

APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.ⁱ This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. State: North Carolina

B. Waiver Title: Community Alternatives Program for Children

C. Control Number:

NC.4141.R06.04

D. Type of Emergency (The state may check more than one box):

☒	Pandemic or Epidemic
☐	Natural Disaster
☐	National Security Emergency
☐	Environmental
☐	Other (specify):

E. Brief Description of Emergency.

1) nature of emergency

On January 31, 2020, Secretary Azar used his authority pursuant to Section 318 of the Public Health Services Act to declare a public health emergency (PHE) in the entire United States. On March 11, 2020, as authorized under Title V of the Stafford Act, President Donald J. Trump announced the World Health Organization officially announced that novel coronavirus (COVID-19) is a global pandemic.

As authorized under Section 1135 of the Social Security Act, North Carolina is respectfully requesting waivers of certain Medicaid and CHIP requirements to ensure continuity of care and to make it easier for health care providers to deliver Medicaid services while protecting the health, safety and well-being of waiver participants at risk of or impacted by COVID-19 because of their higher risk of severe illness.

2) number of individuals affected and the State's mechanism to identify individuals at risk

There are currently 2,720 CAP/C waiver participants being served across the State of North Carolina. Potentially, all those participants are affected by novel coronavirus (COVID-19) outbreak due to their higher risk of severe illness and the potential to spread. To facilitate access for waiver participant experiencing COVID symptoms and to limit close contact of other individuals experiencing COVID symptoms, it is important to take actions to reduce the risk of exposure of the virus to these medically fragile children and make it easier for health care providers to deliver Medicaid services.

To identify at-risk waiver participants, the State will identify all enrolled waiver participants by an active service plan. A communication notice will be provided to all actively enrolled waiver participants and their assigned case managers informing them of higher risk of severe illness and the potential of spread. The case manager will assist each waiver participant to create a COVID-19 emergency plan that will consist of the following elements: health care needs of the waiver participant and family members; how waiver participant or caregivers will be cared for if services were not able to be provided; identification of resources in the community to assist with COVID-19; update to emergency contact list; identification of a safe zone in the home to separate sick individuals from non-sick individuals; plan to obtain prescriptions and food and identification of a plan if the "family's routine day" is altered due to school closures or workplace changes.

The State is requesting the waiving of service limits as described in Appendix C-1/C-3; the ability to offer retainer payments to in-home aide agencies and direct service providers to promote continuity of care; and the ability to conduct initial and annual level of care and reasonable indication of need assessments telephonically.

3) roles of state, local and other entities involved in approved waiver operations; and

- NC Medicaid is administrator and overseer of waiver operations and functions; assigned case management entities provide day-to-day oversight to waiver beneficiaries through case management.
- Area case management entities complete assessments, plans of care, make service authorization requests and approvals. Case Management entity staff conduct safety and welfare checks.
- VieBridge/eCAP is the system by which assessments are completed, POCs developed, and reviews/service authorizations conducted. This system transfers authorizations to prior approvals and forward to the MMIS for reimbursement for services rendered.
- NC Tracks is the state's MMIS which provides for reimbursement to providers of services rendered

4) expected changes needed to service delivery methods, if applicable. The State should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

N/A

F. Proposed Effective Date: Start Date: 3/13/2020 Anticipated End Date: 3/12/2021

G. Description of Transition Plan.

Waiver participants who qualify for waiving of Appendix C-1/C-3 and other waiver rules and requirements because of COVID-19 will be monitored monthly through the duration of this pandemic to ensure health, safety and well-being and linkage to the most appropriate services and care regiment. When the pandemic is resolved, the assigned case managers will conduct a face-to-face home visit to fully assess needs to assure the accuracy of the service plan.

H. Geographic Areas Affected:

Statewide – 100 counties of North Carolina

I. Description of State Disaster Plan (if available) *Reference to external documents is acceptable:*

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. X Access and Eligibility:

i. X Temporarily increase the cost limits for entry into the waiver.

[Provide explanation of changes and specify the temporary cost limit.]

Exceed cost limit of \$129,000 per waiver entry and annual assessment years, however, ensuring the waiver year cost neutrality in the aggregate.

ii. x Temporarily modify additional targeting criteria.

[Explanation of changes]

Waiver participant does not have to use planned waiver services in the amount, frequency and duration listed in the plan of care during the period of this amendment and will not be subjected to discharge due to an inability to access services because of COVID-19.

b. X Services

i. X Temporarily modify service scope or coverage.

[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. X Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.

[Explanation of changes]

Modification of service identified in Appendix C-1/C-3 in scope and coverage to allow flexibilities of the utilization to prevent spread and to best manage the health, safety and well-being of waiver participant. Services that are proposed to be modified:

1. Case management – only monthly telephonic contact with waiver participant and quarterly telephonic contact with service providers to monitor COVID-19 service plan which will be conducted in accordance with HIPAA requirements. Availability of initial and annual telephonic assessment of level of care and reasonable indication of need which will be conducted in accordance with HIPAA requirements.
2. Participant goods and services – coverage of sanitation (disinfectant) wipes, hand sanitizer and disinfectant spray, when they are not provided in the state plan, for CNAs or personal assistants who can continue to render in-home, pediatric and nurse care to waiver participant. The coverage of facial tissue, thermometer and specific colored trash liners to distinguish dirty linen of infected household member to prevent spread when they are not provided in the state plan. The coverage of over-the counter prescription medication and supplements for the management of COVID-19 or the prevention of.
3. Training/Education/Consultative Services – coverage of training to the paid worker on PPE and other identified training needs specific to the care needs of waiver participant to prevent the spread of COVID-19 when trainings are not provided in the state plan.
4. In-home care, pediatric nurse aide, personal care assistance and congregate – services are not required to be used on a monthly basis or directly rendered per the amount, frequency and duration as approved in the service plan but not less than what is approved in the service plan. In-home care, pediatric nurse aide, personal care assistance and congregate – coverage of payment to a non-live-in close relative and legally responsible person for waiver participant whose hired worker is not able to render the service because of impact from COVID-19.
5. Community Transition – coverage of a less than 90-day institutionalized Medicaid beneficiary experiencing COVID-19 symptoms who can safely transition to a home and community-based placement using HCBS services.
6. Home accessibility and adaptation – the coverage of germicidal air filters when they are not provided in the state plan.

Allowances for expansions of approved waiver services that exceed individual service limitations identified in Appendix C-1/C-3. Based on assessed needs of waiver participant who is experiencing COVID-19 symptoms, the following limits may be exceeded:

1. Home accessibility and adaptation –exceed the service limit of \$28,000.00 waiver limit
2. Case management units – additional monthly reimbursement of case management time to manage needs of waiver participant experiencing COVID-19 symptoms to ensure linkage to resources needed for this vulnerable population.
3. Participant goods and services –exceed the \$800.00 fiscal limit
4. Assistive technology - exceed the \$28,000.00 waiver limit

5. Training/Education/Consultative Services – exceed \$500.00 fiscal limit
6. Respite – exceed the 720 in-home respite hours per fiscal year for in-home and coverage of 30 or more days in an institutional.
7. In-home care, pediatric nurse aide, personal care assistance and congregate hours may be increased over the person-centered approvable utilization limits when waiver participant or family member is impacted by COVID-19 due to a change in school attendance, work hours or family status changes.
8. Community transition – exceed the service limit of \$2,500 waiver approval cycle

iii. ___ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).

