

NC Medicaid	Community Alternatives Program for Disabled Adults CAP/DA	Standard Operating Procedure (SOP)	Waiver Enrollment
		Creation Date	11/1/2019
		Implementation Date	3/01/2020
Pages		Revision/Update Date	10/19/2020
SOP Owner	WRenia Bratts-Brown	SOP Co-Owner	Patricia Hill

Standard Operating Procedure

Policy reference: Community Alternatives Program for Disabled Adults, 3K-2; Section 2.1.2b, page 4 Section 3.2 pages, 6-12; Section 4.2.2, pages 18-19; and Section 5.0, pages 20-29; <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>

Federal citation for the purpose of Home- and Community-Based Services authorized under section 1915(c) of the Social Security Act and complies with 42 CFR §440.180.

1. Purpose – To provide a cost-effective alternative to institutionalization for a Medicaid beneficiary in a specified target population, who is at risk of institutionalization if specialized waiver services were not available. These services allow the targeted population (disabled and aged adults) to remain in or return to a home- and community-based setting.
2. Scope – To target services to categorically-eligible Medicaid disabled and aged adults (18 years old and older) who meet the nursing facility level of care established by the CAP/DA clinical coverage policy; and to offer services that are not otherwise available under the State Plan.
3. Abbreviations
 - AA – Administrative Authority
 - CAP- Community Alternatives Program
 - CM- Case Manager
 - CME – Case Management Entity
 - DSP – Direct Service Provider
 - e-CAP – electronic CAP business system
 - HCWD – Health Care for the Working Disabled
 - HSW – Health, safety and well-being
 - IAE – Independent Assessment Entity
 - LOC – Level of Care
 - MAA- Medicaid for the Aged
 - MAB- Medicaid for the Blind
 - MAD – Medicaid for the Disabled
 - PG – Performance Goal
 - PM – Performance Measures
 - POC – Plan of Care
 - QP – Qualified Provider
 - SMA – State Medicaid Agency
 - SP – Service Plan
4. Definition of terms

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Administrative Authority – The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of the waiver functions by other state and local/regional non-state agencies and contracted entities.

Annual Assessment – A comprehensive assessment that is completed by a nurse assessor or an assessment combo team during each waiver participation year for actively participating waiver participants seeking ongoing participation in the CAP/DA waiver.

Applicant - An individual seeking to participate in the Community Alternatives Program for disabled adults (CAP/DA).

Assessment combo team – a team comprising of a nurse and a social worker/human services worker to complete a comprehensive assessment.

Case Manager – Human services professional or nurse 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/DA 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/DA 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/DA waiver, select a qualified provider and select the program service option.

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/DA waiver.

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Level of Care – A process and instrument specified for evaluating/reevaluating an applicant’s or waiver participant’s level of care consistent with care provided 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.

Multidisciplinary Treatment Team Analysis – The review of a comprehensive assessment conducted by a group of professionals from various disciplines to evaluate the functioning level and deficient, stress on the caregiver, and other social determinants of health to identify strategies to mitigate those risk factors.

Service Plan – A person-centered document 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.

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

5. Responsibilities:

(A) To manage the enrollment of waiver participants in the CAP/DA waiver to not exceed 11, 534 participants per each waiver participation year:

- i. Nov. 1, 2019 - Oct. 31, 2020
- ii. Nov. 1, 2020 - Oct. 31, 2021
- iii. Nov. 1, 2021– Oct. 31, 2022
- iv. Nov. 1, 2022 - Oct. 31, 2023
- v. Nov. 1, 2023 - Oct. 31, 2024

(B) To conduct a validation of eligibility, initially and annually, to confirm eligibility requirements are met prior to the initial and continued assignment of a waiver slot. The eligibility requirements are:

- i. meet or continue to meet an institutional-equivalent level of care;
- ii. be in the waiver target group – individual who are 18 years old and older who are disabled or aged;
- iii. be assigned to one of the CAP/DA Medicaid coverage categories (MAA, MAB, MAD or HWD) upon the approval of the CAP/DA Service Plan; and
- iv. freely choice to enroll in CAP/DA waiver.

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(c) To validate individuals entering in or actively participating in the CAP/DA waiver, health care needs can be met at an average per capita cost that is equal to or less than the average per capita cost of individuals using institutional services. The validation is conducted by NC Medicaid initially, annually and when there is a significant change in the status of the waiver participant. Individuals over the cost limit validation threshold can participate in the waiver, and paid claim are monitored closely to assess the actual cost of health care needs. The case manager works closely with the waiver participant to assure linkage to health care services and community resources.

