	**440882.79**	
Equipment, Modification and Technology Total:						**4729029.06**
Assistive Technology	Instance	67	1.30	3076.08	**267926.57**	
Home Accessibility and Adaptation	Instance	1151	13.00	285.73	**4275377.99**	

GRAND TOTAL:	**670596767.28**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**47634.38**
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modification	Instance	50	13.00	285.73	185724.50	
Individual Directed Goods and Services Total:						76451.90
Individual Directed Goods and Services	Instance	350	14.90	14.66	76451.90	
Meal Preparation and Delivery Total:						1086835.20
Meal Preparation and Delivery	Meal	895	154.30	7.87	1086835.20	
Non-Medical Transportation Services Total:						98400.00
Non-Medical Transportation Services	Instance	123	1.00	800.00	98400.00	
Nutritional Services Total:						707.01
Nutritional Services	Instance	1	2.20	321.37	707.01	
Participant Goods and Services Total:						192003.49
Participant Goods and Services	Instance	879	14.90	14.66	192003.49	
Personal Assistant Services Total:						155026422.47
Personal Assistant Services	15 minutes	3223	7898.20	6.09	155026422.47	
Personal Emergency Response Services Total:						2165123.70
Personal Emergency Response Services	Month	5465	9.30	42.60	2165123.70	
Pest Eradication Total:						28653.80
Pest Eradication	Instance	50	1.40	409.34	28653.80	
Respite Services Total:						24092855.12
In-Home	15 minutes	2843	1389.60	6.09	24059353.75	
Institutional	Day	4	37.30	224.54	33501.37	
Specialized Medical Supplies Total:						5015384.74
Resuable Incontinence supplies	per item	21	9.60	21.27	4288.03	
Disposal Liners	per item	2288	940.70	0.35	753312.56	

GRAND TOTAL:	670596767.28
Total Estimated Unduplicated Participants:	14078
Factor D (Divide total by number of participants):	47634.38
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Supplements	per item	4436	1032.07	0.93	4257784.14	
Training/Education and Consultative Services Total:						39.77
Training/Education and Consultative Services	Instance	1	1.10	36.15	39.76	
				GRAND TOTAL:		670596767.28
				Total Estimated Unduplicated Participants:		14078
				Factor D (Divide total by number of participants):		47634.38
				Average Length of Stay on the Waiver:		302

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
Adult Day Health Total:						1569650.27
Adult Day Health	Day	229	154.10	44.48	1569650.27	
CAP In-Home Aide Total:						437438695.68
CAP In-Home Aide II	15 minutes	2520	6365.40	7.49	120145651.92	
CAP In-Home Aide I	15 minutes	7623	6757.00	6.16	317293043.76	
Coordination of care - case management and care advisement Total:						51643118.15
Care Advisor	Month	3945	10.00	389.46	15364197.00	
Case Management	Month	9507	9.80	389.39	36278921.15	
Financial Management Services Total:						5276116.30
Financial Management Services	month	4030	11.80	110.95	5276116.30	
Chore Service-						1124.55
				GRAND TOTAL:		697154953.34
				Total Estimated Unduplicated Participants:		14078
				Factor D (Divide total by number of participants):		49520.88
				Average Length of Stay on the Waiver:		302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Declutter/Garbage Disposal Total:						
Chore Service-Declutter/Garbage Disposal	Instance	2	1.10	511.16	**1124.55**	
Community Integration Services Total:						**13628.92**
Community Integration Services	instance	15	1.50	605.73	**13628.92**	
Community Transition Total:						**21655.66**
Community Transition	Instance	37	1.10	532.08	**21655.66**	
Coordinated Caregiving Total:						**721619.92**
Skilled Service Level	Day	15	262.70	66.74	**262988.97**	
Low Service Level	Day	39	264.80	44.41	**458630.95**	
Equipment, Modification and Technology Total:						**4915000.07**
Assistive Technology	Instance	67	1.30	3106.84	**270605.76**	
Home Accessibility and Adaptation	Instance	1151	13.40	288.59	**4451039.01**	
Vehicle Modification	Instance	50	13.40	288.59	**193355.30**	
Individual Directed Goods and Services Total:						**79772.00**
Individual Directed Goods and Services	Instance	350	15.40	14.80	**79772.00**	
Meal Preparation and Delivery Total:						**1130613.23**
Meal Preparation and Delivery	Meal	895	158.90	7.95	**1130613.22**	
Non-Medical Transportation Services Total:						**98400.00**
Non-Medical Transportation Services	Instance	123	1.00	800.00	**98400.00**	
Nutritional Services Total:						**746.53**
Nutritional Services	Instance	1	2.30	324.58	**746.53**	
Participant Goods and Services Total:						**200341.68**
Participant Goods					**200341.68**	

