

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

The CAP/C waiver will serve medically-complex Medicaid beneficiaries between the ages of 0-20 who meet a defined level of care, are assessed to be medically fragile and are at risk of being institutionalized if waiver services were not available.

Medically fragile is defined as below and the individual must meet all three conditions in order to meet the basic CAP eligibility criteria:

- A primary medical (physical rather than psychological, behavioral, cognitive, or developmental) diagnosis(es) to include chronic diseases or conditions such as chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, chronic endocrine and metabolic disorders, chronic infectious disease, chronic musculoskeletal conditions, chronic neurological disorders, chronic integumentary disease, chronic renal disease, genetic disorders, oncologic and hematologic disorders.
- A serious, ongoing illness or chronic condition requiring prolonged hospitalization (more than 10 days, or 3 admissions), ongoing medical treatments, nursing interventions, or any combination of these; and
- A need for life-sustaining devices such as endotracheal tube, ventilator, suction machines, dialysis machine, J-Tube and G-Tubes, oxygen therapy, cough assist device, and chest PT vest; or care to compensate for the loss of bodily function.

At-Risk of institutionalization is defined as: Participants who meet nursing facility level of care (LOC) criteria with assessed acuity of needs ranging from skilled to hospital level of care and who do not have available resources to meet immediate needs- medical, psychosocial and functional. Resources consist of both formal and informal such as willing and able family members.

Determining Level of care

A service request form (SRF) will be used to make a determination of level of care (LOC). The SRF will replace the currently used LOC instrument known as the FL-2. The SRF will only be completed during the initial consideration of LOC. The annual LOC determination will be generated from the comprehensive assessment. This waiver will use an IT system called e-CAP which is a case management and business system that houses the service request form (SRF) to determine basic eligibility for waiver participation (age requirement, Medicaid eligibility category and meets nursing facility level of care). The approved SRF initiates the next step of waiver eligibility which is completion of a comprehensive interdisciplinary assessment to determine risk of institutionalization.

Number of waiver services to be considered for participation: 1

To be considered for waiver participation, a prospective individual must require a combination of carefully coordinated waiver and non-waiver services to maintain integration in the community. These coordinated services are services that are not readily available through ordinary human services organizations or State Plan. The individual would only need one waiver service that is instrumental in delaying or preventing institutionalization.

Dignity of Risk

Each beneficiary will be carefully assessed for health and well-being. One component of the health and well-being assessment is an emergency back-up plan. Waiver beneficiary/primary representative will be allowed to exercise risk when minor health and safety issues are identified. A risk mitigation tool, called an individual risk assessment, may be used to manage and plan the risk.

Consumer-direction

Consumer-direction will be available for a waiver beneficiary when participating in the waiver. The waiver beneficiary or representative must successfully complete a self-assessment questionnaire and show evidence of ability to direct care before consumer-direction participation may be approved. The hired worker must also show competencies to provide the care as listed on the service plan by documented competency skills.

Conflict-Free case management safeguards

This waiver will be administered by the State Medicaid Agency with local oversight by appointed case management entities. The administrative authority of the waiver will be the Division of Medical Assistance (DMA). DMA will be responsible for core administrative functions, listed in Appendix A. Designated case management entities will be appointed to perform administrative responsibilities to include local approval authority of assessments and service plans. The waiver beneficiary is provided a list of Medicaid-approved agencies in his or her catchment area to select to conduct an independent assessment and plan of care. Upon the completion of the service plan, a service authorization is forwarded to the provider(s) selected by the waiver beneficiary to render the waiver or non-waiver service(s). The waiver beneficiary may choose any provider at any time without forfeiting or experiencing a gap in service provision. The Division of Medical Assistance ensures conflict-free case management through monitoring and oversight of State staff.

Qualifications to become an appointed case management entity; each interested provider must submit a provider credentialing packet/application that provides assurance of the following items listed below.

Each case management entity must meet a provider threshold in order to be appointed by DMA. The required provider threshold includes the following:

The selected agency must be currently enrolled as a Medicaid provider and approved to provide services under In-Home Services and Supports. The agency must be capable of providing case management by both nursing and social work staff. The agency shall also meet the below criteria:

- a. Demonstrated experience with pediatric and medically-complex children.
- b. Demonstrated experience in home and community care case management.
- c. Demonstrated capacity of web-based automation.
- d. Demonstrated experienced staff to ensure case mix and caseload management.
- e. Demonstrated fiscal soundness, on-hand and reserve resources.

The selected entity shall be able to:

- a. Process a service request to determine basic eligibility criteria for waiver participation.
- b. Complete comprehensive assessments to ascertain medical, psychosocial and functional needs for waiver participation.
- c. Coordinate and collaborate in a multidisciplinary team approach for the provision of waiver services that prevent institutionalization.
- d. Develop a person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration and frequency.
- e. Conduct monthly monitoring of the service plan with beneficiary and quarterly monitoring with all approved service providers.
- f. Complete initial trainings and annual trainings.
- g. Maintain standards set by the State Medicaid agency for timely reassessments of qualifications.
- h. Provide privacy and security of all personal health information and electronic personal health information.

The case management entities (CME) are appointed by DMA and attest to this appointment by signing the clinical coverage policy specific to the waiver that explicitly outlines responsibilities, required benchmarks and monthly waiver compliance areas. This agreement will also outline remediation methods when non-compliance is identified as well as corrective action steps to include penalties and sanctions. Case management entities will be the lead local agency for waiver entrance and management in each community and appointed by region per needs-based in counties. The core responsibilities of case management entities are listed in Appendix A.

QAQI Strategies

The State Medicaid Agency will utilize a case management business process IT system called e-CAP that will assist with the management of the day-to-day administrative functions of the waiver as well as function as the quality assurance system for waiver compliance. The IT system is able to provide the State Medicaid Agency real time waiver performance reports daily, quarterly and monthly which allows quick remediation of noncompliant waiver practices.

Level I and Level II critical incidents

Two types of critical incidents, level I and II will be used in this waiver, refer to Appendix G.

The critical incident management system is housed in the IT system. The CMEs are able to use this system to report critical incidents both Level I and Level II and receive guidance from the State Medicaid Office of appropriate remediation of an incident.