6. Measures – Required performance measures that yield a 90% compliance rate to business workflows and timelines.

Program Assurance	Performance Measure	Responsible Entity	Performance Goal/Timeline	Remediation Efforts
Level of Care (LOC)	Number and percent of SRFs completed according to the CAP business rules and timelines	CME NC Medicaid	PG - 90% Timeline: 45 calendar days	Corrective action plan Fine or penalty Termination of contract
Level of Care (LOC)	Number and percent of SRFs that received an exception review when the LOC algorithms did not indicate initial approval of LOC		PG - 100% Timeline – 2 business days	
	Number and percent of active waiver participants who had an annual reevaluation of LOC and election to continue to participate in the CAP/DA waiver before the completion of an updated services plan for each	CME	PG – 100% Timeline – within 12 months of the CAP effective month	Corrective action plan Removal from CME selection freedom of choice form Termination as a Medicaid enrolled provider

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	waiver participation year			
	Number and percent of applicant & participant notification letters completed by the NC Medicaid and CME for each required workflow and timeframe generated by CAP Business system	NC Medicaid CME	PG- 100% Timeline – 1 business day	Corrective action plan Fine or penalty Termination of contract
Program Assurance	Performance Measure	Responsible Entity	Performance Goal/Timeline	Remediation Efforts
Service Plan (SP)	Number and percent of initial, annual and COS service plans completed by the CMEs that processed using the CAP Business rules and timelines	NC Medicaid	PG – 90% Timeline – 14 business day	Corrective action plan Fine or penalty Termination of contract

7. Procedure

Initially and annually, an evaluation of LOC and an assessment of a reasonable indication of need for home and community-based services are performed on all applicants and actively participating waiver participants to confirm eligibility requirements are met prior to enrollment or future ongoing participation in the CAP/DA waiver.

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LOC Procedural steps for new applicants

Step 1 – A request for participation in the CAP/DA waiver is voiced by an applicant and acknowledged and documented by the NC Medicaid, CME or qualified provider (DSP) in the e-CAP system through the generation of a referral request.

Step 2 – A Consent Packet is mailed to the applicant or electronically uploaded to the NCTracks beneficiary portal upon the validation (name, address and date of birth) of the referral. The Consent Packet includes a consent form, a physician’s worksheet, disclosure information about the CAP/DA waiver and case management selection form for the applicant to select a case management entity to complete the comprehensive assessment and the service plan.

Step 3 – The applicant signs and dates the consent form authorizing NC Medicaid or its designee to discuss and gather health care information to initiate the LOC evaluation process, the completion of the service request. The applicant provides the physician worksheet to his/her primary practitioner/physician. The worksheet has designated areas to list diagnosis, medication, and clinical indicators described in the LOC and Medical fragility criteria. The physician worksheet includes a section for the practitioner to recommend the applicant is functioning at a LOC consistent with the waiver requirements.

Step 4 – NC Medicaid or its designee collects clinical health care information using the physician’s worksheet, paid claims, discharge summaries, electronic health records and other resources to complete the service request form to assist with establishing the LOC. The clinical information is entered in the e-CAP system and saved as completed.

Step 5 – The completed SRF entry is scored against the LOC criteria as described in the clinical coverage policy. The e-CAP system has created an algorithm to find all clinical indicators listed in the LOC criteria. A nurse assessor reviews the scored SRF to validate the approval or denial. An approved SRF is moved to the next enrollment step, a determination of reasonable indication of need. A denied SRF is moved to an exception review to seek a second review opinion before an adverse decision is made.

Step 6- A notice letter (approval or denial) is generated by e-CAP and mailed to the applicant by the NC Medicaid within the specified timeframe to acknowledge the decision of the service request. The applicant shall follow the instructions in the notice letter within the specified timeframe.

Step 7 - The e-CAP system assigns a new applicant to a waitlist or to assessment assignment depending on the vacancy of slots in the applicant’s service area.

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Step 8 –The Memorandum of CAP Waiver Enrollment form is completed to indicate the initial CAP service request approval or denial date. NC Medicaid will initiate the Memorandum of CAP Waiver Enrollment when an applicant is placed on a waitlist and the CME will initiate the Memorandum of CAP Waiver Enrollment form when the applicant is immediately placed in the assessment assignment queue. The Memorandum of CAP Waiver Enrollment form is forwarded to the local DSS in the county of the applicant’s residence.

Step 9 – When the applicant is placed in assessment and assignment and does not have Medicaid, a Medicaid application is initiated on behalf of the applicant to ensure Medicaid eligibility is established by the time the service plan is approved. During this process, the applicant is assigned an assessment slot to allow the conducting of the comprehensive assessment by a nurse assessor or an assessment combo team. The completed assessment is evaluated by a multidisciplinary team that includes, at a minimal, a nurse and social worker/human services worker to determine reasonable indication of need for at least one CAP/DA service that will promote community inclusions and reduce risk factors that may lead to an out of home placement. Refer to the Reasonable Indication of Need Standard Operation Procedures for additional guidance in this area.

