NC Medicaid	Community Alternatives Program for Children CAP/C Waiver approval period: 03/01/2017-02/28/2022	Standard Operating Procedure (SOP)	Assessment for Reasonable Indication of Need
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Standard Operating Procedure for Assessment of Reasonable Indication of Need

Policy reference: Community Alternatives Program for Children, 3K-1; Section 3.0 pages 6-14; Section 4.0, page 14-16, Section 5.0, pages 21-28 and Appendix B: Service Definitions and Requirements, pages 83-114; https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

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

1. **Purpose** – To assure an applicant and a currently enrolled waiver participant meets a home and community-based level of care (LOC) initially through an approved service request (SRF) and annually through an approved comprehensive assessment; and from the analysis of the completed comprehensive assessment, there is reasonable indication that at least one waiver service is needed to avoid an institutional placement within 30 calendar days.

2. **Scope** – Three-fold scope of requirement:

    a. Performance of a level of care evaluation initially and annually on all interested individuals wishing to participate in the CAP/C waiver; and
    b. Performance of a medical fragility assessment to all interested individuals wishing to participate in the CAP/C waiver; and
    c. Performance of a comprehensive assessment on all interested individuals wishing to participate in the CAP/C waiver; and
    d. Performance of a multidisciplinary team meeting to review and analyze assessment findings.

3. **Abbreviations**

ANE- Abuse, Neglect and Exploitation
CME – Case Management Entity
CM – Case manager
CNR- Continued Need Review
CPS- Child Protective Services
DAAS – Division of Aging and Adult Services
DHSR- Division of Health Services Regulation
DHHS – Department Health and Human Services
DSP – Direct service providers
DSS – Department of Social Services
e-CAP – electronic CAP business system
FFP- Federal Financial Participation
FoC – Freedom of Choice
GS – Goods and Services
HCB settings – Home- and Community-Based settings
HCBS – Home- and Community-based Services
HIPAA – Health Insurance Portability and Accountability Act
HSW – Health, safety and well-being

IAE – Independent Assessment Entity
LOC – Level of Care
MDT – Multidisciplinary Team
PG – Performance Goal
PM – Performance Measures
PHI – Protected Health Information
POC – Plan of Care
QP – Qualified Provider
QSP – Qualified Service Provider
SMA – State Medicaid Agency
SP – Service Plan

4. Definition of terms

Annual Assessment – a comprehensive assessment that is completed by a nurse assessor for each waiver participation year for actively participating waiver participants seeking ongoing participation in the CAP/C waiver.

Applicant
An individual seeking to participate in the Community Alternatives Program for Children (CAP/C).

Assessment Slots – An approved allocation of the number of individuals to be served through the waiver program at any given time.

Beneficiary
An individual receiving Medicaid benefits

Contact visit – a face-to-face visit with the applicant or enrolled waiver participant for the purpose of collecting health care and informal support information to complete the comprehensive assessment.

Case Manager – An assigned human services professional hired by a case management entity to provide the day-to-day oversight and management of the waiver participant's needs.

Case Management Entity – An appointed agency to provide care coordination for waiver operations in a county. The appointed entity is the local entry point and approval authority for CAP/C services. The case management entity is approved by NC Medicaid to be responsible for the day-to-day case management functions for potential and eligible CAP/C beneficiaries. These agencies may include county departments of social services, county health departments, county agencies on aging, hospitals, or a qualified

CME. The appointed CME shall be an entity capable of providing case management services and other administrative non-reimbursable tasks to ensure care coordination and linkage to needed Medicaid and non-Medicaid services.

Freedom of Choice - The right afforded to a Medicaid beneficiary to choose to participate in the CAP/C waiver, select a qualified provider and select the program service option.

Health and Welfare – Assuring waiver participant's health and welfare by effectively resolving incidents and preventing further similar incidents to the extent possible.

Independent Assessment Entity - An organization procured by NC Medicaid to manage requests from interested applicants seeking participation in the CAP/C or CAP/DA waivers. This entity is also responsible for quality assurance activities for both CAP/C and CAP/DA.

Initial Assessment – A comprehensive assessment that is completed by a nurse assessor for an applicant or active waiver participant seeking participation or ongoing participation in the CAP/C waiver.

Level of Care – A process and instrument specified for evaluating/reevaluating an applicant's or waiver participant's level of care consistent with a level of acuity of an individual enrolled in a hospital or nursing facility

Medicaid – A federal and state program that helps with medical costs for some people with limited income and resources. Medicaid also offers benefits that are not normally covered by Medicaid such as home- and community-based services covered under a waiver program.

Medical Fragility – An evaluation process used to identify medical conditions primarily for an applicant seeking to enroll in the CAP/C waiver. The evaluation identifies clinical indication of a primary health condition, specialized treatment or intervention, hospital stays and documented life-sustaining hands-on assistance to compensate for the loss of bodily function criteria.

Multidisciplinary Treatment Team Analysis – The review of a comprehensive assessment and decision points identified by a group of professionals from various disciplines to identify needs and best method to mitigate risk factors.