Case management entities compliance

A score card will be used to measure the performance of each appointed case management entity. Each case management entity must maintain a 90% compliance rate. Performance less than 90% will require a corrective action plan. If after three months of corrective action and the case management entity is not at a 90% compliance rate, a recommendation may be made to terminate case management entity designation.

Application for a §1915(c) Home and Community-Based Services Waiver

1. Request Information (1 of 3)

- A.** The **State of North Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):
Community Alternatives Program
- C. Type of Request:** **renewal**

Requested Approval Period: (For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

- 3 years 5 years

Original Base Waiver Number: NC.4141

Waiver Number: NC.4141.R06.00

Draft ID: NC.019.06.00

D. Type of Waiver (select only one):

Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)

03/01/17

Approved Effective Date: 03/01/17

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §§440.40 and 42 CFR §§440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

§1915(b)(2) (central broker)

§1915(b)(3) (employ cost savings to furnish additional services)

§1915(b)(4) (selective contracting/limit number of providers)

A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

A program authorized under §1915(i) of the Act.

A program authorized under §1915(j) of the Act.

A program authorized under §1115 of the Act.

Specify the program:

H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.**

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose: This waiver program provides an alternative to institutionalization for individual between the ages of 0-20. These services allow the targeted individuals to remain in or return to a HCB setting. This waiver serves a limited number of medically-complex children who are medically fragile and are at imminent risk due to caregiver network unraveling because of the severity and intensity of the care needs. The array of services of this waiver will lead to a reduction in unplanned institutionalization thus promoting continuous community living.

Goals: Improve/maintain beneficiary capacities for self-performance of ADL and IADLs; improve beneficiary compliance with accepted health and wellness prevention, screening/monitoring standards; reduce beneficiary health and safety risks; implement strategies to avoid unplanned hospitalizations; avoid ER visits as a means for receiving primary care; enhance beneficiary socialization and reduce social isolation; reduce risks of caregiver burnout; increase caregiver capacities; enhance beneficiary awareness self-management of chronic conditions; foster a more engaged beneficiary; promote a positive beneficiary personal outlook; improve informal caregiver(s) outlook and confidence in their caregiving role.

Objectives: QI is responsibility of DMA and jointly shared with appointed agencies. The case management entities and providers cooperate with all quality management activities by submitting all requested documents, including self-audits, within defined timeframes and by providing evidence of follow-up and corrective action when review activities reveal their necessity.

State Assurances: Participant Access: CAP beneficiary has access to home and community-based services and supports in their communities; Person-Centered Service Planning and Delivery: Services and supports are planned and effectively implemented in accordance with each CAP beneficiary's unique needs, expressed preferences, and decisions concerning his/her life in the community; Provider Capacity and Capabilities: There are sufficient HCBS providers, and they possess/demonstrate the capability to effectively serve CAP beneficiary; Participant Safeguards: CAP beneficiary is safe and secure in their homes and communities, taking into account their informed and expressed choices; Participant Rights and Responsibilities: CAP beneficiary receives support to exercise their rights and accept personal responsibilities; Participant Outcomes and Satisfaction: CAP beneficiary is satisfied with his/her service and achieved desired outcomes; System Performance: The system supports CAP beneficiary efficiently/effectively, and constantly strives to improve quality.

Organization Structure: DMA is the administrative authority and outlines the policies/procedures governing the waiver. DMA appoints local entities to provide the day-to-day operation of the waiver to ensure the primary six waiver assurances are met. Medicaid approved entities are appointed by DMA and attest to this appointment by signing the clinical coverage policy specific to the waiver that explicitly outlines responsibilities, required benchmarks and monthly waiver compliance areas. This agreement will also outline remediation methods when non-compliance is identified as well as corrective action steps to include penalties and sanctions. **Service Delivery methods:** 1. The case management entity shall submit to DHHS contractor the following for waiver entrance and service delivery: a. HCBS SRF along with the Physician Attestation in Appendix A, to determine basis eligibility for participation in the CAP program. The SRF establishes initial eligibility and is the first basic component of determining whether a beneficiary is appropriate for CAP services. b. All sections and required fields on Service Request Form must be completed in its entirety to establish eligibility determination for CAP participation. The sections and fields on the form include: 1. Service request; 2. Beneficiary demographics; 3. Beneficiary conditions and related support needs; 4. Informal caregiver availability; 5. Attestation by Physician.

2. The case management entity designated assessors shall complete an initial and annual interdisciplinary comprehensive needs assessment on each beneficiary to determine medical, functional and social acuity level to plan for all the beneficiary's assessed needs. a. Date of LOC request and determination; c. The interdisciplinary comprehensive assessment that identified assessed needs and level of acuity functioning. d. The completed and signed person-centered service plan that identifies the CAP and regular State Plan services in the amount, frequency, duration and scope. 3. The medical, functional and social information collected through the interdisciplinary comprehensive needs assessment are documented in a POC. The POC specifies the person-centered goals, objectives and formal and informal services to address the identified medical and functional care needs of an approved CAP beneficiary. The services documented on the POC effectively meet the needs identified in the assessment.

4. If the CAP beneficiary or legal representative accepts the person-centered service plan by an approved signature, CAP participation is approved. The case management entity shall authorize selected providers according to the approved service plan through service authorizations.

e-CAP will carry out the following: 1. Quality Framework for level of care, administrative authority, service plan, qualified providers, health and welfare, and financial accountability. 2. Critical Incident Reporting System for the waiver programs. The e-CAP system will

provide the platform for the State's Critical Incident Reporting System. 3.HCBS assurance of health and welfare through case management functions of assessing, planning, monitoring, linking and follow-up that are organized and easy tracked for continuous quality improvement strategies.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. **Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. **Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. **Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. **Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. **Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- Yes. This waiver provides participant direction opportunities.** Appendix E is required.
 - No. This waiver does not provide participant direction opportunities.** Appendix E is not required.
- F. **Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. **Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. **Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. **Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. **Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. **Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. **Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
 - Not Applicable
 - No
 - Yes
- C. **Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
 - No
 - Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:
- Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.

Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:
 A notice of the renewal waiver was posted to the DMA website and prominently placed at each local Department of Social Services announcing the renewal of the waiver and a hardcopy of the waiver was also provided to each of the local Department of Social Services for review.
 The announcement of the waiver posting was also placed the CAP IT system's web site. DMA provided Town Hall meetings that were called CAP/C education and training and CAP Stakeholder engagement meetings to all case managers, beneficiaries and other interested parties. During these meetings comments were gather on index cards and surveys to make any needed and necessary changes to the waiver application.
 An announcement on the CAP IT system informed the case managers to notify waiver beneficiaries and other interested stakeholders of the posting of the waiver, current and past history and how to make comments.
 Each case management agency was also provided a FACT sheet to distribute to each waiver beneficiary that outlined the proposed changes and additions to the CAP/C waiver. Additional information provided included the public notice of the waiver and how to obtain a copy of the waiver or how to access electronically.
 During the planning process of the waiver, webinars and information sessions and focus groups were arranged to gather public input. Comments received during the public posting were addressed and modifications to the waiver were incorporated in the appendixes of service plan, consumer direction and health and welfare.
 Summary of comments:
 Comment: What is the timeline for determining if a waiver beneficiary no longer needs waiver services due to a lack of utilization?
 Response: If a waiver beneficiary goes without a waiver services for 90 consecutive days after a need has been identified; a

recommendation may be made to disenroll the waiver beneficiary from the waiver.

Comment: How many waiver services are needed to be considered for waiver participation?

Response: Only one waiver service is needed and that service includes case management.

Comment: Careful consideration needs to be made for individual who speak a different language.

Response: DMA will outline in the clinical coverage policy methods of assuring limited English proficient persons are able to access the waiver.

Comment: Do medical needs need to be met within the average cost limitation of the waiver? Does average refer to some needs being higher and other needs being lower?

Response: Waiver services for children will be planned on a person-centered basis. The average cost for waiver and non-waiver services are planned for \$129,000 which means a child may receive service more than \$129,000 or less than that amount. A child's care needs will not be comprised based on the average identified cost of care.

Comment: Will a decision to disenroll a child if his care needs are significantly over the average cost limits?

Response: DMA has implemented a cost analysis assessment to be conducted monthly to manage utilization of the waiver to assure utilization is within the average cost limits. Outliers will be carefully monitored. A development plan will be implemented 90 calendar day when total expenditures are above the average cost. At end of the 90-day plan, if expenditure remains over the average per capita cost, service limit may on waiver be applied until the average per capita cost is within alignment.

Comment: Could the budgets for modification type services be combined?

Response: The budgets for home and vehicle modification and assistive technology will be combined.

Comment: Could the budget for assistive tricycle be planned for the waiver cycle verse per fiscal year?

Response: The budget for assistive tricycle will be planned for per the waiver cycle.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

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

Last Name:

Smith

First Name:

Teresa

Title:

Administrative Service Manager

Agency:

Division of Medical Assistance

Address:

2501 Mail Service Center

Address 2:

1985 Umstead Drive

City:

Raleigh

State:

North Carolina

Zip:

27699-2501

Phone:

(919) 855-4116 Ext: TTY

Fax:

(919) 733-6608

E-mail:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **North Carolina**

Zip:

Phone: **Ext:** **TTY**

Fax:

E-mail:

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name:

First Name:

Title:	<input type="text" value="Deputy Secretary for Health Services; Division of Medical Assistance"/>	
Agency:	<input type="text" value="Division of Medical Assistance"/>	
Address:	<input type="text" value="2501 Mail Service Center"/>	
Address 2:	<input type="text" value="1985 Umstead Drive"/>	
City:	<input type="text" value="Raleigh"/>	
State:	North Carolina	
Zip:	<input type="text" value="27699-2501"/>	
Phone:	<input type="text" value="(919) 855-4101"/>	Ext: <input type="text"/> <input type="checkbox"/> TTY
Fax:	<input type="text" value="(919) 733-6608"/>	
E-mail:	<input type="text" value="dave.richard@dhhs.nc.gov"/>	

Attachments**Attachment #1: Transition Plan**

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.**
- Combining waivers.**
- Splitting one waiver into two waivers.**
- Eliminating a service.**
- Adding or decreasing an individual cost limit pertaining to eligibility.**
- Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- Reducing the unduplicated count of participants (Factor C).**
- Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915 (c) or another Medicaid authority.**
- Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

The children currently participating in the CAP/C waiver will transition into this waiver upon approval. An assessment of needs of each waiver beneficiary is being analyzed to create a transition plan in anticipation of the renewal waiver. The transition plan will address all medical, social and functional needs to ensure a smooth transition. Beneficiaries will not experience a gap in service provision. However, beneficiaries impacted by the changes of this waiver will be linked to comparable services through NC State Plan, community resources or other alternative waiver services. A transition plan that will be implemented will be evaluated during a change in the beneficiary's status or at the annual reassessment to ensure continuity of care. Any changes from this waiver that adversely impacts a waiver beneficiary, a 90-day notice will be provided to the beneficiary prior to disenrollment, service reduction or service removal. The assigned case management entity will assist the waiver beneficiary to connect to other services in the community that will meet care needs.

The case manager will work with the family to identify resources in the community to meet care needs. Resources available to families include but not limited to personal care services, private duty nursing, Community care of North Carolina, home health, Department of Social Services, vocational rehabilitation, behavioral health, Easter Seals, Children Special Health Care Services, United Way and United Cerebral Palsy. Each waiver beneficiary is entitled to Due Process when a service is denied, suspended or terminated or when the waiver beneficiary is disenrolled from the program. The beneficiary is mailed a letter by trackable mail to inform of the adverse decision. The beneficiary has 30 calendar days from the date of the letter to request an appeal. If the appeal is requested within 10 business days, services remain as planned without interruptions. If the appeal is requested after the 10th day, services can be reinstated on the date in which the appeal was requested. Services remain in place while the decision is under appeal until the final disposition.

The service request form will be used to establish the Level of Care criteria for this waiver target population. A pilot was conducted in August 2015 to test the SRF for children. The service request form will be implemented on the effective date of the waiver.

Designated case management entities will conduct assessments and approve service plans. The State agency currently approves the plans and will continue to approve the plans until this function is transitioned to the case management entities. By January 2017, designated case management entities will have the authority to conduct independent assessments and approve service plans.

