Community Alternatives Program for Disabled Adults (CAP/DA) Approved Renewal Waiver

Approved Waiver Effective October 1, 2013				
New Operational Procedure	**Expired 2008 Waiver Operational Procedure**	**Renewed 2013 Waiver Operational Procedures**	**Reason for Change**	**Impact to Waiver**
Need for CAP/DA Services	Requires case management and one other waiver service.	Requires two waiver services (excluding incontinence supplies, personal emergency response system, and meals preparation and delivery) on a monthly basis that mitigate institutionalization through coordinated case management and hands-on personal assistance. 3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1(e) All new initial assessments must fall under this assurance effective 10/01/2013. Eligible beneficiaries participating in the waiver will not be disenrolled at the onset of the approved waiver. At the annual recertification, each eligible beneficiary will be reassessed to determine institutional level of care needs and those whom only require assistance with incontinence supplies, PERS and delivery and preparation of meals will be referred to appropriate community resources through a coordinate transition process. Each beneficiary that falls into this category during the annual recertification will be provided an opportunity to appeal the adverse decision.	This change allows the identification of direct hands-on personal care that is consistent with institution care. Incontinence supplies, PERS and delivery and preparation of meals are services that are provided through other community resources regardless of waiver participation. A current algorithm in the CAP/DA assessment identifies individuals with minimal needs; often individuals who only receives incontinence supplies, PERS and delivery and preparation of meal are considered (based on MDS-RUGS scoring) to not met nursing facility LOC.	1. Efficient use of resources. 2. Clear identification of acuity of need consistent with institutional care.
Emergency Plan	Beneficiaries who direct their	All CAP/DA beneficiaries (CAP/DA and	Assures continuity of care	1. Efficient

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	own care under consumer-direction (CAP/Choice) are required to have an emergency plan.	CAP/Choice) must have emergency back-up plan with adequate formal and informal support to meet the basic needs outlined in the CAP/DA assessment and plan of care (POC) to maintain their health, safety and well-being. An emergency back-up plan is necessary for times when the formally (personal care aide or personal assistant) arranged support system is unavailable during regularly scheduled work hours and when the unpaid informal support system is unavailable. *3K-2, CAP/DA Clinical Coverage Policy, Section 3.2.1 (h)*	when formal supports are not available. Health and welfare is one of the overarching assurances of 1915 (c) HCBS waiver.	expenditure of Medicaid dollars. 2. A clear identification of continuum of care.
Administrative Authority of the Waiver	Two-way partnership approach-DMA (Administrative Authority) and Lead Agencies (day-to-day overseer of the waiver).	The administrative authority of the waiver will be executed through a three-way partnership approach: DMA (Administrative Authority); Contracted Waiver Entity (day-to-day administrative oversight of the waiver) and Lead Agency (case management providers of waiver services). This three-way execution of the waiver provides efficient and consistent administrative management of waiver programs offered by DMA. The Contracted Waiver Entity (CWE) will provide the day-to-day administrative functions of the waiver and also provide for the Quality	Provides efficient and consistent administrative management of waiver programs (CAP/DA and CAP/C) under the Home and Community care section at DMA. Case management agencies for waiver programs can not financially claim administrative tasks.	1. Efficient use of administrative overhead. 2. Efficient streamline of two HCBS programs (CAP/C and CAP/DA)

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		Improvement Strategy (QIS) Framework. The Contracted Waiver Entity oversees program operations and assures all policies and procedures are followed; processes referrals; ensures beneficiary freedom of choice; ensures quality services; and cooperates with monitoring and reporting activities. Additional roles and responsibilities of the CWE include: • Aggregate budget planning and analysis • Level of Care analysis per the 1915 (c) HCBS Waiver guidelines • Quality Improvement Strategy and Continuous Quality Improvement Strategies • Training Programs (regional and online) • Program mailings (freedom of choice statements welcome letters and waiver compliance notices) • Referral and screening • Waiver entrance *3K-2, CAP/DA Clinical Coverage Policy, Sections 5.7.12(DMA), 6.2 (CWE) & 6.3 (Lead Agency)*		
Selection of Entrant into the Waiver	1. Adults 18 years old and older who are disabled; 2. In need of institutional LOC;	Individuals who qualify under Medicaid categories of MAA, MAD and MAB and need a level of care consistent with institutional level of care are eligible for a level of care	Provides consistency across the waiver in accepting and processing referrals.	1. Set parameters in prioritizing individuals when CAP/DA