[Complete Section A-Services to be Added/Modified During an Emergency]

iv. X Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches) Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

Services of in-home aide, pediatric nurse aide, congregate care, personal care assistance and respite may be provided in a hotel, shelter, church, or facility-based setting when the waiver participant is displaced from the home because of COVID-19 will not duplicate services regularly provided by facility-based settings.

A portable ramp or equipment may be approved to assist with transfers and mobility to allow ease of access in the temporary setting.

v. X Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

Services of in-home aide, pediatric nurse aide, congregate care, personal care assistance and respite may be provided in a hotel, shelter, church, or any facility-based setting which will not duplicate services regularly provided by facility-based settings outside of North Carolina when the participant is displaced from home because of the COVID-19, and an telephonic assessment which will be conducted in accordance with HIPAA requirements attests that services are required, the provider is qualified and the setting is safe. The case manager will complete the telephonic assessment.

A portable ramp or equipment may be approved to assist with transfers and mobility to allow ease of access to setting.

c. X Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

The coverage of payment of hands on personal care for a non-live-in close relative who is not the parent or legal guardian.

d. x Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. x Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

During the pandemic, when live-in family member, legally responsible person or close kinship are approved to render services of in-home aide, pediatric nurse care, personal care assistance and congregate, a registry check, competency validation, and consumer direction training overview, particularly in fraud, waste and abuse and the enrollment in consumer direction are required. The waiving of the CPR certification upon enrollment will be implemented for a live-in relative, legally responsible person or a kinship relative, and a plan to obtain the CPR certification must be identified within 30 days.

Payment to a legally responsible person to provide in-home aide, pediatric nurse aide or congregate services to a CAP/C beneficiary may be made when any **one** of the following extraordinary circumstances is met:

- a. There are no available certified nursing assistants (CNAs) or personal care assistants in the CAP/C beneficiary's county or adjunct counties through a Home Health Agency, In-Home Aide Agency or under consumer direction due to the impact of COVID19, and the CAP/C beneficiary needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
- b. The CAP/C beneficiary requires short-term isolation, 90-days or less, due to experiencing symptoms of COVID-19 and extensive to maximal assistance with bathing, dressing, toileting and eating, and the CAP/C beneficiary chooses to receive care in his or her home instead of an institution.
- c. The CAP/C beneficiary requires physician-ordered 24-hour direct observation and, or supervision specifically related to symptoms of COVID-19 and the legally responsible person is not able to maintain full or part-time employment due to multiple absences from work to monitor and, or supervise the CAP/C beneficiary; regular interruption at work to assist with the management of the CAP/C beneficiary's monitoring or supervision needs; or an employment termination.
- d. The CAP/C beneficiary has specialized health care needs specific to COVID -19 that can be only provided by the legally responsible person, 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 beneficiary and avoid institutionalization.
- e. Other documented extraordinary circumstances not previously mentioned that places the CAP/C beneficiary's health, safety and well-being in jeopardy resulting in an institutional placement that are directly related to COVID-19.

The below assurances are implemented:

1. When a live-in family member, legally responsible person or close kinship is authorized to receive payment for providing personal assistance services, the CAP/C beneficiary is temporarily enrolled in the consumer-direction program. The enrollment in this service will provide quality assurance of the health, safety and well-being of the CAP/C beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.

2. The assigned Case Management Entity (CME) shall monitor the CAP/C beneficiary closely to ensure the services are provided according to the service plan and the waiver participation business requirements are met. Weekly monitoring visits will be conducted telephonically.
3. The COVID-19 Care Management Plan must be completed and fully describes the ability of the caregiver to function in that role.
4. A competency skill checklist must be completed on live-in family member, legally responsible person or close kinship to identify ability and any training needs.
5. A training will be provided in fraud, waste and abuse
6. A training will be provided on critical incident reporting and management
7. A training will be provided in abuse, neglect and exploitation

ii. ___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the provider type for each service].

iii. ___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. X Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

The initial and annual assessments to be completed telephonically by the assessor throughout the duration of the pandemic which will be conducted in accordance with HIPAA requirements.

f. ___ Temporarily increase payment rates

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider].

g. X Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

Service plans may be developed and approved telephonically which will be conducted in accordance with HIPAA requirements. Approved service plans shall be monitored telephonically which will be conducted in accordance with HIPAA requirements by the case manager, monthly. A quarterly telephonic contact which will be conducted in accordance with HIPAA requirements to service providers to monitor COVID-19 service plans and approved service modifications.

Telephonic service plan approvals include an electronic signature (e.g., via email, fax or social media exchange when in accordance with HIPAA requirements) and other state approved waiving requirements through an 1135 waiver.

The approved services listed on the service plan in the amount, frequency and duration will continue to be approved through waiver service authorization updates. Prior approval segments will be transmitted to the MMIS for claims adjudication.

h. ___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i. __X_ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

Necessary supports including communication and personal care available through in-home aide, personal care assistance and congregate care may be provided in a hospital, rehabilitation facility, or short-term institution when the waiver participant is displaced from home because of COVID-19 and such supports are not otherwise available in these settings. Supplemental services provided in the hospital or other institutional placement can only be provided for up to 30 consecutive days. There may be more than one 30 consecutive day period.

j. __X_ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

Authorize payment to direct care workers (providers of personal care services) in the amount, frequency and duration as listed on the currently approved service plan when a waiver participant or hired worker is directly impacted by COVID-19 not to exceed a 30-day consecutive authorization period. If nursing facility has a bed hold that is less than 30 days, the retainer payment will not exceed that amount.

Retainer payments are only authorized to maintain the previously assigned worker at the agreement of both parties (the waiver participant and the employee). When a retainer payment is authorized, a retainer agreement is implemented which includes

the following statement “the employee who is being retained will not be eligible for unemployment and the waiver participant may receive a new in-home aide employee to provide care per the assessed needs as result of COVID-19.” The retainer agreement will be approved on a 30-day approval period. The retainer agreement will be updated in 30-day intervals to ensure the continued appropriateness of the retainer agreement. If the agreement needs to be extended after the 30-day authorization period, another agreement will be implemented with a new 30-day effective period at least one day after the expiration of the previous agreement.

The retainer agreement includes the following:

Name of Beneficiary

Name of employee who is being retained

Authorization period

Service agreement Level

Wage rate

A retainer payment is only implemented due to a state of emergency through this Appendix K when the hired worker is experiencing sickness from COVID-19; the hired worker is unavailable due to caring for sick family member impacted by COVID-19; the waiver participant is sick due to COVID-19; or the waiver participant refuses to allow or wants to limit hired workers into his or her home in an attempt to reduce or mitigate the risk of exposure or the spread of COVID-19.

k. ___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards]

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l. ___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

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m. ___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

The extension of NC.4141.R06.04 Evidentiary Report through August 30, 2020.