The following services will be disconnected as these services are available under State Plan and are available to waiver beneficiaries if the Medicaid criteria are met. These services and any amount, frequency and duration over the current limits are available to waiver beneficiaries 0-20 under EPSDT:

Palliative care counseling - this service is available under State plan (Hospice Services and Behavioral Health). Waiver beneficiaries can also use waiver services of to meet this need if medically necessary.

Palliative Care Expression Therapy-this service is available under State plan (Hospice Services and Behavioral Health). Waiver beneficiaries can also use waiver services of training, educational and consultative services or participant goods and services to meet this need if medically necessary.

Palliative care Bereavement Counseling -this service is available under State plan (Hospice Services and Behavioral Health). Waiver beneficiaries can also use waiver services of training, educational and consultative services or participant goods and services to meet this need if medically necessary.

Waiver beneficiaries receiving the above listed services will be referred to Hospice or behavioral health to arrange continuation of these services or similar services or the CME will access the need for these services utilizing waiver services of training, educational and consultative services or participant goods and services. Each waiver beneficiary will be granted a 90-day transition to ensure there are not gaps in services and there are no health and safety risk factors.

The CAP case management IT system is undergoing an update of its functionality to accommodate the changes in the waiver. Priority functionality such as level of care instrument used, assessment, service plan, critical incident reports, Quality Improvement System (QIS) and case monitoring will be in place by March 2017. Other non-priority, but essential functionality will be updated on an Iterative schedule with a completion date of December 2017.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.

Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.

Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state of North Carolina worked with stakeholders to draft a transition to come in compliance with rule. The transition plan addresses assessment, remediation, stakeholder engagement, education and milestones for achieving full compliance with this rule. The transition plan supports individuals through a person-centered process that builds upon our already existing system and supports to ensure compliance with rules. The Transition plan ensure all self-determined individual exercises their rights to privacy, dignity, respect and freedom from coercion while they make decisions about their lives and what they want to do in their daily activities, who they want to socialize with and their surroundings.

DHHS team worked with the HCBS Stakeholder Committee to inform of the HCBS Final Rule and to establish the transition plan.

The State Medicaid Agency:

- Conducted Statewide Listening Sessions.
- Developed and publicized the NC Transition Plan and administered the Self-Assessment tool. Comments were used to enhance this process.
- Systemic review of rules and regulations were conducted hat identified barriers to community integration. Strategies were identified that presented obstacles for people to be full members of their communities. Rules reviewed included NCAC, clinical coverage policy, service definitions.

All working document pertaining to this transition was posted on the website. Individuals requesting materials by mail, fax, or email were provided this accommodation.

Public notice for the transition plan was announced in the following forums:

- In person Statewide Listening Sessions;
- Face to face MCO Innovations waiver stakeholder groups/committees;
- Face to face Stakeholder Engagement Group (SEG) presentation;
- In person Statewide Family chat sessions;

- DHHS HCBS website;
- In person collaborative meetings with partners;
- DHHS Newsletter (over 100,000 on the listserv);
- Other forms of social media, e.g. Twitter (over 2,700 engaged);
- State Stakeholder group were provided electronic and hard copies of the transition plan and other documentation to share with their organizations/membership/beneficiaries;
- MCO Provider Network Bulletins;
- MCO Care Coordination Departments communicated individually with beneficiaries.

The transition plan, time line, self-assessment, work plan, and person first version of the plan were included in the public notice. The companion document (this is a supplemental document to the Provider Self-Assessment designed to assist providers in the completion of the assessment – an individual companion document for beneficiaries is being developed to mirror the individual assessment as well) was not posted until after the public comment period (it incorporated feedback from the public comment). We posted updated documents as soon as possible after their development. We updated the timeline during the public comment period to demonstrate where we were in the process (the original was maintained on the website, as well).

A Self-Assessment piloted in May 2015 to assess the provider community. This Pilot was successful in facilitating additional service system education on this significant change in service provision expectations as well as facilitate individuals, case management entities (Local Lead Agencies), Providers, the State and Communities to work collaboratively to demonstrate what a full life in the community looks like. This unified approach facilitated the development and sharing of concrete methods for achieving life in the community. The Pilot helped Service Providers identify if they were meeting the Rule, allowing for additional time to inform the responsible agency how they were going to meet it and by what date. The Pilot helped responsible agencies prepare for responding to proposals for compliance to the rule.

Changes were made to the self-assessment as a result of comments and suggestions. A self-assessment validation tool was created to validate the completed self-assessment. Additional training was provided to Stakeholders to prepare for the statewide rollout of the self-assessment. The statewide rollout of the self-assessment launched on July 15, 2015 with a completion date of September 15, 2015.

The State assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the State's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver (*select one*):

- The waiver is operated by the State Medicaid agency.**

Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (*select one*):

- The Medical Assistance Unit.**

Specify the unit name:

Division of Medical Assistance

(Do not complete item A-2)

- Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

Specify the division/unit name. This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency.

(Complete item A-2-a).

- The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

Specify the division/unit name:

In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. *(Complete item A-2-b).*

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

- a. Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:

As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

- b. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable) (*select one*):

- Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**

Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*: CSRA under contract with the State Medicaid Agency provides for the Medicaid management of the waiver to include prior approval, claim reimbursement, provider enrollment, rate utilization management and waiver expenditures managed against approved limits.

- No. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable).**

Appendix A: Waiver Administration and Operation

- 4. Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*Select One*):

- Not applicable**

- Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.

Check each that applies:

- Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

Specify the nature of these agencies and complete items A-5 and A-6:

To ensure compliance with regulations, DMA utilizes agencies with HCBS experience, proven in the community and have the resources/capacity to provide specific administrative functions, case management, care coordination and insight on how to ensure the six waiver assurances. The appointed CME accepts their administrative roles and agrees to work collaboratively with DMA in the execution of the waiver by signing the governing Clinical Coverage policy. The appointed CME's primary responsibilities are to ensure waiver practices and that there is continuous quality improvement. The CME is prohibited from providing other waiver/non-waiver services when providing case management to a waiver beneficiary; one of the assurances of conflict-free case management.

A Request for Provider is announced on the DMA's website upon a need for a CME. Any agency that has experience in

HCBS are able to submit a proposal to become a CME. Each CME must meet a provider qualification threshold that includes:

currently enrolled as a Medicaid provider and approved to provide services under In-Home Services and Supports. capable of providing case management by both nursing and social work staff. Demonstrated experience with: Medically-complex children; HCB case management; web-based automation; qualified staff to ensure case mix and caseload management; fiscal soundness, and reserve resources.