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	3. First-come first-service; 4. Priority given to transferring from NF, CAP/C, individuals at risk of being institutionalized and MFP.	determination and an assessment to identify their imminent risk of institutionalization. Each individual who are screened through a referral and screening process are most likely considered at risk of institutionalization given the overarching eligibility for waiver participation. Individuals applying for participation in the waiver are consideration on a first-come first-serve basis. To plan continuity of care for individuals currently eligible for participation in a 1915 (c) HCBS waiver managed by state Medicaid, those whom want to be deinstitutionalized and those whom need immediate protection from abuse, neglect or exploitation are placed in a priority category and are expedited for immediate consideration of waiver participation. If there is an existing waitlist in the county of residence, these individuals are prioritized to the top of the waitlist. Eligible waiver participants who are prioritized include the following: • Age 18-21transitioning from the children's waiver 1915 (c) HCBS waiver for children (CAP/C). • Individuals with an active Aids diagnosis with a T-Count of 200 (discontinued 1915 (c) HCBS waiver that merged		services can not be immediately rendered. 2. Efficient waitlist management and slot utilization.

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		participants in the disabled adult waiver). • Eligible approved disabled waiver beneficiaries who are transferring to another county. • Previously approved disabled waiver beneficiaries who are transitioning from a short-term rehabilitation placement within 90 days of the placement. • Individuals transitioning from a nursing facility with Money Follows the Person designation. • Individuals transitioning from a nursing facility utilizing service of Community Transition. • Individuals identified at risk by their local Department of Social Services who has an order of protection by Adult Protective Service for abuse, neglect or exploitation. *3K-2, CAP/DA Clinical Coverage Policy, Sections 2.1.2 & 3.2.1*		
Waitlist Management	Lead Agency manages slot and reports utilization monthly to DMA	DMA will closely monitor waitlist across the state monthly to assure accuracy of individuals on the waitlist; prioritization of referrals, actual wait time for each referral per county and statewide; and maximum slot utilization. Quarterly DMA will review		1. Efficient use of resources. 2. Clear identification of management of waiver slots.

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		underutilization, provide LA 30 days to implement plan to fill slots. If slots are not filled/planned to be filled, slots will be distributed to another LA.		
Level of Care (LOC)	Intermediate and skilled	The beneficiary shall meet the minimum requirement for HCBS nursing facility LOC criteria approved by DMA prior to participation in the CAP/DA program defined in Subsection 1.1.19. The HCBS LOC is comparable to the Nursing Facility LOC clinical coverage with the following exclusions: Registered nurse not required for a minimum of 8 hours daily; Provided for the intervention, safeguarding (health, safety and well-being) or stabilization of the HCBS waiver population to promote continuous community living while preventing institutionalization as a result of chronic medical and physical disabilities; Does not require the degree of medical consultation, observation and support services provided by a licensed nurse includes assessing, planning, observing and management of a recorded treatment plan according to that which is established and approved by a physician, practitioner or clinician, and rendering direct services to the beneficiary.	Aligns HCBS practices with nursing facility LOC practices and other waiver programs.	1. Promotes consistency among Medicaid State Plan institutional level of care and home and community-based programming. 2. A clear identification of skilled need that is consistent with institutional care.

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		3K-2, CAP/DA Clinical Coverage Policy, Sections 3.2.1		
Qualification of Level of Care	Nursing facility that includes intermediate and skilled care needs.	HCBS Nursing Facility LOC criteria: A disability of medical and physical abnormalities includes primary medical diagnoses that are chronic in nature. The overriding medical condition is primarily physical rather than psychological, behavioral, or developmental (if the primary medical condition is cognitive, the diagnosis will primarily consist of Alzheimer's or dementia). The individual needs in-home supports and services similar to that provided in an institution. The beneficiary requires interventions to engage in activities of daily living in order to prevent adverse physical and medical consequences that may require institutional placement to maintain health, safety, and well-being. *3K-2, CAP/DA Clinical Coverage Policy, Sections 1.1.19 & 3.2.1*	The Service Request Form was designed to take into account the previously used FL-2 tool to ensure consistency, where appropriate, but just as important to correct or compensate for gaps or deficiencies in the FL-2 form that hamper providers having a clear picture of the beneficiary being referred in addition to determining level of care. Consequently, the design of the new Service Request Form is reliable, valid and fully comparable to the previously used tool as	1. Promotes a community inclusion definition that sustains and stabilizes functional and medical needs for continuous community living. 2. Promotes an efficient use of an array of home and community services provided through the waiver.