Contact Person(s)

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

First Name:	Melanie
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Last Name	Bush
Title:	Deputy Director
Agency:	DHHS – Division of Health Benefits
Address 1:	1985 Umstead Drive
Address 2:	2501 Mail Service Center
City	Raleigh
State	NC
Zip Code	27609-2501
Telephone:	919-855-4182
E-mail	Melanie.bush@dhhs.nc.gov
Fax Number	919-733-6608

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

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

Signature:

State Medicaid Director or Designee

Date:

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First Name:	Dave
Last Name	Richard
Title:	Deputy Secretary
Agency:	DHHS – Division of Health Benefits

Address 1:	1985 Umstead Drive
Address 2:	2501 Mail Service Center
City	Raleigh
State	NC
Zip Code	27609-2501
Telephone:	919-855-4101
E-mail	Dave.richard@dhhs.nc.gov
Fax Number	

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver which the state is temporarily modifying, enter the entire service definition and highlight the change. 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 Specification	
Service Title:	Case Management
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	
A service that directs and manages the special health care, social, environmental, financial and emotional needs of a CAP beneficiary in order to maintain the beneficiary's health, safety and well-being and continuous community integration. Case management is a CAP service offered to CAP beneficiaries to assist in navigating community systems and gaining access to Medicaid services to meet their identified needs. The comprehensive interdisciplinary assessment identifies the lack of an informal support system and the need for intervention by a case manager. When the assessment identifies a CAP beneficiary to be at risk of institutionalization, case management must be listed in the service plan on a monthly basis. The CAP beneficiary has the option to select an approved case management provider to provide guidance and assistance through the annual participation in the CAP waiver. There are two types of case managers under case management and four principles of case management (listed below): The two types of case managers are: a. Case Manager provides services for a CAP beneficiary participating in provider-led services. b. Care Advisor provides specialized case management to a CAP beneficiary participating in consumer-directed care. The care advisor focuses on empowering participants to define and direct their own personal assistance and services. The care advisor guides and supports the CAP beneficiary, rather than directs and manages the CAP beneficiary throughout the service planning and delivery process. These functions are done under the guidance and direction of the CAP beneficiary or responsible party. There are Four Principle Activities of Case Management: a. assessing b. care planning c. referral and Linkage d. monitoring & Follow-up At the completion of a comprehensive, independent assessment, risk indicators are identified through risk assessment algorithms. If the results of the risk assessment show the waiver beneficiary to be at high risk, the case management entity must conduct a face-to-face home visit each month for the first three months of the assessment. During the quarterly review, risk indicators are reassessed to determine the ongoing monitoring patterns. When the risk indicators are medium to low, the case management entity will conduct face-to-face visits on a quarterly basis. Planning for the pandemic, case management activities may be performed telephonically when conducted in accordance with HIPAA requirements to assess, care plan and monitor the waiver participant. The initial and annual level of care assessments may be performed telephonically in addition to the in-person assessments to include change of status assessments. The timelines to complete the level of care assessment may be extended for up to 60 calendar days. Telephonic service plan approvals include an electronic signature (e.g., via email, fax or social media exchange when in accordance with HIPAA requirements) and other state approved waiving requirements through an 1135 waiver. Electronic signatures will have disclaimer/attestation for approval of the plan in the e-CAP system for new requests or revisions. The case management activities include the following documented forms which must be maintained in the CAP beneficiary's case file:	

a.	Service request form;
b.	comprehensive assessments;
c.	service plan;
d.	case management notes;
e.	service authorizations;
f.	copies of claims generated by the case management entity;
g.	any required documents generated by other providers and approved by the case management entity;
h.	related correspondence in compliance with all applicable federal and state laws, rules and regulations;
i.	electronic signatures as described above.

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

If a request is made to transfer to another case management entity, a root cause analysis must be performed within five (5) days to ensure the health and well-being of the CAP beneficiary, as well as to identify utilization limits and access the performance of the previous and newly requested case management entity. DMA shall approve the transfer of case management entity.

The following activities are not considered reimbursable case management activities:
 completing time sheets;
 traveling time;
 recruiting staff;
 scheduling and supervising staff;
 billing Medicaid;
 documenting case management activities;
 any form of case management activities for an individual not approved to participate in CAP to include preparation for due process

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

Case Management hours may exceed the monthly reimbursable limits per month for the management of waiver participant in wake of pandemic to assess medical services and other community supports when determine necessary as evidence by excessive case management activities as described in the case notes.

Provider Specifications			
Provider Category(s) (check one or both):	☐	Individual. List types:	☒ Agency. List the types of agencies:
			Case Management Entities
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person	☐ Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
case management entity	N/A	N/A	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.

Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Case Management	NC Medicaid		Initially and every five years	
Service Delivery Method				
Service Delivery Method (check each that applies):	☐	Participant-directed as specified in Appendix E	☒	Provider managed



ⁱ Numerous changes that the state may want to make necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Service Specification	
Service Title:	Participant Goods and Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	
A service for waiver beneficiaries that provides for the provision of equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that ensures the health, safety and well-being and the waiver beneficiary or responsible party does not have the funds to purchase the medically necessary item or service. These services, equipment, and/or supplies are purchased through the case management entity. Medicaid providers who have the capacity as verified by the case manager shall provide items and services of sufficient quality and appropriateness to meet the needs of the beneficiary. Some items may be purchased directly through a retailer as long as the items meet the specifications of the service definition. Participant goods and services are items that are intended to: • increase the waiver beneficiary's ability to perform ADLs or IADLs; • decrease dependence on personal assistant services or other Medicaid-funded services Specific supplies, when not available in the state plan, are coverable to assist in preventing the spread of COVID-19. These supplies are: Sanitation (disinfectant) wipes;	

- hand sanitizer and disinfectant spray for CNAs or personal assistants who can continue to render in-home, pediatric and nurse care to waiver participant;
- facial tissue;
- thermometer; and
- specific colored trash liners to distinguish dirty linen of infected household member to prevent spread.

The coverage of over-the counter prescription medication and supplements when prescribed by a physician and not available in the state plan, for specific management of COVID-19 or the prevention of.

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

The cost of participant goods and services for each beneficiary may exceed \$800.00 annually (July –June). Any item over \$200.00 must be approved by a SMA consultant. Products and items such as gloves, masks, oxygen, equipment listed on the State Medicaid Plan are prohibited from being reimbursed by this service unless approved by the State Medicaid Agency.

