NC Medicaid	Community Alternatives Program for Disabled Adults CAP/DA Waiver approval period: 11/01/2019-10/31/2024	Standard Operating Procedure (SOP)	Community Alternatives Program Home and Community-Based Services Willing Provider Enrollment Packet
		Creation Date	11/01/2019
		Implementation Date	11/18/2019
Pages	8	Revision/Update Date	
SOP Owner	WRenia Bratts-Brown	SOP Co-Owner	Patricia Hill

Standing Operating Procedure

Policy reference: Community Alternatives Program for Disabled Adults, 3K-2; Section 6.0
https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies

Federal citation for the administration of a 1915(c) Home and Community-based Services Waiver:
42 CFR §441.302

1. Purpose - The State Medicaid Agency (SMA) retains ultimate administrative authority (AA) and responsibility for the health, safety, and well-being of waiver participants through an assurance that an adequate system is in place to monitor and confirm all CAP Home and Community-Based Services (HCBS) are provided by willing qualified providers.

2. Scope - When all qualifying conditions are met, all enrolled North Carolina Medicaid providers are eligible to render one or more of the 24 types of HCBS offered though the CAP waiver by creating a Manage Change Request to add the corresponding CAP taxonomy using the NCTracks Portal. Table 1 below lists the 24 approved HCBS:

Table 1 – CAP/DA HCBS Services

CAP/DA HCBS	Procedure Code	Taxonomy Code
Adult Day Health	S5102	261QA0600X
CAP In-home Aide Services	S5125 & S5125 UN	251J00000X and/or 253Z00000X
Case Management Services	T1016	251B00000X
Care Advisor Services	T2041	251B00000X
Chore Services - declutter and garbage disposal	T1020	251B00000X
Community Transition Services	T2038	251B00000X and/or 332B00000X
Community Integration Services	T2033	251B00000X and/or 332B00000X
Coordinated Caregiving Services	G9003 & G9004	253Z00000X
Equipment and Modifications	S5165	251B00000X and/or 332B00000X
Financial Management Services	T2040	251X00000X
Individual Goods and Services	T2025	251B00000X and/or 332B00000X
Meal Preparation and Delivery	S5170	332U00000X
Non-Medical Transportation	A0090	251X00000X
Nutritional Services	H2010	251B00000X
Participants Goods and Services	T2025	251B00000X and/or 332B00000X
Personal Assistance Services	S5135 & S5135 UN	253Z00000X
Personal Emergency Response Services (PERS)	S5161	333300000X
Pest Eradication	T5999	251B00000X
Respite – Institutional	H0045	385H00000X
Respite – In-home	S5150	385H00000X
Specialized Medical Supplies:		332B00000X

- disposable liners - reusable liners - medication dispensing boxes	T4535 T4539 T2028	
Technology	T2029	251B00000X and/or 332B00000X
Training, Education and Consultative services	S5111	251B00000X
Oral Nutritional Supplements	B4150 BO, B4152-B4155BO, B4157-B4162BO	332B00000X

3. Abbreviations of commonly used terms
   - AA – Administrative Authority
   - CAP – Community Alternatives Program
   - DHSR – Department of Health Services Regulation
   - DSP – Direct service provider
   - HCBS – Home and Community-based Services
   - HSW – Health, safety and well-being
   - MDT – Multidisciplinary treatment
   - PCSP – Person-centered service plan
   - POC – Plan of care
   - SMA – State Medicaid Agency
   - SP – Service Plan

4. Definition of terms:
   Willing Qualified Provider – an organization that meets all enrollment requirements set forth by NC Medicaid; meets the minimum qualification outlined in Section 6.0 in the CAP Clinical Coverage Policy 3K-2; and agree to abide by all business rules set forth in the CAP Clinical Coverage Policy as listed above.

5. Responsibilities - The SMA, AA of the waiver maintains mandatory oversight of assuring an adequate system is in place to monitor and confirm all willing providers are qualified to render CAP HCBS by validating that:
   a. On an initial and continuous basis, all direct service providers meet licensure and/or certification standards as set forth by regulatory agencies.
   b. On a continuous basis, all direct service providers adhere to all policy standards prior to the furnishing of CAP HCBS services.
   c. On a quarterly basis, non-licensed/non-certified providers are monitored to assure adherence to program requirements.

d. On a quarterly basis, through multidisciplinary treatment team (MDT) collaboration, willing qualified providers monitor the service plan for health, safety, and well-being.
e. On an as authorized basis, direct service providers deliver services in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the plan of care.
f. On a daily basis, waiver participants are provided services in the least restrictive environment, free from seclusion, restraint, and restrictive intervention.
g. On an initial, annual, and as needed basis, waiver participants are provided free choice to select among wiling qualified provider to render an approved CAP HCBS that is free from conflict.

6. Measure - Each willing qualified provider shall meet the minimum qualifications and requirements to render any one of the above listed CAP services by illustrating the listed measures displayed in column 3 of Table 2.

