CAP/C Waiver 30-Day Public Comments

Sections in the Waiver Template	Comments	Reponses
Major Changes	What are waiver services and is case management a waiver service?	Waiver services are a set of services only available to individuals who are eligible to participate in the waiver. The services include: Assistive technology; CAP in-home aide; Care advisor; Case management; Community transition service; Financial management services; Home accessibility and adaptation; Motor vehicle modifications and adaptation; Participant goods and Services; Pediatric and nurse aide services; Respite care (institutional and non-institutional); Specialized medical equipment and supplies; and Training, education and consultative services. Case management is a waiver service and must be used in order to participate in the waiver.
Additional Requirements -I	Where is the summary of comments?	The summary of comments are entered into to the waiver template after the 30-days public comment period expires. The Medicaid agency reviews the comments and then provides a summary of themes, trends and actions taken. Comments from this document were included in this section of the waiver template.
Additional Requirements - K	Why are DMA forms not available in Spanish? Or any other language? There are significant shortfalls in meeting this standard currently.	DMA complies with Section 1557 of ACA; refer to Appendix B: Participant Access and Eligibility B-8: Access to Services by Limited English Proficiency Persons for the definition of Section 1557.
Attachments # 2	Were these groups really involved or was this left over wording from the Innovations waiver? The plan has not been posted to the website, nor has other plans presented by DMA to the workgroup.	This information is consistent across all waivers as the HCBS Transition plan addressed all 1915 (c) HCBS Waivers. The HCBS Transition plan was approved the week of Nov. 14, 2016. The plan is be posted to the Department of Health and Human Services website at the following link: https://www2.ncdhhs.gov/hcbs/index.html

Appendix B B-1b	90 days is not consistent; other sections say 30 days	90 days is the correct timeframe to use when determining continuation of waiver participation when a needed waiver services is not being used during a 90-day period. 90 days is the correct language to use in the waiver template.
Appendix B B-1b	This whole section regarding average per capita cost should be removed.	Because waiver services for children will be planned as an average cost, this section of the waiver template was revised to indicate how DMA would manage cost neutrality of the CAP/C waiver when the average per capita cost exceeds the average per capita cost of institutional care. In this section, the following information is included in the waiver template: CAP service provisions are planned at an average per capita cost per year of $129,000. To ensure cost neutrality of the waiver, a cost analysis of the total waiver budget and each individual's cost expenditure will be conducted quarterly. When the average per capita cost of the waiver budget is 75% over the identified limit, DMA will do the following: a. Develop a cost utilization plan with a timeline of 90 calendar days to align the total waiver costs within the CAP budgetary limits; b. implement a 60 calendar-day cost adjustment plan if the 90 calendar-day cost utilization plan is not able to align with the established budgetary limits; and c. At end of the 60 calendar days, if the cost adjustment plan fails to align the waiver budget within the established budgetary limit, service utilization limits shall be implemented until the waiver is within the cost neutrality limits. Upon the discovery of out layers (waiver participants exceeding the average per capital cost by 75% in each assessment quarter) in each quarter of analysis, the case manager is informed in conjunction with the waiver beneficiary of the out layer in an

		attempt to reassess needs or to identify other formal or informal services to meet care needs in an attempt to reduce the average per capital cost of care. If the average per capita cost for the waiver beneficiary is 100% over the average per capita cost of institutional care for two consecutive quarters, an evaluation will be conducted to determine the suitability of waiver participation. If it is determined that care needs are more costly than the average per capita cost of institutional care, a conference meeting will be convened to identify a health, safety and well-being plan for the waiver beneficiary. If a waiver beneficiary's needs increases, the case manager will implement services to meet the need through programming called short-term intensive. These services are able to be prorated across the annual cycle of the waiver year so to maintain the average per capita cost. Each waiver beneficiary is entitled to Due Process when a service is denied, suspended or terminated or when the waiver beneficiary is disenrolled from the program. The beneficiary is mailed a letter by trackable mail to inform of the adverse decision. The beneficiary has 30 calendar days from the date of the letter to request an appeal. If the appeal is requested within 10 business days, services remain as planned without interruptions. If the appeal is requested after the 10 business day, services can be reinstated on the date in which the appeal was requested. Services remain in place while the decision is under appeal until the final disposition.
Appendix B: Participant Access and Eligibility B-2	What should be selected, individual cost limit or institutional cost limit	DMA accesses eligibility based on institutional cost limit. Although there is no individual limit, services must be consistent with the average per capita cost of institutional care.
Appendix B: Participant Access and Eligibility B-2	Should information about individual cost limits be removed from the waiver template since children will not be assessed on an individual limit?	The information in this section is required per the Centers for Medicare & Medicaid Services guidelines.
Appendix B: Participant Access and Eligibility B-3: Number of Individuals Served	Why is the State limiting the number of participants?	Because of budgeting requirements and the way Medicaid funds services, utilization limits must be applied to ensure waiver cost neutrality.
Appendix B: Participant Access and Eligibility B-3: Number of Individuals Served	Where did the number come from, should the number be 3950?	The waiver template was updated to reflect the number of waiver beneficiary minus the number of reserved waiver beneficiaries. This section was update to reflect 3950.