Provider Specifications

Provider Category(s) (check one or both):	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Business and Retail

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

☐	Legally Responsible Person	☐	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Business Retail	Business commercial license		
Commercial	Business commercial license		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Business	NC Medicaid and Case Management entity	Initially and at time of service provision
Commercial		

Service Delivery Method

Service Delivery Method (check each that applies):	☒	Participant-directed as specified in Appendix E	☒	Provider managed
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Service Specification			
Service Title:	Training, Education and Consultative Services		
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:			
Service Definition (Scope):			
A service for a CAP beneficiary that provides for training, orientation, and treatment regimens, regarding the nature of the illness or disability and its impact on the CAP beneficiary and family for the individuals (such as family members, neighbors, friends, or companions) who provide unpaid care, support, training, companionship, or supervision. The purpose of this training is to enhance the decision-making ability of the beneficiary, the ability of the beneficiary to independently care for his or herself, or the ability of the family member or personal assistant in caring for the CAP beneficiary. Training and education consists of information and techniques for the use of specialized equipment and supplies and updates as necessary to maintain health and safety and well-being. This service will cover training to the paid workers on PPE specific to the care needs of waiver participant to assist to prevent the spread of COVID-19 when trainings are not provided in the state plan. All training and education services are documented in the service plan as a goal with the expected outcomes. This service covers conference registration and enrollment fees for classes. Service is provided by community colleges, universities, or an organization with a training or class curriculum approved by DHB. Each waiver beneficiary will be assessed using person-centered planning methodology. If a waiver beneficiary's status changes, and requires service units over the average limit, an assessment of needs will be evaluated on an individual basis. Service requests that meet eligibility criteria will be approved at the assessed need, DMA will closely monitor the individual and wavier average per capita cost to maintain cost neutrality of the waiver.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Service may exceed \$500 per fiscal year (July 1- June 30) to assist with preventing the spread of COVID-19. This service does not include the cost of travel, meals, or overnight lodging to attend a training event or conference Individuals who are paid service providers are excluded from this service. This service does not cover the cost for license, certification or credentials.			
Provider Specifications			
Provider Category(s) (check one or both):	☐	Individual. List types:	☒ Agency. List the types of agencies:
			Business/Commercial /Education settings
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person	☐ Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)

Business	Commercial license			
Commercial	Commercial license			
Education settings				
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Business	Case management entity and NC Medicaid		prior to service provision	
Commercial	Case management entity and NC Medicaid		prior to service provision	
Educational setting	Case management entity and NC Medicaid		prior to service provision	
Service Delivery Method				
Service Delivery Method (check each that applies):	x	Participant-directed as specified in Appendix E	x	Provider managed

Service Specification	
Service Title:	In-Home Care Aide Service
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	
Personal Care Services under North Carolina state plan differs in service definition and provider type from the services offered under the waiver. Personal Care services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging the participant describes the flexibility of activities that may encourage the participant to maintain skills while also providing supervision for independent activities. During the pandemic, this service is not required to be used on a monthly basis and can be rendered in varying amounts, frequencies and duration as approved in the service plan to manage symptoms or the spread of COVID-19, but not less than what is previously approved in the service plan. A service for CAP beneficiaries that, during the hours of service provision, provides hands-on (not merely set-up, cuing, or supervision) assistance with a minimum of two limited to extensive ADLs who are unable to perform these tasks independently due to a medical condition identified and documented on a validated assessment. The need for assistance with ADLs relates directly to the CAP beneficiary's physical disability, and functional limitations. In-home aide services, when medically necessary, shall be provided in the community, home, or educational settings. The personal care needs must fall within the NA I scope of nursing practice. Individual participating in this waiver will be assessed to determine if the in-home aide service is medically necessary in a similar process conducted through EPSDT. During the pandemic, a short-term intensive service plan will be created to manage the needs of the waiver participant due to COVID-19 and the mandate to practice social distancing. Short-term intensive services are used for a significant change in the health, safety and well-being or acuity status of the CAP beneficiary. The Short-term intensive service plan will extend through the duration of the pandemic and as long as needed by the waiver participant or at the expiration of the approved Appendix K. Short-term intensive services are listed in the service plan and is consistent with the needs identified in the COVID-19 care management plan. This service may be provided in an in-patient facility when waiver participant is institutionalized because of COVID-19 symptoms. Necessary supports including communication and personal care available through in-home aide, pediatric nurse aide, congregate care, and personal care assistance may be	

provided in a hospital, rehabilitation facility, or short-term institution when the waiver participant is displaced from home because of COVID-19 and such supports are not otherwise available in these settings. Supplemental services provided in the hospital or other institutional placement can only be provided for up to 30 consecutive days. There may be more than one 30 consecutive day period.

A legally responsible, child, sibling, or other relatives can be hired as the employee when a CAP beneficiary is 18 years of age or older.

The employment of a legally responsible person, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if :

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

When determined appropriate per the CAP COVID-19 Care Management Plan payment for services rendered by a family caregivers or legally responsible person and guardian may be permissible for a 30 consecutive day approval period specifically to quarantine or the practice of social distancing mandated, according to the extraordinary policy outlined in the waiver. Monitoring requirements as described in the extraordinary criteria will be implemented.

A CAP beneficiary can use up to 14 days per year of recreational leave, when planned for in the initial and annual person-centered service plan. The exact dates of the leave do not have to be included in the service plan when the initial or annual plan is completed.

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

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

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

A legally responsible person, child, sibling, or other relatives can be hired as the employee when a CAP beneficiary is 18 years of age or older.

The employment legally responsible person, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if:

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

When determined appropriate per the CAP COVID-19 Care Management Plan payment for services rendered by a family caregivers or legally responsible person and guardian may be permissible for a 30 consecutive day approval period specifically to quarantine or the practice of social distancing mandated, according to the extraordinary policy outlined in the waiver. Monitoring requirements as described in the extraordinary criteria will be implemented.

Payment to a legally responsible person provide in-home aide, pediatric nurse aide or congregate services to a CAP/C beneficiary may be made when any one of the following extraordinary circumstances is met:

- a. There are no available certified nursing assistants (CNAs) or personal care assistants in the CAP/C beneficiary's county or adjunct counties through a Home Health Agency, In-Home Aide Agency or under

consumer direction due to the impact of COVID19, and the CAP/C beneficiary needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.

b. The CAP/C beneficiary requires short-term isolation, 90-days or less, due to experiencing symptoms of COVID-19 extensive to maximal assistance with bathing, dressing, toileting and eating, and the CAP/C beneficiary chooses to receive care in his or her home instead of an institution.

c. The CAP/C beneficiary requires physician-ordered 24-hour direct observation and, or supervision specifically related to symptoms of COVID-19 and the legally responsible person is not able to maintain full or part-time employment due to multiple absences from work to monitor and, or supervise the CAP/C beneficiary; regular interruption at work to assist with the management of the CAP/C beneficiary's monitoring or supervision needs; or an employment termination.

d. The CAP/C beneficiary has specialized health care needs specific to COVID-19 that can be only provided by the legally responsible person, 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 beneficiary and avoid institutionalization.

e. Other documented extraordinary circumstances not previously mentioned that places the CAP/C beneficiary's health, safety and well-being in jeopardy resulting in an institutional placement directly related to COVID-19.