The selected agency shall be able to:

1. Process a service request to determine basic eligibility criteria for waiver participation.
2. Complete comprehensive assessments to ascertain medical, psychosocial, and functional needs for waiver participation.
3. Coordinate and collaborate in a multidisciplinary team approach for the provision of waiver services that prevent institutionalization.
4. Develop a person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration, and frequency.
5. Conduct monthly monitoring of the service plan with beneficiary and quarterly monitoring with all approved service providers.

CME are prohibited to provide waiver and non-waiver services to a waiver beneficiary who is also providing case management.

The CME is responsible for day-to-day case management functions:

- Provide written authorization for approval/participation in the waiver.
- Provide each waiver beneficiary/primary caregiver freedom of choice among waiver services/providers.
- Provide monthly monitoring of the service plan with waiver beneficiary to ensure safe community living.
- Provide direct observation of hands-on personal care services performed with the waiver beneficiary to include personal care quarterly. A child with a high risk indicator score as identified in a completed assessment must have a face-to-face visit based on the risk-indicator scores and monthly multidisciplinary team meeting.
- Initiate Due Process tasks when an adverse decision is made and coordinate with waiver beneficiary, providers and due process management vendor.
- Provide assistance, when requested, in verifying whether medical documentation supports nursing facility level of care.
- Mitigate risk when a referral to Children Protective Services is made.
- Provide monthly and quarterly Case Management/Care Advisement to the waiver beneficiary. A child with a high risk indicator score as identified in a completed assessment must have a face-to-face visit every two months and monthly multidisciplinary team meeting.
- Review all initial and revised service plans to provide written authorization for approval and participation in the waiver. A home visit must be conducted at least quarterly. However, a child with moderate to high risk indicator scores as identified in a completed assessment must have a face-to-face visit as indicated per risk and monthly multidisciplinary team meeting. This visit is conducted in waiver beneficiary's primary residence to ensure health and well-being. The CME will observe the home environment for the provision of services by paid caregiver(s). Annually, a home visit must be conducted to perform the annual reassessment.
- Make a monthly or as needed visit, based on risk indicators with the beneficiary/responsible party to review the health and care needs, satisfaction with services, and assess the provision of all services/supplies to confirm their continued appropriateness.
- Hold a quarterly multidisciplinary treatment team meeting with providers receiving a service authorization/participation notice to review the provision of and continued appropriateness of service plan. A child with a high risk indicator score as identified in a completed assessment must have a face-to-face visit in accordance with his or her risk-indicator score with the MTM.
- Document changes in medical, functional and psychosocial status.
- Review quality assurances reports monthly to remedy any identified issues.
- Contact the waiver beneficiary/responsible party following the construction/installation of home modifications to confirm that the modifications safely meet the waiver beneficiary's needs.
- Contact the waiver beneficiary/responsible party within 48 hours of learned discharge from a hospital/rehabilitation facility to assess health status and changes in needs.
- Ensure that services offered to a waiver beneficiary do not duplicate other services.
- Locate and coordinate sources of assistance from informal sources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal supports.
- Ensure that the policies/procedures of the waiver are upheld to maintain the health/well-being of the waiver beneficiary.
- Authorize services in the amount/duration/frequency as identified on the service plan along with a description of the tasks. Ensure that waiver beneficiaries are aware of their right to select from among enrolled service providers and choose waiver services of their choice.

- Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The **contract(s)** under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Specify the nature of these entities and complete items A-5 and A-6:

The State Medicaid Agency has a contract with an IT vendor to provide an electronic case management and business process system for the daily management of waiver administrative activities. This IT platform provides case managers, beneficiaries and providers the means by which continuous quality improvement strategies are organized, tracked and made more effective. The system also provides access to waiver beneficiary eligibility, assessed needs, care planning, monitoring, due process and critical incidences. The IT system's real time access also provides accuracy in care planning and monitoring. The IT system will assist the State Medicaid Agency in ensuring that all policies and procedures are followed per waiver guidelines; processes referrals; ensures waiver beneficiary freedom of choice; ensures quality services; and cooperates with monitoring and reporting activities. The IT system provides for:

1. A coordinated and consistent process to assess, plan, monitor and link beneficiaries who are participating in the waiver;
2. A coordinated and consistent quality improvement strategy framework that continuously improves waiver performance; and
3. A coordinated and consistent methodology to provide quality assurance for the six mandated waiver assurances (Level of Care; Service plan; Qualified Providers; Administrative Authority; Financial Accountability; and Health and Welfare).

The CAP IT system also performs the following:

- Applies prior authorization limits to all waiver services.
- Monitors utilization of waiver services.
- Provides real time data analysis of the performance of the waiver for continuous quality improvement strategies.
- Randomly selects, for the purpose of auditing, case files from appointed case management entities to ensure compliance with the six federal waiver according to all applicable state and federal laws, state and federal rules and regulations, and agency policy.
- Provides alerts and checkpoints to ensure the assessments and service plans are completed per the waiver policy
- Tracks mediation and appeal for Due Process.

The CAP IT system will act as the State's quality assurance system by providing real time reports and data for:

- Waiver beneficiary enrollment.
- Waiver enrollment against approved limits.
- Waiver expenditures managed against approved limits.
- Level of care evaluation and determination.
- Waiver beneficiary service plans.

The CAP IT system will:

- Perform on-line workflow management processes and tools for the various administrative authority responsibilities related to waiver enrollment, monitoring waiver limits, level of care evaluations, review of service plans, prior authorization of waiver services, utilization management, and quality assurance/quality improvement.
- Process on-line request process for service/level of care determination that is standardized and computerized for both waiver programs and other HCBS services, as appropriate.
- Generate module for electronically-generated prior approvals for the waiver program, including an interface to MMIS to transmit prior approvals for use in MMIS claims processing.
- Generate quality assurance reporting system for the waiver programs that meets CMS reporting guidelines that can be implemented using a service provider interface, case management interface and administrative authority interface.
- Refine reporting model for a continuous quality improvement program that allows DMA to analysis quality data state-wide and direct targeted, time-limited quality improvement initiatives state-wide in response to identified quality problems or best practices.
- Implement Web based model for continuing education designed to support DMA implementation of a continuous quality improvement program.