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		Refer to Section 3.2.1 in 3K-2 policy under: **HCBS Nursing Facility Level of Care Criteria includes the need for any of the following**	result of the combination of information from the FL-2 form and the PASRR that nursing facility use after the initial LOC is determined.	
LOC Instrument	FL-2	**Service Request Form** is a combination of the FL-2 the state uses for nursing facility and home and community based services program and the PASRR that is used only for nursing facility. The new LOC tool is comparable with the institutional LOC tool and will meet the level of care for individuals in a NF and home and community based services. The new LOC tool will be more robust and more versatile than the current FL-2 level of care instrument. It is designed to support more consistent review for level of care/eligibility determination and also incorporate essential PASRR functionality through expanded questions related to diagnoses, behavior, mood and interpersonal functionality. Also, for the first time, the Service Request Form, new LOC tool will provide DMA the capacity to implement a computerized approach to	Provides a framework for comprehensive interdisciplinary team planning that yields a holistic assessment of functional, medial and social needs which results in a person-centered plan of care.	1. Efficient expenditure of Medicaid dollars. 2. Clear identification of acuity of needs that is consistent with institutional care.

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		eligibility determination based on scoring algorithms tied to the information collected through the this newly revised LOC tool. The service request form is a comprehensive initial assessment to determine basic eligibility for the program. The form can be generated by the beneficiary, family member, case manager, IHA agency or physician. The physician will validate the request for waiver participation with his signature. **A LOC determination must be completed at initial enrollment and with each annual reevaluation (assessment) as needed when significant changes in condition occur.** 3K-2, CAP/DA Clinical Coverage Policy, Sections 1.1.30 & 3.2.1		
LOC Determents	FL-2 and a needs assessment of cognition; mood/behavior; communication/vision; diseases diagnosis; infections; health conditions; medication; nutritional status; continence; skin; special treatment; physical functional; home;	Service Request Form establishes basic LOC eligibility and the needs assessment establishes acuity of LOC (low, medium or high). Through e-CAP, the assessment analyzes personal health information; caregiver information; medical diagnoses; medication and precautions; skin; neurological; sensory and communication;	Promotes a comprehensive interdisciplinary team planning approach that identifies a holistic view of functional, medical and social needs. This process will yield a comprehensive person-centered assessment	1. Efficient expenditure of Medicaid dollars. 2. Clear identification of acuity of needs that is consistent

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	social supports and economic status.	pain; musculoskeletal; cardio-respiratory; nutritional; elimination; mental health; informal support; and housing and finances to derive an acuity level. The acuity level is computed through e-CAP using the following logic: determine if beneficiary is eligible for Level 3 (high) acuity; if not, determine if the beneficiary meets the level 1 criteria (low acuity); if not, assign the beneficiary to Level 2 (intermediate or medium acuity). The assignment of acuity level is performed based on a rule-out of high and low levels of acuity. The first step is to determine Level 3 acuity eligibility. The e-CAP system will follow the scoring logic listed below: • e-CAP will determine if the beneficiary has a current treatment that alone signals high acuity or an interpersonal functioning behavior that signals high risk. These single indicators include ventilator, suctioning, pulse oximetry, non-vent., tracheostomy, nebulizer Care, homicidal, combative/history of altercations, dangerous to others, physically abusive, suicide/ideation in varying degrees. • For each single indicator, treatment	and service planning of ongoing community needs.	with institutional care.

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		must be indicated as being provided by frequency or type and meet a specified threshold. • If a beneficiary is receiving any of the single-indicator treatments and meets the additional requirement listed, the beneficiary is automatically assigned to the high acuity category. • If the beneficiary does not meet the single-indicator treatment criteria, then e-CAP will test to see if there is some combination of indicators that will result in level 3 (High) acuity. Combination indicators that will be used to reflect eligibility include: number of medications, number of PRN medications, number of prescribed treatment regiments, more than 5 mood and behavioral indicators, more than 5 interpersonal functioning indicators, more than 3 unplanned hospitalizations, current involvement with Adult Protective Services for safety and protection. • If the beneficiary does not meet the Level 3 acuity scoring threshold, then e-CAP will evaluate to see if the beneficiary falls into the Level 1 (Low)		

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		acuity category. Level I will rule-out indicators from Level III algorithm. Indicators for Level I (Low) acuity will include 3 or fewer diagnosis, medically stable, no PRN medications, fewer than 5 prescribed medication, two or fewer treatment indicators (example: cardiac monitoring, CAP/BiPAP), weight management, continence management), two or fewer mood and behavior indicators, no interpersonal or functioning indicators, no involvement with APS, and no unplanned hospitalizations. • All beneficiaries that do not meet the high acuity or low acuity criteria are assigned to the intermediate acuity scoring category. ***Acuity Budgetary limits include:*** ***High- $3537- consistent with current waiver processes*** ***Intermediate-$2730, consistent with current waiver processes*** ***Low-$1960, calculated from average monthly cost over waiver years*** *3K-2, CAP/DA Clinical Coverage Policy, Sections 1.1.30, 3.2.1 & 5.3*		