The below assurances are implemented:

1. When a legally responsible person is authorized to receive payment for providing personal assistance services, the CAP/C beneficiary is temporarily enrolled in the consumer-direction program. The enrollment in this service will provide quality assurance of the health, safety and well-being of the CAP/C beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.
2. The assigned Case Management Entity (CME) shall monitor the CAP/C beneficiary closely to ensure the services are provided according to the service plan and the waiver participation business requirements are met. Weekly monitoring visit will be conducted telephonically.
3. The COVID-19 Care Management Plan must be completed and fully describes the ability of the caregiver to function in that role.
4. A competency skill checklist must be completed on live-in family member, legally responsible person or close kinship to identify ability and any training needs.
5. A training will be provided in fraud, waste and abuse
6. A training will be provided on critical incident reporting and management
7. A training will be provided in abuse, neglect and exploitation

Retainer payments are only authorized to maintain the previously assigned worker at the agreement of both parties (the waiver participant and the employee). When a retainer payment is authorized, a retainer agreement is implemented which includes the following statement "the employee who is being retained will not be eligible for unemployment and the waiver participant may receive a new in-home aide employee to provide care per the assessed needs as result of COVID-19." The retainer agreement will be approved on a 30-day approval period. The retainer agreement will be updated in 30-day intervals to ensure the continued appropriateness of the retainer agreement. If the agreement needs to be extended after the 30-day authorization period, another agreement will be implemented with a new 30-day effective period at least one day after the expiration of the previous agreement.

The retainer agreement includes the following:

Name of Beneficiary

Name of employee who is being retained

Authorization period

Service agreement Level

Wage rate

A retainer payment is only implemented due to a state of emergency through this Appendix K when the hired worker is experiencing sickness from COVID-19; the hired worker is unavailable due to

caring for sick family member impacted by COVID-19; the waiver participant is sick due to COVID-19; or the waiver participant refuses to allow or wants to limit hired workers into his or her home in an attempt to reduce or mitigate the risk of exposure or the spread of COVID-19.

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

Individuals with criminal offenses (listed above) occurring more than 10 years previous to the date of the criminal report may qualify for an exemption. The financial manager shall inform the CAP beneficiary when a prospective employee is within the 10-year rule and the CAP beneficiary shall have the autonomy to approve the exemption. During the pandemic, when family members are choosing to direct care, waiving of the CPR certification and a statewide criminal background check is permitted for a live-in relative or a kinship relative, but a county-based criminal background check is required in conjunction with a registry check, competency validation, consumer direction training overview, particularly in fraud, waste and abuse and consumer direction enrollment.

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

This service may be provided in an alternative setting such as hotels, shelters, schools, churches when not duplicative to services regularly provided by facility-based settings.

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

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

A legally responsible person, child, sibling, or other relatives is eligible for hire as the employee when requirements are met. The employment of a spouse, parent, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if:

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

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

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

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

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

Consumer-directed providers shall:

- a. undergo a statewide background check and registry check prior to hire; and
- b. demonstrate competencies and skill sets to care for the CAP beneficiary as documented by the consumer-directed participant or responsible party and uploaded to the case file by the case management entity. Documentation must be provided when specific training and education services are needed, and documentation is available to support training needs were met.

Individuals with the following criminal records are excluded from hire although these restrictions may be waived if over 10 years old:

a. Felonies related to manufacture, distribution, prescription, or dispensing of a controlled substance; b. Felony health care fraud; c. More than one felony conviction; d. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult; e. Felony or misdemeanor patient abuse; f. Felony or misdemeanor involving cruelty or torture; g. Misdemeanor healthcare fraud; h. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult; i. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or j. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC.					
Provider Specifications					
Provider Category(s) (check one or both):	☒	Individual. List types:	☒	Agency. List the types of agencies:	
	Personal assistant		In-home Aide Agencies		
			Home Health Agencies		
Specify whether the service may be provided by (check each that applies):		☒	Legally Responsible Person	☒	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):					
Provider Type:	License (specify)		Certificate (specify)		Other Standard (specify)
Personal Assistant					Pass competency assessment
In-home Aide Agencies			CNA		Personal assistant
Home Health Agencies			CNA		Personal assistant
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:			Frequency of Verification	
In-home Aide Agencies	NC Medicaid and case management entity			initially and annually	
Home Health Agencies	NC Medicaid and case management entity			initially and annually	
Personal assistant	NC Medicaid and case management entity			initially and annually	
Service Delivery Method					
Service Delivery Method (check each that applies):	☒	Participant-directed as specified in Appendix E			☒ Provider managed

Service Specification	
Service Title:	Pediatric Nurse Aide Services
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope):	

Personal Care Services under North Carolina state plan differs in service definition and provider type from the services offered under the waiver. Personal Care services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging the participant describes the flexibility of activities that may encourage the participant to maintain skills while also providing supervision for independent activities.

During the pandemic, this service is not required to be used on a monthly basis and can be rendered in varying amounts, frequencies and duration as approved in the service plan to manage symptoms or the spread of COVID-19, but not less than what is previously approved in the service plan.

A service for CAP beneficiaries who require extensive hands-on (not merely set-up, cueing, or supervision) assistance with a minimum of two Activities of Daily Living (ADL) who are unable to perform these activities independently due to a medical condition or diagnosis identified and documented on an assessment. The care needs must fall under the category of Nurse Aide II or certification in pediatric, or a recommendation by an RN that competencies are met in the area of need. Individual participating in this waiver will be assessed to determine if the pediatric nurse aide service is medically necessary in a similar process conducted through EPSDT.

During the pandemic, a short-term intensive service plan will be created to manage the needs of the waiver participant due to COVID-19 and the mandate to practice social distancing. Short-term intensive services are used for a significant change in the health, safety and well-being or acuity status of the CAP beneficiary. The Short-term intensive service plan will extend through the duration of the pandemic and as long as needed by the waiver participant or at the expiration of the approved Appendix K. Short-term intensive services are listed in the service plan and is consistent with the needs identified in the COVID-19 care management plan.

This service may be provided in an in-patient facility when waiver participant is institutionalized because of COVID-19 symptoms. Necessary supports including communication and personal care available through in-home aide, pediatric nurse aide, congregate care, and personal care assistance may be provided in a hospital, rehabilitation facility, or short-term institution when the waiver participant is displaced from home because of COVID-19 and such supports are not otherwise available in these settings. Supplemental services provided in the hospital or other institutional placement can only be provided for up to 30 consecutive days. There may be more than one 30 consecutive day period.

Services must be substantial. This means that the beneficiary's needs can be met by trained unlicensed personnel at the Nurse Aide II level. Nurse Aide services could not and shall not be provided by personal care aides/home health aides not registered with the North Carolina Division of Health Services Regulations.

The registered nurse maintains accountability and responsibility for the delivery of safe and competent care (N.C. Board of Nursing). Decisions regarding the delegation of any nurse aide tasks are made by the licensed nurse on a beneficiary-by-beneficiary basis.

The criteria stated below shall be met in order for a task to be delegated to unlicensed personnel. The task:

- a. is performed frequently in the daily care of a beneficiary or group of beneficiaries;
- b. is performed according to an established sequence of steps;
- c. involves little or no modification from one client situation to another;
- d. may be performed with a predictable outcome;
- e. does not involve ongoing assessment, interpretation, or decision-making that cannot be logically separated from the task itself; and
- f. does not endanger the beneficiary's life or well-being.