GRAND TOTAL:	**697154953.34**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**49520.88**
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Services	Instance	879	15.40	14.80		
Personal Assistant Services Total:						**161511672.17**
Personal Assistant Services	15 minutes	3223	8135.10	6.16	**161511672.17**	
Personal Emergency Response Services Total:						**2186978.23**
Personal Emergency Response Services	Month	5465	9.30	43.03	**2186978.24**	
Pest Eradication Total:						**28940.10**
Pest Eradication	Instance	50	1.40	413.43	**28940.10**	
Respite Services Total:						**25101020.09**
In-Home	15 minutes	2843	1431.30	6.16	**25066185.14**	
Institutional	Day	4	38.40	226.79	**34834.94**	
Specialized Medical Supplies Total:						**5215819.62**
Resuable Incontinence supplies	per item	21	9.90	21.48	**4465.69**	
Disposal Liners	per item	2288	968.90	0.35	**775895.12**	
Nutritional Supplements	per item	4436	1063.70	0.94	**4435458.81**	
Training/Education and Consultative Services Total:						**40.16**
Training/Education and Consultative Services	Instance	1	1.10	36.51	**40.16**	

GRAND TOTAL:	**697154953.34**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**49520.88**
Average Length of Stay on the Waiver:	302

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
Adult Day Health Total:						**1632496.12**
Adult Day Health	Day	229	158.70	44.92	**1632496.12**	
CAP In-Home Aide Total:						**454901880.76**
CAP In-Home Aide II	15 minutes	2520	6556.40	7.56	**124907287.68**	
CAP In-Home Aide I	15 minutes	7623	6959.70	6.22	**329994593.08**	
Coordination of care - case management and care advisement Total:						**52159399.01**
Care Advisor	Month	3945	10.00	393.36	**15518052.00**	
Case Management	Month	9507	9.80	393.28	**36641347.01**	
Financial Management Services Total:						**5419221.60**
Financial Management Services	month	4030	12.00	112.06	**5419221.60**	
Chore Service-Declutter/Garbage Disposal Total:						**1239.05**
Chore Service-Declutter/Garbage Disposal	Instance	2	1.20	516.27	**1239.05**	
Community Integration Services Total:						**14682.96**
Community Integration Services	instance	15	1.60	611.79	**14682.96**	
Community Transition Total:						**23860.56**
Community Transition	Instance	37	1.20	537.40	**23860.56**	
Coordinated Caregiving Total:						**750716.75**
Skilled Service Level	Day	15	270.60	67.41	**273617.19**	
Low Service Level	Day	39	272.70	44.86	**477099.56**	
Equipment, Modification and Technology Total:						**5125101.44**
Assistive Technology	Instance	67	1.40	3137.91	**294335.96**	
Home Accessibility and Adaptation	Instance	1151	13.80	291.47	**4629651.19**	

GRAND TOTAL:	**723287848.66**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**51377.17**
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Vehicle Modification	Instance	50	13.80	291.47	201114.30	
Individual Directed Goods and Services Total:						82673.50
Individual Directed Goods and Services	Instance	350	15.80	14.95	82673.50	
Meal Preparation and Delivery Total:						1175768.66
Meal Preparation and Delivery	Meal	895	163.60	8.03	1175768.66	
Non-Medical Transportation Services Total:						98400.00
Non-Medical Transportation Services	Instance	123	1.00	800.00	98400.00	
Nutritional Services Total:						786.79
Nutritional Services	Instance	1	2.40	327.83	786.79	
Participant Goods and Services Total:						207628.59
Participant Goods and Services	Instance	879	15.80	14.95	207628.59	
Personal Assistant Services Total:						167978325.15
Personal Assistant Services	15 minutes	3223	8379.20	6.22	167978325.15	
Personal Emergency Response Services Total:						2208832.77
Personal Emergency Response Services	Month	5465	9.30	43.46	2208832.77	
Pest Eradication Total:						29229.20
Pest Eradication	Instance	50	1.40	417.56	29229.20	
Respite Services Total:						26105238.25
In-Home	15 minutes	2843	1474.20	6.22	26068956.73	
Institutional	Day	4	39.60	229.05	36281.52	
Specialized Medical Supplies Total:						5372323.24
Resuable Incontinence supplies	per item	21	10.20	21.70	4648.14	
Disposal Liners	per item	2288	998.00	0.35	799198.40	