Step 10 - A notice letter is generated by e-CAP and mailed by NC Medicaid to the applicant within the designated timeframe to acknowledge the decision (approved or denied) of the assessment. The applicant shall follow the instructions in the notice letter.

Step 11- A freedom of choice letter to select enrollment in CAP/DA is generated by e-CAP when the assessment indicates reasonable indication of need. The letter is mailed by the NC Medicaid or its designee to the applicant within the specified timeframe for the applicant to agree to enroll in the CAP/DA waiver and receive home- and community-based services in lieu of institutional service planning. The agreement is acknowledged by the applicant’s signature and must be received by NC Medicaid or its designee within the established timeline. A permanent slot is assigned to the waiver participant.

Step 12 –The Memorandum of CAP Waiver Enrollment form is completed by the CME to indicate the final CAP enrollment decision – “beneficiary approved for CAP participation or beneficiary denied for wavier enrollment”.

During the interim plan for the independent assessments, the CAP effective date is when the assessment is placed in the assessment and assignment queue in the e-CAP system. This date should be listed on the Memorandum of CAP Waiver Enrollment form. The case manager shall document the CAP approval date for the date the assessment was approved by the multidisciplinary team.

If the applicant chooses not to sign the freedom of choice letter, it may be an indication that the applicant does not want to enroll in the CAP/DA waiver. Waiver enrollment efforts will

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stop. The e-CAP system will be prompted to generate a notice letter within 30 calendar day to close out the waiver enrollment workflow. 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.

During these procedural steps, the case management entities may track the progression of the referrals entered by using the Referral Tracker report.

Procedural steps for actively enrolled waiver participants

On an annual basis, the LOC of an enrolled waiver participant is reevaluated from the data that is entered in the comprehensive annual assessment.

Step 1 – An e-CAP anniversary notification letter is mailed to the waiver participant 90 calendar days in advance. The case management entity may initiate the annual assessment from the date the assessment is placed in the assessment queue but no later than 30 calendar days of the month of the CAP effective date. The 30-day completion timeline begins on the 1st day of the month of the CAP effective date. The engagement to conduct the annual assessment should be an agreed upon date by the waiver participant and the assigned assessor.

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

If the assessment does not reflect an ongoing LOC consistent with the LOC criteria outlined in the CAP/DA clinical coverage policy, a new SRF is completed to reestablish the LOC. When the LOC cannot be reestablished, an evaluation must be conducted to determine, if the waiver services were to be discontinued would the waiver participant's functioning level, ADL performance, burden on the caregiver, and other determinants exacerbate health care conditions thus jeopardizing community inclusion. When the answer is yes, the waiver participants will be deemed to meet a LOC because removing the home-and community-based services would lead to an institutional placement.

Step 2- A summary narrative is entered in e-CAP to describe the risks identified in the assessment and which waiver and State Plan Medicaid services that may be used to mitigate ongoing risks. The summary narrative should include information on how reasonable indication of need was established by describing findings of the waiver

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participant's functioning level, ADL deficient, the burden on the caregiver, and other social determinants of health.

When the multidisciplinary team rules that reasonable indication of need cannot be established, an evaluation must be conducted to determine if the waiver services were to be discontinued would the waiver participant's functioning level, ADL performance, the burden on the caregiver, and social determinants of health impact exacerbate. When the answer is yes, the waiver participants will be deemed to have reasonable indication of need because removing the home-and community-based services would lead to institutional placement.

Step 3 - A notice letter is generated by e-CAP and mailed or electronically uploaded in the NCTracks Beneficiary Portal by NC Medicaid or its designee to the actively enrolled waiver participant within the designated timeframe to acknowledge the decision (approved or denied) of the assessment. The waiver participant shall follow the instructions in the notice letter.

Step 4- A freedom of choice letter is generated by e-CAP when the assessment indicates a reasonable indication of need. The letter is included in the notice letter when a favorable decision is reached. The waiver participant must sign and date the freedom of choice letter within the specified timeframe for the waiver beneficiary to continue be enrolled in the CAP/DA waiver and receive home and community-based services in lieu of institutional service planning. The agreement is acknowledged by the waiver participant's signature.

If the waiver beneficiary chooses not to sign the freedom of choice letter, transition plan with occur within 15 calendar days to terminate the waiver participant from the CAP/DA waiver. Due process rights are not granted.