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

When determined appropriate per the CAP COVID-19 Care Management Plan payment for services rendered by a family caregivers or legally responsible person and guardian may be permissible for a 30 consecutive day approval period specifically to quarantine or the practice of social distancing mandated, according to the

extraordinary policy outlined in the waiver. Monitoring requirements as described in the extraordinary criteria will be implemented.

During the pandemic, a short-term intensive service plan will be created to manage the needs of the waiver needs. Short-term intensive services are used for a significant change in the health, safety and well-being needs or acuity status of the CAP beneficiary. The Short-term intensive service plan will extend through the duration of the pandemic and as long as needed by the waiver participate through the approval period of the Appendix K. Short-term intensive services are listed in the service plan.

A CAP beneficiary can use up to 14 days per year of recreational leave, when planned for in the initial and annual person-centered service plan. The exact dates of the leave do not have to be included in the service plan when the initial or annual plan is completed.

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

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

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

When determined appropriate per the CAP COVID-19 Care Management Plan payment for services rendered by a family caregivers or legally responsible person and guardian may be permissible for a 30 consecutive day approval period specifically to quarantine or the practice of social distancing mandated, according to the extraordinary policy outlined in the waiver. Monitoring requirements as described in the extraordinary criteria will be implemented.

Payment to a legally responsible person provide in-home aide, pediatric nurse aide or congregate services to a CAP/C beneficiary may be made when any **one** of the following extraordinary circumstances is met:

- a. There are no available certified nursing assistants (CNAs) or personal care assistants in the CAP/C beneficiary's county or adjunct counties through a Home Health Agency, In-Home Aide Agency or under consumer direction due to the impact of COVID19, and the CAP/C beneficiary needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
- b. The CAP/C beneficiary requires short-term isolation, 90-days or less, due to experiencing symptoms of COVID-19 extensive to maximal assistance with bathing, dressing, toileting and eating, and the CAP/C beneficiary chooses to receive care in his or her home instead of an institution.
- c. The CAP/C beneficiary requires physician-ordered 24-hour direct observation and, or supervision specifically related to symptoms of COVID-19 and the legally responsible person is not able to maintain full or part-time employment due to multiple absences from work to monitor and, or supervise the CAP/C beneficiary; regular interruption at work to assist with the management of the CAP/C beneficiary's monitoring or supervision needs; or an employment termination.
- d. The CAP/C beneficiary has specialized health care needs specific to COVID-19 that can be only provided by the legally responsible person, 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 beneficiary and avoid institutionalization.
- e. Other documented extraordinary circumstances not previously mentioned that places the CAP/C beneficiary's health, safety and well-being in jeopardy resulting in an institutional placement directly related to COVID-19.

The below assurances are implemented:

1. When a legally responsible person is authorized to receive payment for providing personal assistance services, the CAP/C beneficiary is temporarily enrolled in the consumer-direction program. The enrollment in this service will provide quality assurance of the health, safety and well-being of the CAP/C beneficiary and provides the controls to ensure that payments are made only for the services authorized to provide.
2. The assigned Case Management Entity (CME) shall monitor the CAP/C beneficiary closely to ensure the services are provided according to the service plan and the waiver participation business requirements are met. Weekly monitoring visit will be conducted telephonically.
3. The COVID-19 Care Management Plan must be completed and fully describes the ability of the caregiver to function in that role.
4. A competency skill checklist must be completed on live-in family member, legally responsible person or close kinship to identify ability and any training needs.
5. A training will be provided in fraud, waste and abuse
6. A training will be provided on critical incident reporting and management
7. A training will be provided in abuse, neglect and exploitation

Retainer payments are only authorized to maintain the previously assigned worker at the agreement of both parties (the waiver participant and the employee). When a retainer payment is authorized, a retainer agreement is implemented which includes the following statement "the employee who is being retained will not be eligible for unemployment and the waiver participant may receive a new in-home aide employee to provide care per the assessed needs as result of COVID-19." The retainer agreement will be approved on a 30-day approval period. The retainer agreement will be updated in 30-day intervals to ensure the continued appropriateness of the retainer agreement. If the agreement needs to be extended after the 30-day authorization period, another agreement will be implemented with a new 30-day effective period at least one day after the expiration of the previous agreement.

The retainer agreement includes the following:

Name of Beneficiary

Name of employee who is being retained

Authorization period

Service agreement Level

Wage rate

A retainer payment is only implemented due to a state of emergency through this Appendix K when the hired worker is experiencing sickness from COVID-19; the hired worker is unavailable due to caring for sick family member impacted by COVID-19; the waiver participant is sick due to COVID-19; or the waiver participant refuses to allow or wants to limit hired workers into his or her home in an attempt to reduce or mitigate the risk of exposure or the spread of COVID-19.

Individuals with the following criminal records are excluded from hire when consumer-direction is selected:

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

Note: Individuals with criminal offenses occurring more than 10 years previous to the date of the criminal report may qualify for an exemption. The financial manager shall inform the CAP beneficiary when a prospective employee is within the 10-year rule and the CAP beneficiary shall have the autonomy to approve the exemption.

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

This service may be provided in an alternative setting such as hotels, shelters, schools, churches when not duplicative to services regularly provided by facility-based settings.

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

The employment of a spouse, parent, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if:

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

When determined appropriate per the CAP COVID-19 Care Management Plan payment, payment for services rendered by a family caregivers or legally responsible person and guardian may be permissible for a 30 consecutive day approval period.

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

Legally responsible person may be hired to provide personal care services to CAP beneficiaries when warranted by the COVID-19 Care Management Plan. This applies for both traditional and consumer-directed services.

A legally responsible person, child, sibling, or other relative is eligible for hire as the employee of CAP beneficiary. The employment of a spouse, parent, grandparent, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if:

- a. CAP provider are 18 years of age or older; and
- b. Meets the qualifications to perform the level of personal care determined by the CAP COVID-19 Care Management Plan.

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

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

Nurse Aide services shall not be provided at the same day or time as other personal care-type services. Pediatric Nurse Aide Services may not be provided if it duplicates other Medicaid or non-Medicaid services.