Appendix A: Waiver Administration and Operation

- 5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The State Medicaid Agency is responsible for assessing the performance of the contracted entity, local/regional non-state entities and local/regional non-governmental non-state entity. The case management entities-(hospitals, DSSs, local health departments, case management agencies, Home Health Agencies, or federally recognized Tribes) will be monitored on a monthly basis to ensure compliance of the six waiver assurances and its associated performance measures. Each case management entity will be required to maintain a 90% compliance rate of waiver practices to maintain status as the local lead entry point in the community. The CAP IT system will provide the State Medicaid Agency monthly data reports in the timeliness and accuracy to policy in the areas of level of care, service plan, qualified provider, financial accountability, health and welfare and administrative authority. On a quarterly basis, the cumulative score will be aggregated to evaluate the performance of all appointed case management entities.

The Medicaid agency uses a representative sample when reviewing case management entities compliance rate. The representative sample consists of .95 confidence interval with a margin of error at 5%. The monitoring of these entities will be achieved through the objectives and benchmarks outlined through the contractual agreements. The State Medicaid Agency will conduct a quarterly evaluation of the performance of each entity through data analysis and compliance and satisfaction surveys. The data analysis will inform if each entity is meeting its established benchmarks and objectives and the quality assurance of the waiver. Each entity must maintain at least a 90% compliance rate of waiver processes that include waiver eligibility, waiver utilization limits and claim reimbursement.

Each appointed case management entity is required to maintain a compliance rate of 90% at each quarterly assessment. Each month,

a compliance score will be generated to inform each case management entity of areas of noncompliance to allow for improvement in noncompliant performance areas. Technical assistance will be provided to the case management entity during each month of non-compliance and at each quarter, if the score is below 90%. The case management entity will be allowed to perform, under a corrective action plan, at less than 90% for a total of 2 consecutive quarters before a decision is made to rescind their case management appointment. During this time span, DMA will provide technical assistance to assist with quality improvement of noncompliant performances. If after the 2 quarters of technical support (corrective action plan), the score remains below the 90% threshold, DMA will notify the case management entity that within 60 days their case management entity appointment will be rescinded. A Medicaid Bulletin will be posted to solicit a new provider for that catchment area with a transition timeframe of 60 days. During the solicitation and transition timeline, DMA will provide close oversight and technical assistance to the relinquishing case management entity to ensure the health and safety of each impacted waiver beneficiary.

If multiple qualified providers submit the required documentation, a selection committee is convened to evaluate the credentials and capacity of the organization given the needs of the service area. An established scale will be used for this evaluation. The organization with the highest score from the scale will be awarded the appointment as case management entity.

The State Medicaid Agency will monitor quarterly the accessibility and usability of the State's MMIS system, CSRA/NCTracks to ensure claims are processing per waiver business rules.

DMA will monitor the performance and usability of e-CAP (CAP waiver case management IT system) on a monthly basis. A monthly assessment will be conducted to determine if the case management business system in the areas of waiver entrance, eligibility, assessed needs, utilization limits and health and welfare are functioning per the scope of work and established timelines. Noncompliance area(s) will be remediated quickly through corrective action plans. If noncompliance areas cannot be remediated within a three month time span, fines and penalties will be imposed. If the non-compliance area(s) span over six months and cannot be remediated, a recommendation will be made to terminate the contract.

Appendix A: Waiver Administration and Operation

- 6. Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The State Medicaid Agency will assess performances of all appointed entities through monthly data analysis, quarterly desk-top audits and yearly accountability audits.

The monitoring of those entities is achieved through the objectives and benchmarks outlined through the clinical coverage policy. The State Medicaid Agency will conduct a quarterly evaluation of the performance of each entity through data analysis, complaints and satisfaction surveys. The data analysis will inform if each entity is meeting its established benchmarks and objectives and the quality assurance of the waiver. Each entity must maintain at least a 90% compliance rate of waiver processes such as waiver eligibility, waiver utilization limits and claim reimbursement.

The State Medicaid Agency will monitor, quarterly, the accessibility and usability of the State's MMIS system, NCTracks to ensure claims are processing per waiver business rules. When noncompliance issue(s) are identified, a corrective action plan will be implemented. A root cause analysis will be performed to identify causes and future preventive measures.

The e-CAP system for the case management business processes will be monitored on a monthly basis to ensure accessibility and ease of use for the case manager to perform required waiver functions. The CAP IT system will also be evaluated to ensure compliance of waiver policies and procedures in the areas of waiver entrance, eligibility, assessed needs, utilization limits and health and welfare. A root cause analysis will be performed to identify causes and future preventive measures.

The case management entities are monitored on a monthly basis to ensure compliance to the six waiver assurances and its associated performance measures. Each case management entity is required to maintain a 90% compliance rate of waiver practices to maintain status as the local entry point in the community. The IT system will provide the State Medicaid Agency monthly data analytic reports in the timeliness and accuracy to policy in the areas of level of care, service plan, qualified provider, financial accountability, health and welfare and administrative authority.

The appointed case management entities' primary responsibilities are to ensure waiver practices and that there is continuous quality improvement of the waiver. Public local agencies such as the departments of social services, public health agencies, hospitals, case management agencies and home health organizations that have experience in serving this target population are able to act in the capacity of an appointed case management entity by DMA. A public Medicaid Bulletin is placed on the DMA's website as well as the State's MMIS website announcing an available service area. A description of the waiver program is provided along with the location of the service area and the demographic of waiver participants. The announcement also lists the required credentials to be an appointed case management entity. Each organization must meet a threshold in order to be appointed. The required threshold consists of:

The selected agency must be currently enrolled as a Medicaid provider and approved to provide services under In-Home Services and Supports. The agency must be capable of providing case management by both nursing and social work staff. The agency shall also meet the below criteria:

- a. Demonstrated experience with pediatric and medically-complex children.
- b. Demonstrated experience in home and community care case management.
- c. Demonstrated capacity of web-based automation.
- d. Demonstrated experienced staff to assure case mix and caseload management.

e. Demonstrated fiscal soundness, on-hand and reserve resources.