GRAND TOTAL:	723287848.66
Total Estimated Unduplicated Participants:	14078
Factor D (Divide total by number of participants):	51377.17
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Nutritional Supplements	per item	4436	1095.60	0.94	4568476.70	
Training/Education and Consultative Services Total:						44.26
Training/Education and Consultative Services	Instance	1	1.20	36.88	44.26	
				GRAND TOTAL:		723287848.66
				Total Estimated Unduplicated Participants:		14078
				Factor D (Divide total by number of participants):		51377.17
				Average Length of Stay on the Waiver:		302

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
Adult Day Health Total:						1698720.85
Adult Day Health	Day	229	163.50	45.37	1698720.86	
CAP In-Home Aide Total:						473189669.82
CAP In-Home Aide II	15 minutes	2520	6753.10	7.64	130016083.68	
CAP In-Home Aide I	15 minutes	7623	7168.50	6.28	343173586.14	
Coordination of care - case management and care advisement Total:						52681521.79
Care Advisor	Month	3945	10.00	397.29	15673090.50	
Case Management	Month	9507	9.80	397.22	37008431.29	
Financial Management Services Total:						5473384.80
Financial Management Services	month	4030	12.00	113.18	5473384.80	
Chore Service-						1251.43
				GRAND TOTAL:		750510160.12
				Total Estimated Unduplicated Participants:		14078
				Factor D (Divide total by number of participants):		53310.85
				Average Length of Stay on the Waiver:		302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Declutter/Garbage Disposal Total:						
Chore Service-Declutter/Garbage Disposal	Instance	2	1.20	521.43	**1251.43**	
Community Integration Services Total:						**14829.84**
Community Integration Services	instance	15	1.60	617.91	**14829.84**	
Community Transition Total:						**22767.43**
Community Transition	Instance	37	1.20	512.78	**22767.43**	
Coordinated Caregiving Total:						**781025.83**
Skilled Service Level	Day	15	278.70	68.09	**284650.24**	
Low Service Level	Day	39	280.90	45.31	**496375.58**	
Equipment, Modification and Technology Total:						**5317865.34**
Assistive Technology	Instance	67	1.40	3169.29	**297279.40**	
Home Accessibility and Adaptation	Instance	1151	14.20	294.39	**4811569.04**	
Vehicle Modification	Instance	50	14.20	294.39	**209016.90**	
Individual Directed Goods and Services Total:						**86145.50**
Individual Directed Goods and Services	Instance	350	16.30	15.10	**86145.50**	
Meal Preparation and Delivery Total:						**1223774.67**
Meal Preparation and Delivery	Meal	895	168.60	8.11	**1223774.67**	
Non-Medical Transportation Services Total:						**98400.00**
Non-Medical Transportation Services	Instance	123	1.00	800.00	**98400.00**	
Nutritional Services Total:						**832.77**
Nutritional Services	Instance	1	2.50	333.11	**832.78**	
Participant Goods and Services Total:						**216348.27**
Participant Goods					**216348.27**	

GRAND TOTAL:	**750510160.12**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**53310.85**
Average Length of Stay on the Waiver:	302

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
and Services	Instance	879	16.30	15.10		
Personal Assistant Services Total:						**174687141.46**
Personal Assistant Services	15 minutes	3223	8630.60	6.28	**174687141.46**	
Personal Emergency Response Services Total:						**2230687.31**
Personal Emergency Response Services	Month	5465	9.30	43.89	**2230687.30**	
Pest Eradication Total:						**31630.50**
Pest Eradication	Instance	50	1.50	421.74	**31630.50**	
Respite Services Total:						**27147238.12**
In-Home	15 minutes	2843	1518.40	6.28	**27109574.34**	
Institutional	Day	4	40.70	231.35	**37663.78**	
Specialized Medical Supplies Total:						**5606879.68**
Resuable Incontinence supplies	per item	21	10.50	21.92	**4833.36**	
Disposal Liners	per item	2288	1028.00	0.36	**846743.04**	
Nutritional Supplements	per item	4436	1128.40	0.95	**4755303.28**	
Training/Education and Consultative Services Total:						**44.70**
Training/Education and Consultative Services	Instance	1	1.20	37.25	**44.70**	

GRAND TOTAL:	**750510160.12**
Total Estimated Unduplicated Participants:	**14078**
Factor D (Divide total by number of participants):	**53310.85**
Average Length of Stay on the Waiver:	302