Appendix B: Participant Access and Eligibility B-3: Number of Individuals Served	Will the waiver be managed by the State	The 4,000 waiver slots will be managed by the State. The waiver template was revised to select, "waiver capacity is allocated/managed on a statewide basis."
Appendix B: Participant Access and Eligibility B-3: Number of Individuals Served	Slots should be managed on a first-come, first service basis and not split among case management agencies.	This section was revised in the waiver template to read: If a case management entity determines the inability to fully utilize assigned slot(s), the case management entity may refuse all or some of the slots by submitting an official notice to DMA that outlines the reasons why slots are being surrendered. The "surrendered slots" will be immediately reallocated to another case management entity that has the capacity to accept the slot (s).
Appendix B: Participant Access and Eligibility B-3: Number of Individuals Served	Why should there ever be a county specific wait time.	The information in the waiver provides guidance on how DMA tracks the wait time for all waiver beneficiaries requesting and receiving waiver services. There will not be county specific wait times.
Appendix B: Participant Access and Eligibility B-6: Evaluation/Reevaluation of Level of Care	Which wavier service count? Case management? Waiver supplies like reusable diapers or diaper liners?	The minimum number of waiver services is one. To be determined at-risk of institutionalization which is the eligibly requirement to participate in the waiver, the individual would need some form of personal care or assistive technology/modification and case management for ongoing community inclusion.
Appendix B: Participant Access and Eligibility B-6: Evaluation/Reevaluation of Level of Care	Not consistent in this application- other sections say every consecutive 90 days	The wavier template informs the monitoring of the provision of waiver service to be conducted at least monthly. To determine ongoing need for waiver participation, an assessment is performed quarterly and if during any 90 day period a waiver service is not used and documented to be needed, a recommendation could be made to disenroll the waiver beneficiary from the program.
Appendix B: Participant Access and Eligibility B-7: Freedom of Choice	Who is able to make a CAPC referral	A "no-wrong door" concept is used for CAP/C. A referral for participation in the CAP/C program may be initiated by a physician, case manager, provider agency, and hospital discharge planner, an individual interested in participating in the program or by a Department of Social Services.
Appendix B: Participant Access and Eligibility B-7: Freedom of Choice	DMA interpretation of "conflict-free case managing" is not consistent with other states. All forms of case management (including assessment) need to be separate from other services like home care but these is not a need to	DMA is in the process of implementing the business rules surrounding conflict-free case management. These rules will be outlined in the CAP/C Clinical Coverage Policy.

	split ongoing case management from assessment. This is a huge inconvenience to families and prevents continuity of care	
Appendix B: Participant Access and Eligibility B-8: Access to Services by Limited English Proficiency Persons	We have huge concerns the LEP standards are not being met by DMA.	Federal law requires that all Medicaid providers in North Carolina comply with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act of 1964 (Title VI), Section 504 of the Rehabilitation Act (Section 504), and Section 1557 of the Affordable Care Act (Section 1557). The ADA requires the provision of reasonable accommodations. Such accommodations may include providing individuals who are deaf, deaf-blind, or hard of hearing with auxiliary aids and services, such as sign language interpreters, to achieve effective communication. Title VI prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. Programs that receive Federal funds cannot distinguish among individuals on the basis of race, color or national origin, either directly or indirectly, in the types, quantity, quality or timeliness of program services, aids or benefits that they provide or the manner in which they provide them. The courts have held that Title VI prohibits recipients of Federal financial assistance from denying limited English proficient (LEP) persons access to programs, based on their national origin. Section 1557 builds upon already existing federal laws and prohibits discrimination on the basis of sex in any health programs and activities receiving federal financial assistance, such as Medicaid providers and the state Medicaid program. In general, the requirements adopted under Section 1557 include equal treatment of men and women with respect to health coverage and prohibitions against discrimination based on pregnancy, gender identity, and sex stereotyping. This section also updated notice