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Case Manager Qualification	RN Public Health I or SW Public Health I	4 year Bachelor Social Work Degree with 1 year of direct experience in long-term care or home and community services; or 4 year Bachelor Human Services Degree with 2 years of direct experience in long-term care or home and community services; or registered nurse who holds a current NC license with 1year of case management experience in long-term care or home and community services. Must complete a DMA certified training program within 90-days of employment. 3K-2, CAP/DA Clinical Coverage Policy, Sections 6.3, 6.4 & 6.5	Identifies competencies necessary to meet the needs of physically disabled and aging beneficiaries.	Efficient use of case management and service utilization.
Qualified CAP/DA Lead Agency	Four specified entities (DSS, health department, aging agency and hospital) appointed by County Commissioners	A CAP/DA lead agency must be an organization with three or more years of direct home and community-based services and case management experience serving individuals at risk of institutionalization. Each case management agency must enroll as a NC Medicaid provider and be approved by DMA to provide lead agency waiver services. At every three years, the case management entity must recertify as a Medicaid provider. Qualified Case Management Providers must have: • A resource connection of the service area as to provide continuity and	Provides freedom of choice of providers (42 CFR431.51 (a) (i)). Identifies competencies necessary to meet the needs of physically disabled and aging beneficiaries.	1. Efficient use of case management and service utilization. 2. Efficient method to incorporate choice of providers. 3. Efficient and consistent administrative management of service

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		appropriateness of care; • Experience in Geriatric and physical disabilities; • Polices/procedures in place that aligns with the waiver governance of the state and federal laws and statues; • 3 years of progressive and consistent home and community base experience; • Ability to provide case management by both social worker and Nurse; • Maintain a physical location; • Computer technology/IT web-base connectivity to support the requirement of current and future automated programs; • Meet the regulatory criteria under DHHS/DHRS • Staff to participant ratio (appropriate case mix); • Ability to implement of services within 10 days of POC approval; • A clear understand of person-centered planning; • Participate in peer reviews; and • Sufficient cash revenue or reserve		utilization. 4. Sets clear parameters in maintaining choice and person-centered planning.

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Service Plan	Monthly monitoring of beneficiary and providers Quarterly monitoring or beneficiary and providers	Monthly contact with the beneficiary Quarterly contact with all services providers. One of the assurances of the CAP/DA waiver mandates provisions are in place to assure the waiver participant is receiving the services as assessed and the services are consistency meeting needs. To meet this mandate and to provide a comprehensive assessment that the waiver participant's are being adequately met, performing an interdisciplinary quarterly meeting meets this assurance of the waiver. The interdisciplinary meetings will replace previous telephone contact with providers. Interdisciplinary meetings can be performed by teleconference or Skype.	Promotes a comprehensive interdisciplinary team planning approach that identifies a holistic view of functional, medical and social needs. This process will yield a comprehensive person-centered assessment and service planning of ongoing community needs.	1. Efficient use of case management and service utilization.
Service Plan Completion of the assessment and POC	60-days from FL-2	45-days from date of the assigned slot. The assurances of the CAP/DA waiver mandate an initial assessment and POC to be conducted in a reasonable time. The timeline is to assure compliance with waiver assurances and promptness of service provision to waiver participant. One of the assurances of the CAP/DA waiver mandates provisions are in place to assure the waiver participant is receiving the services as assessed and the services are consistency meeting needs. To meet this mandate and to provide a comprehensive assessment that the		

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		waiver participant's are being adequately met with reasonable promptness.		
Benefit Packet	a. Adult day health b. Personal care aide c. Home modification and mobility aides d. Meal preparation and delivery e. Institutional respite services f. Non-institutional respite services g. Personal Emergency Response Services h. Waiver supplies i. Participant goods and services j. Transition services k. Training and education services l. Assistive technology m. Case management n. Care advisor (CAP/Choice only) o. Personal assistant (CAP/Choice only) p. Financial management services (CAP/Choice)	a. Adult day health b. Personal care aide c. Home accessibility and adaptation d. Meal preparation and delivery e. Institutional respite services f. Non-institutional respite services g. Personal Emergency Response Services h. Specialized medical equipment and supplies i. Participant goods and services j. Community transition services k. Training, education and consultative services l. Assistive technology m. Case management n. Care advisor (CAP/Choice only) o. Personal assistant (CAP/Choice only) p. Financial management services (CAP/Choice only) *3K-2, CAP/DA Clinical Coverage Policy, Sections 1.0, 6.1.5, 6.1.12, 6.1.13*	Provides administrative consistency across HCBS waivers (CAP/C and CAP/DA). *The current service definition identified in the State Plan clinical coverage policy and within the 2008 waiver application will not change nor exclude a beneficiary from receiving any one of these services.*	1. Efficient and consistent administrative management of the 1915 (c) waivers offered through DMA. 2. Clear identification of 1915 (c) waiver services provided through Medicaid.