The selected agency shall be able to:

- a. Process a service request to determine basic eligibility criteria for waiver participation.
- b. Complete comprehensive assessments to ascertain medical, psychosocial and functional needs for waiver participation.
- c. Coordinate and collaborate in a multidisciplinary team approach for the provision of waiver services that prevent institutionalization.
- d. Develop a person-centered service plan that identifies the responsible party to render the service and the service needs by the amount, duration and frequency.
- e. Conduct monthly monitoring of the service plan with beneficiary and quarterly monitoring with all approved service providers.
- f. Complete initial trainings and annual trainings.
- g. Maintain standards set by the State Medicaid agency for timely reassessments of qualifications.
- h. Provide privacy and security of all personal health information and electronic personal health information.

On a quarterly basis, the cumulative score will be aggregated to evaluate the performance of all appointed case management entities. Medicaid providers of waiver services will be monitored on an annual basis through waiver claims and an attestation of waiver compliance.

Appendix A: Waiver Administration and Operation

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*): In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Level of care evaluation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Review of Participant service plans	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Qualified provider enrollment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Execution of Medicaid provider agreements	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Establishment of a statewide rate methodology	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: 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 waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. As necessary and applicable, performance measures should focus on:

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver

- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of case management entities who completed waiver participant’s annual recertification of need within the specified timeframe. Numerator: number of case management entities who completed waiver participant’s annual recertification of need within the specified timeframe Denominator: number of case management entities

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system, case management entities' files and DMA’s MMIS that is managed by CSRA.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system, case management entities' files and DMA’s MMIS that is managed by CSRA	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Not Applicable	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis (<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: IT Contractor	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify:
	<input type="text"/>

Performance Measure:

Number and percent of case management entities that submitted a service authorization for waiver services within five days of the approved service plan date. Numerator: number of case management entities that submitted a service authorization for waiver services within five days of the approved service plan date **Denominator:** number of case management entities

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entities' files.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entities' files	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	<input type="checkbox"/> Other Specify:
	<input type="text"/>

Performance Measure:

Number and percent of case management entities that maintained a 95% utilization rate of approved waiver slots. Numerator: number of case management entities that maintained a 95% utilization rate of approved waiver slots Denominator: number of case management entities

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entities' files.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entities' files	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
	Specify: <input type="text"/>

Performance Measure:
Number and percent of case management entities with a core case management responsibility compliance score of 90% or better. Numerator: number of case management entities with a core case management responsibility compliance score of 90% or better. Denominator: number of case management entities

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
 If 'Other' is selected, specify:
The source of these reports are from the CAP IT case management system and case management entities' files.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entities' files	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: IT Contractor	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Performance Measure:

Number and percent of CME experience survey respondent who report overall waiver assistance/guidance was provided by the administrative authority when required within a timely manner. Numerator: number of CME experience survey respondent who report overall waiver assistance/guidance was provided by the administrative authority within a timely manner
Denominator: number of experience surveys

Data Source (Select one):

Participant/family observation/opinion

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: IT Contractor	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The appointed CMEs' primary responsibilities are to ensure waiver practices and that there is continuous quality improvement of the waiver. The appointed CMEs are the organizations DMA have assigned to be the local lead for waiver management. An organization that seeks designation as the CME must meet the criteria DMA sets forth as a qualified provider of home and community based services. When appointed as the CME, these entities are responsible for gathering the information to assist in determining the basic eligibility criteria for waiver participation and completing the assessment to assist in determining level of acuity and need for services to support inclusion into the community. The waiver beneficiary has the freedom to choose a CME at any time. Upon approval for waiver participation, participant rights and freedom of choice are explained. A list of CMEs in their catchment area is offered to each waiver beneficiary for his or her selection. DMA uses a case management business IT system to evaluate all waiver beneficiaries/provider agencies in the processing/performance of waiver activities. To validate the efficiency and capacity of the CAP IT system programmed to support DMA's administrative operation, the sampling methodology will be a 100% for waiver year one. Appointed case management entities that provide the day-to-day oversight of the waiver program are required to meet additional thresholds that validate readiness and ability to provide oversight of the waiver program at the local level. The IT system has a quality improvement system for the following:
- Program participation –tracks the waiver enrollment date to ensure annual reassessments are performed in a timely manner, by sending alerts to the assigned case manager two months prior to the due date. The system also checks for a level of care determination, a consent form and freedom of choice notice, prior to the approval of waiver participation.
 - Waiver entrance- validates medical and functional status are consistent with nursing facility of care, through the approval of a service request form (SRF). When the level of care is met and a waiver slot is available, the IT system places the SRF in the assignment assessment queue, to prepare for the next phase of waiver entrance (comprehensive assessment) process. Information from the SRF is auto-populated through a method of prompted questions to ensure all medical, functional, behavioral and social needs were holistically assessed. Key risk factors from the assessment auto-populate to the service plan to plan for all identified needs.
 - Utilization management- stores all service plans and its associated budget limits to ensure the waiver is cost neutral and does not exceed the established average per capita cost. The IT system places service utilization limits on all waiver services authorized by the CME to prevent over utilization. The placement of utilization limits ensures a 100% compliance rate of claim reimbursement. Thus allowing waiver services to be paid in the amount, frequency and duration as planned in the service plan. These limits ensure services do not exceed the service plan and to ensure services are not reimbursed prior to the effective date. The IT systems has the capacity to run real time data analytic reports daily for the purpose of claims analysis that allows for quick remediation, if needed.
 - Quality Improvement System- has a robust QIS through data analytic that is real time. The data report allows real time discovery and quick remediation, when required. Desktop audits can be performed immediately to evaluate the rate of compliance to waiver practices.
- As a safeguard to ensure compliance to waiver policies and practices, and to ensure established benchmarks are met monthly, on a quarterly basis, an analysis of the case management entity's performance will be conducted. All case management entities will be evaluated quarterly against waiver QIS. A score card will be generated through IT system that will be reviewed monthly by the State Medicaid Agency to ensure compliance of waiver assurances and its associated performance measures. Each quarter, the cumulative results will inform waiver compliance and the need for remediation that could possibly include sanctions until Continuous Quality Improvement (CQI). Continuous failure to comply with waiver assurances will result in case management provider termination.
- A score of 90 and better, the case management entity will be rated an A organization.
 - A score of 89 or less, the case management entity will be rated a B organization.
 - A score less than 89, the case management entity is in jeopardy of termination.
- Each case management entity must maintain a 90% compliance rate on a quarterly basis. The score of each case management entity will be shared with waiver beneficiaries through the Introductory or Annual Letter and freedom of choice documents and other stakeholders through the DMA's website.
- The core case management responsibilities include the following:
- assessing, care planning, monitoring, follow-up and linkage. Responsibilities also include waiver enrollment, waiver enrollment managed against approved limits, waiver expenditures managed against approved levels, level of care evaluation, review of participant service plans, prior authorization of waiver services and utilization management.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
- The State Medicaid Agency has a number of safeguards in place to discover/identify problems/issues within the waiver program when an appointed entity is performing administrative functions. The State Medicaid Agency has appointed a State fiscal contractor and case management entities to perform tasks of participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved limits level of care evaluation; review of waiver beneficiary service plan; prior authorization of waiver services; utilization management; Quality assurance and quality improvement activities.
- Upon discovery of non-compliance for an appointed case management entity, the State Medicaid Agency notifies the case