Service Plan – A system to address applicant's and waiver participant's assessed needs, health and safety risk factors and personal goals. The service plan includes the

Plan of Care (POC) which lists the services to mitigate risk(s) in the type, frequency, duration and amount.

Qualified provider – An individual or entity that meets the qualifications that are specified in the clinical coverage policy and waiver application for the service that the provider renders.

Restraints - Personal restraints such as hold, drugs or mechanical intervention

Seclusion - The act of iisolating an individual away from others.

Waiver participant – a Medicaid beneficiary enrolled in the CAP/C waiver program

5. **Responsibilities:**
    a. performance of a comprehensive assessment on all interested individuals wishing to participate in the CAP/C waiver by scheduling an in-person home visit to identify health conditions, functioning level, informal support network and social determinants; and
    b. performance of a multidisciplinary team meeting to review and analyze assessment findings to identify risk impact and reasonable need for at least one waiver service that will assist to avoid an institutional placement;
    c. drafting of a narrative of assessment findings and MDT collaboration that identifies appropriateness for waiver enrollment or continued enrollment;
    d. notification to the applicant or waiver participant in writing of the assessment findings and enrollment decisions;
    e. completion of the required workflow in the e-CAP business system that is consistent with the enrollment decision.

6. **Measure** - Performance measures that yield a 90% compliance rate to waiver assurances of level of care, administrative authority, and the business requirement timelines.

Program Assurance	Performance Measures	Responsible Entities	Performance Goal/Timeline	Remediation Efforts
Level of Care (LOC) and Administrative Authority (AA)	Number and percent of applicants and active waiver participants who had	NC Medicaid VieBridge CME Designated entity	100% of the time when the preceding workflow is completed/ Within 12 months of the	1. Corrective action plan 2. Fine/Penalty 3. Termination of contract

	initial an annual evaluation of LOC prior to the completion of a service plan for each waiver participation year		initial waiver enrollment date	4. Reduction in or elimination of FFP 5. Termination of waiver application
	Number and percent of applicant & participant notification letters completed by the NC Medicaid and CME for each required assessment workflow and timeframe generated by CAP Business system	NC Medicaid VieBridge CME Designated entity	100% of the time when the preceding workflow is completed/ within 1 business day	
	Number and percent of initial waiver participants who had on file a signed freedom of choice provider form selecting a CME provider	NC Medicaid VieBridge CME Designated entity	100% of the time when the preceding workflow is completed/ 1 business day of the receipt of notice from applicant/waiver participant	

Level of Care (LOC) and Administrative Authority	Number and percent of initial waiver applicants who exercised freedom of choice by choosing to participate in CAP/C waiver and that choice was correctly entered in the e-CAP system	NC Medicaid CME Designated entity	100% of the time when the preceding workflow is completed/ 1 business day of the receipt of notice from applicant or waiver participant	1. Corrective action plan 2. Fine/Penalty 3. Termination of contract 4. Reduction in or elimination of FFP 5. Termination of waiver application
	Number and percent of actively participating waiver applicants who exercised freedom of choice by choosing to participate in the CAP/C waiver and that choice was correctly entered in e-CAP systems	NC Medicaid VieBridge CME Designated entity	100% of the time when the preceding workflow is completed/ 1 business day of the receipt of notice from applicant or waiver participant	
	Number and percent of active waiver participants who met the annual LOC and	NC Medicaid VieBridge CME Designated entity	100% of the time when the preceding workflow is completed/ Within 12 months of initial	

	assessment requirements prior to the submission of new POC PAs for each waiver participation year		comprehensive assessment	

7. **Procedure**

Initially and annually, through an analysis of a comprehensive assessment by a multidisciplinary team**,** a CAP/C waiver enrollment eligibility decision is determined for an interested applicant or actively participating waiver participant. The team decides that there is a reasonable indication that at least one home and community-based waiver service is needed by the interested applicant or actively participating waiver participant to avoid an institutional placement.

Procedural steps for new applicants

Step 1 – The e-CAP system will place an individual in the assessment assignment queue when an assessment slot is available which identifies the need to initiate a contact visit using the scheduling function in e-CAP. NC Medicaid, the independent assessment entity, or case management entity will assign a nurse assessor or an assessment combo team combo to complete the assessment.

Step 2 – The assigned nurse assessor or an assessment combo team will conduct the comprehensive assessment in the home or designated approved location. The assessor(s) will ask questions from each of the sections in the assessment packet and request that the applicant or primary caregiver demonstrates how specific tasks, activities of daily living and instrumental activities of daily living are performed. The assessor(s) will review all medications (active and expired) in the home and all medical equipment and supplies. The assessor(s) will assess entryways, egress and living areas of the home to evaluate accessibility for the applicant or waiver participant.

Step 3 – All initial assessments will be reviewed and evaluated by a multidisciplinary team at NC Medicaid that includes, at a minimum, the nurse assessor and a social worker/human service worker to determine a reasonable indication of need for at least one CAP/C waiver service that will promote community inclusion and reduce risk factors that may lead to an out of home placement. The MDT will carefully review the

assessment results in addition to the composite score and risk indicators to reach a decision of CAP/C HCBS waiver enrollment eligibility.