An employee submitting an application for hire under the consumer-directed care must comply with all policies and procedures of the consumer-direction program and successful pass a background check. During the pandemic, when family members are choosing to direct care, waiving of the CPR certification and a statewide criminal background check is permitted for a live-in relative or a kinship relative, but a county-based criminal

background check is required in conjunction with a registry check, competency validation, consumer direction training overview, particularly in fraud, waste and abuse and consumer direction enrollment.					
Provider Specifications					
Provider Category(s) (check one or both):	☒	Individual. List types:	☒	Agency. List the types of agencies:	
		Personal assistant		In-home Aide Agencies	
				Home Health Agencies	
Specify whether the service may be provided by (check each that applies):	☒	Legally Responsible Person	☒	Relative/Legal Guardian	
Provider Qualifications (provide the following information for each type of provider):					
Provider Type:		License (specify)	Certificate (specify)	Other Standard (specify)	
Verification of Provider Qualifications					
Provider Type:	Entity Responsible for Verification:			Frequency of Verification	
In-home Aide Agencies	NC Medicaid and case management entity			initially and annually	
Home Health Agencies	NC Medicaid and case management entity			initially and annually	
Personal assistant	NC Medicaid and case management entity			initially and annually	
Service Delivery Method					
Service Delivery Method (check each that applies):	☒	Participant-directed as specified in Appendix E		☒	Provider managed

Service Specification	
Service Title:	Institutional and Non-Institutional Respite
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope):	
Respite care provides short-term support to a family caring for a CAP beneficiary. It can be used as day, evening, or overnight care to meet a range of beneficiary needs such as caregiver relief. Respite care may be provided either in the beneficiary's residence or in a facility licensed to provide the LOC required by the beneficiary such as a nursing facility or hospital. Institutional Respite is a service for CAP beneficiaries that provides temporary support to the primary caregiver(s) by taking-over the care needs for a limited time. The provision of this service takes place in a Medicaid-certified nursing facility or a hospital with swing beds. Institutional respite is computed on a daily capitation rate per the current Fee Schedule. will not exceed 30 consecutive days. Institutional Respite may	

not exceed 30 consecutive days in the authorization period, but there may be more than one 30 consecutive day period

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

This service may be provided in an alternative setting such as hotels, shelters, schools, churches. Institutional Respite may not exceed 30 consecutive days in the authorization period, but there may be more than one 30 consecutive day period.

Respite hours may exceed more than that total to 720 hours/fiscal year when identified in the COVID-19 Care Management Plan and be used for the following two purposes:

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

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

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

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

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

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

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

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

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

The maximum limit of 720 hours/fiscal year may be exceeded to manage the symptoms or the spread of the COVID-19.

Respite cannot be provided by a legally responsible party or a live-in family member.

The request for respite must fall within the guideline and definition of respite. When weekly/daily requests for respite to cover additional hours of care, the case manager shall consider service plan revision to meet the new needs of the beneficiary.

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

Provider Category(s) (check one or both):	☒	Individual. List types:	☒	Agency. List the types of agencies:
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person	☐	Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):				
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)	
Personal Assistant			Pass competency assessment	
In-home Aide Agencies		CNA	Personal assistant	
Home Health Agencies		CNA	Personal assistant	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
In-home Aide Agencies	NC Medicaid and case management entity		initially and annually	
Home Health Agencies	NC Medicaid and case management entity		initially and annually	
Personal assistant	NC Medicaid and case management entity		initially and annually	
Service Delivery Method				
Service Delivery Method (check each that applies):	☒	Participant-directed as specified in Appendix E	☒	Provider managed

Service Specification	
Service Title:	Home Accessibility and Adaptation
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope):	
Home accessibility and adaptation provides equipment and physical adaptations or minor modification, as identified during an assessment, to enhance the CAP beneficiary's mobility, safety, and independence in the primary private residence. This service often plays a key role in preventing institutionalization. Items acquired through this waiver service will exclude items covered under the Home Health Final Rule. An assessment must be completed by a Physical Therapist (PT), Occupational Therapist (OT), Rehabilitation Engineer, or Assistive Technology Professional (for ECUs/EADLs) certifying medical necessity. A copy of the	

assessment must be submitted with the request for Home Modifications (with the exception of floor coverings, air filters, and generators). A physician's signed order may be needed to certify that the requested adaptation is medically necessary. The physician's order must be on file with the participant's records. When feasible there must be up to two competitive quotes for home modifications to determine the most efficient method to complete the request. An appropriate professional shall provide the modifications or adaptations to the primary private residence.

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

The case management entity shall file a claim to Medicaid for this service to reimburse the contractor when the modification is completed and determined acceptable by the beneficiary and the case manager. The original invoice must be retained in the beneficiary's record.

Home modifications can be provided only in the following settings:

- a. A primary private residence where the CAP beneficiary resides that is owned by the individual or the family;
- b. A rented residence when the modifications are portable; or
- c. A rented residence, when the landlord is not obligated to modify the home to the beneficiary's physical or medical need.

Approval for floor coverings, air filtration, and generators must be based on nurse assessment and MD certification.

The following are the only approved home accessibility, adaption and modifications:

- a. Wheelchair ramps, stationary or portable;
- b. Threshold ramps, used to allow wheelchairs to move over small rises such as doorways or raised landings;
- c. Grab bars or safety rails mounted to wall;
- d. Modification of bathroom facilities to improve accessibility for a disabled individual, including: roll in shower, sink modifications, water faucet controls, tub modifications, toilet modifications (such as raised seat, rails), floor urinal adaptations, and plumbing modifications that are necessary for the above listed items;
- e. Widening of doorways for wheelchair access, turnaround space modifications for bath chairs and wheelchair access;
- f. Bedroom modifications other than doorway widening to accommodate hospital beds and wheelchairs (for example, removing a closet to add space);
- g. Lift systems and elevators, that are used inside a beneficiary's private primary residence and are not otherwise covered under DME (for example, ceiling track);
- h. Porch stair lifts;
- i. Floor coverings when evidence of fall risk is documented, or when those floor coverings are contributing to asthma exacerbations requiring repeated emergency room or hospital treatment;
- j. Portable or whole house air filtration system and filters under the following circumstances:
 1. For beneficiaries with severe allergies or asthma, when all other preventive measures such as removal of the allergen or irritant, removal of carpeting and drapes have been attempted, and the beneficiary's asthma remains classified as moderate persistent or severe persistent, and a physician has certified that air filtration is of benefit. Ozone generators and electronic or electrostatic or other air filters which produce ozone or less than or equal to 50 parts per billion ozone byproduct is not covered.
 2. For beneficiaries susceptible to infection, when adequate infection control measures are already in place yet the beneficiary continues to acquire airborne infections, and when a physician has certified that air filtration is of benefit in preventing infection, a germicidal air filter (with UV light) may be provided.
 3. The smallest unit that meets the beneficiary's needs is covered; i.e., if a beneficiary spends most of his or her time confined to a specific area of the house, then a whole-house system is not approved.

k. Portable Back-up generator for a ventilator, when the beneficiary uses the ventilator more than eight hours per day and in the event of a power outage the beneficiary would require hospitalization if not for the presence of the generator.

l. 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 (i.e. lights, door strikes and openers, HVAC, TV, telephone, hospital bed, computer, small appliances, etc.). All Environmental Control Units perform most of the same functions but vary by the method of control that best suits the beneficiary. An ECU or EADL can range from a single function device up to a whole house computer-based system.

m. the coverage of germicidal air filters, when not available in the state plan.