		requirements to ensure access to individuals with limited English proficiency (LEP).
Appendix C : Participant Services home and/vehicle modification	Why so limiting? There is nothing her to assist beneficiaries with low vision and or hearing impairments.	Services to assist individuals 20 and under with hearing or vision impairments are covered by Medicaid State plan or other Divisions specializing in those areas. DMA also complies with ADA, see above.
Appendix C : Participant Services home and/vehicle modification	What is considered a new construction?	A dwelling that is under construction and not able to be occupied by a resident.
Appendix C : Participant Services Respite	When would a plan revision be required if respite is requested on a daily basis?	The request for respite must fall within the guideline and definition of respite. When a respite request is made weekly/daily, a service plan should be considered to determine if the care needs of the child/family has changed. Respite care is consumer-directable.
Appendix C : Participant Services Personal Care	Are parents, spouse or close relative able to provide care and get paid to provide the care to their child.	Under consumer-direction, a parent, spouse, legal guardian or surrogate may be paid to provide care when a waiver beneficiary is 18 years old and older.
Appendix C : Participant Services Medical Equipment and Supplies	Is there a budget for adaptive car seats and vehicular transportation vest? Will this no longer come out of the vehicle modification budget?	Adaptive car seats and vehicular transportation vests will be covered by the waiver service called Medical Equipment and supplies. These items will not come from the vehicle modification budget.
Appendix D: Participant-Centered Planning and Service Delivery D-1 Service Plan Development	DMA should be responsible for writing this Welcome letter to ensure that complete and accurate information is being shared across all agencies.	DMA will write the Welcome Letter. The Welcome letter is a template and will populate based on the information derived from the assessment and Service Plan.
Appendix D: Participant-Centered Planning and Service Delivery D-2 Service Plan Implementation and Monitoring	Quarterly multidisciplinary team meetings- nice idea, but seems unrealistic. Who are “all of the providers”?	Providers listed on the service plan.

Areas of Concerns

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The application process has become more complicated with substantially more documentation during the referral stage. While this information will help evaluate the need for services, we worry that it will delay the process for families who may already be in crisis.	An expedited process is available when services are needed immediately.
In terms of services (page 6 of the Stakeholder Engagement document), it will help if the process of children receiving hospice care (Concurrent Care of the Affordable Care Act) in addition to CAP/C is made easier. According to the ACA, children are entitled to hospice care services. Currently, it is very cumbersome for a child with CAP/C to get hospice services.	Medicaid beneficiaries under the age of 21is entitled to receive all Medicaid services while participating in the waiver when eligibility criteria are met. Waiver beneficiaries will be able to access Hospice services as well as palliative services when the criteria are met.
Will eligibility based on criteria listed be determined at the initial application process or will it be assessed at every renewal?	At the initial entry into the program
Criterion c: replace endotracheal tube with tracheostomy tube; include non-invasive ventilation, all feeding tubes - nasogastric tube, transpyloric tube, gastrostomy tube, gastrojejunostomy tube and feeding pumps, vagal nerve stimulator, catheterization and central line management. This will help Consultants evaluate the needs of children better.	The requirement is only used to determine medical-fragility and those diagnosis are taken in consideration during the analysis of the request.
Criterion c: Also, there are some children who do not have technology, but need constant medical assessment and management of intractable symptoms. Examples include seizures necessitating medication administration, secretions needing constant suctioning, and autonomic storming necessitating assessment of need for medication use.	This information is taken into consideration during the analysis of the request
Criterion c: There are children who have extensive medical needs at home but do not meet the criteria above. For example, an adolescent	EPSDT allows individuals under the age of 20 to have access to Medicaid services that are medically necessary.

with Duchene Muscular Dystrophy who needs a lift system at home cannot receive this service now because he is not eligible for CAP/C with the current system.	
Current policy states that to receive vehicle modification through CAP/C, the vehicle should be no older than 5 years. This restricts many families to modify their vehicle to transport the medically fragile child. It will help if this restriction is relaxed to 10 years. Alternatively, mileage instead of number of years can be used as a criterion.	The policy has been updated to state: A vehicle inspection must be conducted for vehicles that are 7 – 10 years old, or for vehicles with 80,000 – 150, 000 or more miles Vehicle modification excludes the following: a. Vehicles over ten (10) years old; or b. Vehicles with 200, 000 or more miles.
Proposal to move in-home services such as CAP Nursing and Personal Care Services to the State Plan	Personal care service of In-Home Aide has been added back to the waiver service benefit package.