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Risk Assessment and Mitigation	Process under development.	Individual Risk Agreement Form developed to allow responsibility for the agreed upon course of action and the accountability for choice. *3K-2, CAP/DA Clinical Coverage Policy, Sections 7.5*	Sets a framework of person-centered planning while promoting flexibility and responsibility in continuity of care needs.	1. Efficient expenditure of Medicaid dollars. 2. Sets clear parameters maintaining choice and person-centered planning.
Health Welfare	Process under development.	The primary consideration underlying the provision of services and assistance for disabled and elderly adults is their desire to reside in a community setting. Enrollment and continuous participation in CAP/DA waiver may be denied based upon the inability of the program to ensure the health, safety, and well-being of the beneficiary. Based on assessment of the beneficiary's medical, mental, psychosocial and physical condition and functional capabilities conditions may warrant inability to participate in the waiver when **one** of the following conditions listed in Section 7.4 cannot be mitigated for the beneficiary *3K-2, CAP/DA Clinical Coverage Policy, Sections 7.4*	Promotes the ability to track and trend real time data of APS concerns and critical incidences in order to implement strategies, services or programs to mitigate risk.	1. Efficient expenditure of Medicaid dollars. 2. Establishes a clear definition of risk of health and well-being of waiver participation. 3. Promotes collaboration among divisions while protecting the health and well-being of

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				waivers beneficiaries.
Responsibility for Review of and Response to Critical events or Incidences	Follow the guidelines of APS reporting.	Critical Incidents will be reported based on whether it is a Level I or Level II Incident. **Level I Incidents** must be reported within 5 *business* days in the e-CAP system. These incidences include: • hospitalizations, • ER visits, • falls, • death by natural causes, • failure to take medication as ordered. **Level II Incidents** must be reported within 5 *business* days to DMA. These incidences include: • APS referrals, • death other than expected or natural causes, • restraints and seclusions, • misappropriation of consumer-directed funds, • falls requiring hospitalization or results in death, • traumatic injury, • medication administration that results	Promotes ability to track and trend real time data of critical incidences in order to implement strategies, services or programs to mitigate risk.	1. Efficient expenditure of Medicaid dollars. 2. Assures the health and welfare of waiver beneficiaries.

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		• in injury or hospitalization, • wandering away from home, • homicide/suicide and media related events.		
Restraints		CAP/DA does not permit the use of restrictive interventions that restrict participant movement; participant access to other individuals, locations, or activities; restrict participant rights; or that employ aversive methods to modify behavior, unless provided for a waiver participant for whom it is not used as a restraint, but for safety - such as bed rails, Gerri chair, lift chair, safety straps on wheelchairs. *3K-2, CAP/DA Clinical Coverage Policy, Sections 3.2.1*		
Quality Framework Management System	AQUIP (on-line case management tool).	e-CAP (web-based case management and business process tool). 3K-2, CAP/DA Clinical Coverage Policy, Sections 7.10 and 7.10.1	Provides efficient and consistent administrative management of waiver programs (CAP/DA and CAP/C) under the Home and Community care section at DMA.	1. Efficient and consistent administrative management of the 1915 (c) waivers offered through DMA. 2. Efficient expenditure of Medicaid dollars.

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Financial Accountability	Remain with ICF or SNF monthly budget limit All waiver services and State Plan services attributed to monthly budgetary limits	The monthly cost limits of the budget should only include waiver services Three budgetary limits based on acuity of care: ***High- $3537- consistent with current waiver processes*** ***Intermediate-$2730, consistent with current waiver processes*** ***Low-$1960, calculated from average monthly cost over waiver years***		
Program Integrity Case Documentation		All assessment, care planning, monitoring, referral, follow-up and linkage activities in the case record and on approved agency forms. The documentation must fully detail the purpose of the intervention of the case management or advisement activity to include date and duration of time taken to complete the case management or advisement task. The documentation is completed within 72-business hours of the intervention and is signed and dated by the case manager or care advisor. Timely and accurate documentation is required for all Medicaid services.		