Table 2 – CAP/DA Qualifications and Requirements

HCBS Type	Required Qualifications & Requirements	Supporting Documentation
Case Management and Care Advisement	Enrollment as a NC Medicaid provider	Approved NC Medicaid Provider Approval Letter
	3 years of progressive and consistent home and community-based services experience	1. Types of HCBS rendered and how those services were rendered 2. Number of years rendering those services 3. Locations those service(s) were rendered 4. Number of individuals served by services rendered 5. Number of years working directly with individuals zero and older with chronic and severe physical disabilities 6. Number of waiver participants wishing to serve. 7. References
	Connection to the service area	1. Physical location of the central office 2. Farthest expected proximity to waiver participants zip codes from central office and home-based offices 3. Number of years serving the catchment area

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	Polices & Procedures	Policies that provide guidance on the following: • Accepting referrals • Conducting assessments • Developing and approving person-centered service plan • Monitoring health, safety and well-being • Performance of home visits • Managing critical incidents • Knowing signs of fraud, waste of abuse and when to make a report • Administrating services that are free of seclusion, restraint and restrictive intervention • Rendering services that are free from conflict • Advisory Board • Marketing strategy • Communication plan
	Qualified staff	1. Number of and discipline of professional and supportive staff 2. Qualification of each staff 3. Timeframe of the conducting of the background check for each staff 4. Attestation all staff has passed a background check
	Architectural ability to support the requirement of current and future automated programs	1. Description of virtual office. 2. Cyber security 3. HIPAA requirements 4. Safeguarding of PHI and ePHI
HCBS Type	Required Qualifications & Requirements	Supporting Documentation
Coordinated Caregiving	Enrollment as a NC Medicaid provider	Approved NC Medicaid Provider Approval Letter
	3 years of experience of delivering HCBS to elders and adults with disabilities and their caregivers	1. Types of HCBS rendered and how those services were rendered 2. Number of years rendering those services 3. Locations those service(s) were rendered

		4. Number of individuals served by services rendered 5. Number of years working directly with individuals zero and older with chronic and severe physical disabilities 6. Number of waiver participants wishing to serve. 7. References
	Connection to the service area	1. Physical location of the central office 2. Farthest expected proximity to waiver participants zip codes from central office and home-based offices 3. Number of years serving the catchment area
	Polices & Procedures	Policies that provide guidance on the following: • Accepting referrals • Conducting assessments to determine care needs of the waiver participant and caregiver • Developing and carrying out the care plan • Monitoring health, safety and well-being of waiver participant to determine level of support to the caregiver • Conducting home visits • Managing Critical incidents • Knowing signs of fraud, waste of abuse and when to make a report • Administrating services that are free of seclusions, restraint and restrictive interventions • Rendering services that are free from conflict • Types and frequency of training modules, coaching techniques to support the waiver participant and caregiver • Marketing plan

		• Communication strategy
	Qualified staff	1. Number of professionals and supportive staff 2. Qualification of each staff 3. Timeframe of the conducting of the background check for each staff 4. Attestation all staff has passed a background check
	Architectural ability to support the requirement of current and future automated programs	1. Description of virtual office 2. Cyber security 3. HIPAA requirements 4. Safeguarding of PHI and ePHI
HCBS Type	Required Qualifications & Requirements	Supporting Documentation
Financial Management services	Enrollment as a NC Medicaid provider	Approved NC Medicaid Provider Approval Letter
	3 years of experience of developing, implementing and maintaining a record management process	1. Number of years' experience providing financial management services through both the Agency with Choice and Fiscal and Employer Agent
	Ability to transact business in the State of North Carolina	1. Internal Revenue Services that documents ability to transaction business in North Carolina
	Financial Stability	Solvency statement
	Policies and Procedures	Policies that provide guidance on the following: • Accepting referrals • Consumer-direction enrollment • Filing IRA required documents • Compliance with Department of Labor Laws • Conducting background checks and confirming hire-ability • Creating a pay rate that is within budget • Training and coaching to support individuals to direct care • Managing Critical incidents • Knowing signs of fraud, waste of abuse and when to make a report

		• Administrating services that are free of seclusion and restraint • Rendering services that are free from conflict • Payroll • Customer service
	Architectural ability to support the requirement of current and future automated programs	1. Description of virtual office 2. Cyber security 3. HIPAA requirements 4. Safeguarding of PHI and ePHI

7. Procedure - A Manage Change Request must be completed in the NCTracks portal to add the CAP taxonomies and procedure codes, refer to Table 1 on the provider Medicaid application profile to receive final approval and payment. Of the 24 CAP HCBS (see table 1), three (3) of those services require the completion of a CAP provider enrollment packet for prior approval of eligibility to render. When qualifying conditions have been validated, an approval confirmation letter which includes an effective and start is granted by NC Medicaid. The three (3) CAP HCBS that require prior approval are:
    a. Case Management Services,
    b. Coordinated Caregiving Services, and
    c. Financial Management Services.

    To request to be a willing provider of case management services, coordinated caregiving and financial management services, interested providers must mail the CAP willing provider enrollment packet to the attention of the CAP Unit at NC Medicaid at 2501Mail Service Center, Raleigh, NC 27609-2501.The application packet will be reviewed within 90 calendar days from the date of receipt to confirm that minimum qualifications and requirements are met. A CAP willing qualified provider notice letter will be provided by the 95th calendar day of the receipt of the enrollment packet. Requests for case management services are approved based on the needs of specific service areas. If technical assistance is needed to compile supporting documentation, you may arrange an appointment on Wednesdays from 12:00-1:00 p.m. by calling 919-855-4367.

    The reimbursement methodology for case management, care advisement and financial management is a monthly flat rate. The rate may be claimed by the last day of each given month when services are rendered and correctly documented. The documentation requirements are listed in the Table 4 below.

HCBS	Documentation Requirement for Reimbursement
Case management and Care Advisement	1. Completion of monthly and quarterly monitoring tasks 2. Case note that documents completed case management activities.

	3. Completion of Critical Incident Reports, when applicable and associated root cause analysis. 4. Completion of Individual Risk. Agreements, when applicable. 5. Completion of initial, annual and COS assessments. 6. Completion of initial and annual Person-Centered Services Plan. 7. Completion of revisions to the POC. 8. Linking, referring and following up.
Financial Management	1. Upload of all supporting documentation in the e-CAP system that confirms enrollment in consumer-direction. 2. Production of monthly expenditures reports.