Step 4- A summary narrative is developed by the MDT and agreed upon through a signature page. The summary narrative is entered in e-CAP to describe the health care conditions, risks identified in the assessment and other pertinent information.

Step 5 - A notice letter is generated by e-CAP and mailed by NC Medicaid or CME to the applicant within the designated timeframe to acknowledge the decision of the assessment. If the decision is favorable, a freedom of choice letter is generated with the notice letter to allow the applicant to select to enroll in CAP/C HCBS waiver. The applicant shall follow the instructions in the notice letter. The agreement to enroll in the CAP/C waiver is acknowledged by the applicant's signature and date.

Step 6 - The CME updates the Memorandum of CAP Waiver Enrollment form to indicate the CAP enrollment decision – "beneficiary approved for CAP participation or beneficiary denied for waiver enrollment". If the applicant selects to enroll in the CAP/C waiver, the form is uploaded in supporting documents in e-CAP for access to the selected case management entity.

Step 7 - If the applicant chooses not to sign the freedom of choice letter within the specified timeline, it may be an indication that the applicant does not want to enroll in the CAP/C waiver. Waiver enrollment efforts will stop. The e-CAP system will be prompted to generate a notice letter to close out the waiver enrollment workflow after 30 calendar days of non-reply by the applicant. The letter must be mailed to the applicant by the NC Medicaid within the specified timeframe. The applicant shall follow the instructions in the notice letter, which will include an appeal notice.

Step 8 – Upon the agreement by the applicant to enroll in the CAP/C waiver, the CME may begin the development of the service plan.

Procedural steps for actively enrolled waiver participants
On an annual basis, the LOC and continued need for at least one waiver service must be reevaluated for all enrolled waiver participants in the month of the initial enrollment in the CAP/C waiver.

Step 1 – An e-CAP anniversary notification letter is mailed to the waiver participant. A comprehensive assessment is completed by a nurse assessor or an assessment combo team on an annual basis, at least 12 months from the last completed comprehensive assessment, but no later than the original month of the CAP/C

enrollment. The results of the annual evaluation will identify the ongoing eligibility for LOC and a reasonable indication of need for the currently approved CAP/C waiver services and other waiver services that have been identified to promote community inclusion and reduce risk factors that may lead to an out of home placement.

Step 2- The e-CAP system will place an individual in the assessment assignment queue up to 90 calendar days in advance of the annual assessment which identifies the need to initiate a contact visit using the scheduling function in e-CAP. The independent assessment entity or case management entity will assign a nurse assessor or an assessment combo team to complete the assessment.

Step 3 The assigned assessor(s) will conduct the comprehensive assessment in the home or designated approved location. The assessor(s) will ask questions from each of the sections in the assessment packet and request that the CAP/C participant or primary caregiver demonstrates how specific tasks, activities of daily living and instrumental activities of daily living are performed. The nurse assessor will review all medications (active and expired) in the home and all medical equipment and supplies. The assessor will assess the entryways, egress, and living areas of the waiver participant's home to evaluate the accessibility.

Step 4- A summary narrative is developed by the MDT and agreed upon through a signature page. The summary narrative is entered in e-CAP to describe the health care conditions, risks identified in the assessment and other pertinent information.

Step 5 - A notice letter that includes a freedom of choice letter is generated by e-CAP and mailed by CME to the waiver participant when a favorable decision is reached within the designated timeframe. The agreement to enroll in the CAP/C waiver is acknowledged by the applicant's signature and date.
If an adverse decision is reached, the assessment and the summary narrative are forwarded to NC Medicaid for a quality assurance final review. An adverse notice letter is generated by NC Medicaid if the final decision confirms there is no continued need for at least one waiver service and the removal of CAP/C waiver services will not lead to an out of home placement. The waiver participant shall follow the instructions in the notice letter.

Step 6 - The CME updates the Memorandum of CAP Waiver Enrollment form to indicate the CAP enrollment decision – "beneficiary approved for ongoing CAP participation or beneficiary denied for waiver enrollment". CME identifies the date the service plan becomes effective.

Step 7 - If the waiver participant chooses not to sign the freedom of choice letter, waiver participation will be terminated after 30 calendar days of non-reply from the waiver participant. The waiver participant shall be granted due process rights. The due process letter will be generated in the e-CAP system and must be mailed to the waiver participant by the NC Medicaid within the specified timeframe. The waiver participant shall follow the instructions in the due process letter.

Step 8 – Upon the agreement by the participating waiver participant to enroll in the CAP/C waiver, the CME may begin the development of the service plan.

CAP/C Home and Community-Based Services

- Assistive technology
- Case Management – case management and care advisement
- CAP/C In-home aide
- Community transition
- Home accessibility and adaptation
- Pediatric nurse aide services
- Respite services - Institutional respite and In-Home Aide respite
- Specialized medical equipment and supplies
- Goods and services – Participant, Individual-directed, Pest eradication, Nutritional services, Non-medical transportation
- Training, education and consultative
- Financial management service; and
- Vehicle modification