The home accessibility and adaption service consists of the following:

- a. Technical assistance in device selection;
- b. Training in device use by a qualified assistive technology professional;
- c. Purchase, necessary permits and inspections, taxes, and delivery charges;
- d. Installation;
- e. Assessment of modification by the case manager and by any applicable inspectors to verify safety and ability to meet beneficiary's needs; and
- f. Repair of equipment, as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment, and only when not covered by warranty. The CAP beneficiary or his or her family shall own any equipment that is repaired.

The case management entity authorizes the services through a service authorization.

Note: Medicaid assumes no liability related to use or maintenance of the equipment and assumes no responsibility for returning the private primary residence to its pre-modified condition. Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of CAP services, unless the modification is to the provider's own home for the exclusive use of that CAP beneficiary.

Each waiver beneficiary will be assessed on a person-centered planning basis. Catastrophic occurrences that may cause the waiver beneficiary to use more services than the established average limits will be assessed on an individual basis. Service requests that meet the eligibility criteria will be approved at the assessed need regardless of the established limits. DMA will closely monitor the individual and waiver average per capita cost to maintain cost neutrality of the waiver.

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

The combined budget for vehicle and home modification and assistive technology may exceed \$28,000. The beneficiary may use this combined budget for a home modification. The case management entity shall track the cost of home accessibility and adaptation in order to avoid exceeding the \$28,000 limit over the lifetime of the waiver (five years).

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded.

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

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

Items that are covered through DME, orthotics and prosthetics, home health supplies, and EPSDT are obtained through the respective programs prior to requesting from the CAP. The CAP does not cover items that are covered by one of these programs but were denied for the particular beneficiary for lack of medical necessity.

Home modification excludes the following:

- a. Home modifications that add to the total square footage of the home;
- b. home renovations;
- c. A dwelling where the owner refuses the modification;
- d. The modification in a rented residence is not portable;
- e. Purchase of locks;
- f. New construction;
- g. Service agreements, maintenance contracts, and extended warranties;
- h. Roof repair, central air conditioning,
- i. swimming pools, hot tubs; spas, saunas
- j. Items that have general utility to non-disabled individuals;
- k. Replacement of equipment that has not been properly used, has been lost or purposely damaged;
- l. computer desk and other furniture; and
- m. plumbing.

Medicaid is the payer of last resort; if the beneficiary has private insurance that covers the item, that third-party insurance should be billed.

Funding for Home accessibility and adaptation is assigned on a per-residence and per beneficiary basis in the event there are two or more CAP beneficiaries living in one primary private residence.

Provider Specifications

Provider Category(s) (check one or both):	☒	Individual. List types:	☒	Agency. List the types of agencies:

Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person	☐	Relative/Legal Guardian
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Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Business	Commercial license	Business	
Commercial	Commercial license	Commercial	

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Business	Case management entity and NC Medicaid	prior to service provision

Commercial	Case management entity and NC Medicaid	prior to service provision
Service Delivery Method		
Service Delivery Method (check each that applies):	☒	Provider managed

Service Specification			
Service Title:	Community Transition		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
Service Definition (Scope):			
A service for prospective CAP beneficiaries who make the transition from an institution to their own primary private residence in the community. The funds are used to pay the necessary expenses for a CAP beneficiary to establish a basic living arrangement. Community transition services are available to cover one-time expenses. These expenditures are for initial set-up expenses. Community Transition Services may cover: a. Equipment, essential furnishings, and household products; b. Moving expenses; c. Security deposits or other such payments (e.g., first month's rent) required to obtain a lease on an apartment or primary private residence; d. Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating); e. Environmental health and safety assurances, such as pest eradication, allergen control, one-time cleaning prior to occupancy; f. Personal hygiene supplies; g. First week supply of groceries; h. Up to a one-month supply of medication in instances when the beneficiary is not provided with medication upon discharge from the nursing facility The coverage of this service is extended to individuals with a less than 90-day institutional stay who is experiencing COVID-19 symptoms and can safely transition to a home and community-based placement using HCBS services. Items and services (including rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary. The beneficiary shall provide a receipt for each purchase or invoice for each payment. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service definition.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Community transition services are available to cover one-time, initial set-up expenses, may exceed \$2,500 over lifetime of the CAP, five (5) years. Service does not include ongoing payments for rent. Service must be utilized with 90 calendar days from the date of beneficiary's discharge from an institution.			
Provider Specifications			
Provider Category(s) (check one or both):	☐	Individual. List types:	☒ Agency. List the types of agencies:
			Business/Commercial

Specify whether the service may be provided by (<i>check each that applies</i>):	☐	Legally Responsible Person	☐	Relative/Legal Guardian
Provider Qualifications (<i>provide the following information for each type of provider</i>):				
Provider Type:	License (<i>specify</i>)	Certificate (<i>specify</i>)	Other Standard (<i>specify</i>)	
Business	Commercial license			
Commercial	Commercial license			
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Business	Case management entity and NC Medicaid		prior to service provision	
Commercial	Case management entity and NC Medicaid		prior to service provision	
Service Delivery Method				
Service Delivery Method (<i>check each that applies</i>):	☒	Provider managed		

Service Title:	Financial Management Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
Service Definition (Scope):	
A service provided for waiver participant who is directing his or her own care to ensure that consumer-directed funds outlined in the service plan are managed and distributed as intended. Financial managers provide education and training to orient the waiver participant to the roles and requirements of the consumer-directed model of care. Financial managers facilitate the employment of the personal assistant(s) employee and the requirements of the consumer-directed model by completing the following tasks: • Serving as the participant's Power of Attorney for Internal Revenue Service's (IRS) processes; • Submitting payment of payroll to employees hired to provider services and supports; • Providing payroll statements on at least a monthly basis to the personal assistant(s); • Ordering employment related supplies and paying invoices for approved waiver related expenses; • Deducting all required federal, state taxes, including insurance and unemployment fees, prior to issuing payment; • Administering benefits to the personal assistant(s) as directed by the waiver participant; • Filing claims for self-directed services and supports; • Maintaining separate accounts on each participant's consumer-directed services; • Tracking and monitoring individual budget expenditures; • Producing expenditure reports as required by the state Medicaid agency; and • Completing criminal record history checks, age verification, and health care registry checks on the personal assistant(s).	
The financial management services may be conducted telephonically and the when new waiver participants are choosing to direct care for the first time, a CPR certification can be waived during the pandemic, but a plan need	

to be in place to obtain the certification within 30-days. A registry check, competency validation and consumer direction training overview, particularly in fraud, waste and abuse and consumer direction enrollment are mandatory requirements.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
\$93.00 per month is the maximum limit for financial management services. When financial management services are being shared due to a waiver participant transferring from one FM provider to another in one planning month, \$46.50 is the maximum limit per each FM provider for that planning month. The Waiver Service 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			
Provider Specifications			
Provider Category(s) (check one or both):	☐	Individual. List types:	☒ Agency. List the types of agencies:
			Financial management agency
Specify whether the service may be provided by (check each that applies):	☐	Legally Responsible Person	☐ Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Financial management services		Yes	
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Financial management	NC Medicaid and case management entity		initially and annually
Service Delivery Method			
Service Delivery Method (check each that applies):	☒	Participant-directed as specified in Appendix E	☒ Provider managed