management entity of the non-compliant area and requests a corrective action plan to correct the non-compliant area. Technical assistance and/or training on policies and procedures are provided. State Medicaid Agency approves the corrective action plan and follows-up with the case management entity to ensure the corrective action plan (remediation plan) is completed. If warranted by persistent non-compliance (more than 2 occurrences of the same areas), sanctions are enforced to include enrollment restrictions for 60-days or until the remediation is reached, if remediation efforts cannot be achieved within 60 days. Individuals requesting or waiting for services and active waiver beneficiaries will be notified of the sanction to allow informed choice and selection of another case management entity, if desired. If remediation efforts are not reached, actions will be made to dissolve that entity as an appointed case management entity. Individuals requesting or waiting for services and active waiver beneficiaries will be notified of the inability of the case management entity to remediate noncompliant area(s) to allow selection of another case management entity. In after three months of unsuccessful remediation to include technical assistance, training and suspension of new enrollment, the State Medicaid Agency will initiate termination of the case management entity. A transition plan will be implemented to reduce an access to care concern.

Upon discovery of non-compliance for the CAP IT vendor, the State Medicaid Agency notifies the IT vendor of the non-compliant area(s), requests a corrective action plan to correct the non-compliant area(s) and provide technical assistance and/or training on policies and procedures. The State Medicaid Agency approves the corrective action plan (remediation plan) and follows-up with the IT vendor to ensure the corrective action plan is completed. If warranted by persistent non-compliance, civil financial penalties are enforced. If consistent non-compliant performance exists, a recommendation will be made to terminate the contract. A transitional plan would be developed prior to the termination of the contract to ensure the health and safety of waiver participants.

Upon discovery of non-compliant area(s) exhibited by waiver Medicaid providers, the State Medicaid Agency Program Integrity Unit will investigate and imposed sanction, if necessary, based on the severity of the incident. A recommendation may be made for an action of closure or civil fines.

Upon discovery of non-compliant area(s) for the fiscal intermediary for consumer-directed services, The State Medicaid Agency notifies the FMS of the non-compliant area(s) and requests a corrective action plan to correct the non-compliant area (s). Technical assistance and/or training on policies and procedures are provided. The State Medicaid Agency approves the corrective action plan (remediation plan) and follows-up with the FMS, to ensure the corrective action plan is complete. If persistent non-compliance continues to exist, action will be made to dissolve that entity as an FMS.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Administrative Authority, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301 (b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
<input type="checkbox"/> Aged or Disabled, or Both - General					
	<input type="checkbox"/>	Aged			<input type="checkbox"/>
	<input type="checkbox"/>	Disabled (Physical)			
	<input type="checkbox"/>	Disabled (Other)			
<input checked="" type="checkbox"/> Aged or Disabled, or Both - Specific Recognized Subgroups					
	<input type="checkbox"/>	Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
	<input checked="" type="checkbox"/>	Medically Fragile	0	20	<input type="checkbox"/>
	<input type="checkbox"/>	Technology Dependent			<input type="checkbox"/>
<input type="checkbox"/> Intellectual Disability or Developmental Disability, or Both					
	<input type="checkbox"/>	Autism			<input type="checkbox"/>
	<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
	<input type="checkbox"/>	Intellectual Disability			<input type="checkbox"/>
<input type="checkbox"/> Mental Illness					
	<input type="checkbox"/>	Mental Illness			
	<input type="checkbox"/>	Serious Emotional Disturbance			

b. **Additional Criteria.** The State further specifies its target group(s) as follows:

Condition for waiver entrance/enrollment:

1. Meets the Medically Fragile the Level of Care (LOC criteria);
2. Meet the eligibility criteria for Long-Term Care (LTC) Medicaid and be assigned to one of the defined Medicaid categories;
3. Be determined to be at-risk of institutionalization based on the findings in the comprehensive assessment;
4. Requires 1 or more coordinated waiver services to maintain health, safety and well-being in the community; and
5. Requires the management of waiver services and other services to promote community inclusion and integration.

Each waiver beneficiary must meet an established nursing facility LOC to meet the basic waiver entrance criteria. When LOC is determined, the results of the comprehensive assessment identifies the functional level of acuity of either skilled or hospital. The individual cost limit is based on a combination of both nursing facility level of care and hospital level of care.

The definition for medical fragility include the following:

1. A primary medical (physical rather than psychological, behavioral, cognitive, or developmental) diagnosis(es) to include chronic diseases or conditions such as chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, chronic endocrine and metabolic disorders, chronic infectious disease, chronic musculoskeletal conditions, chronic neurological disorders, chronic integumentary disease, chronic renal disease, genetic disorders, oncologic and hematologic disorders.
2. Prolonged hospitalization (more than 10 days, or 3 admissions)over a 12 months timeframe, ongoing medical treatment, nursing interventions, or any combination of these; and
3. A need for life-sustaining devices such as endotracheal tube, ventilator, suction machines, dialysis machine, J-Tube and G-Tubes, oxygen therapy, cough assist device, and chest PT vest; or care to compensate for the loss of bodily function.

The waiver beneficiary must:

- require hands-on support or assistance 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.
- meet the minimum requirement for HCBS nursing facility LOC criteria approved by DMA prior to participation in the CAP program. The HCBS LOC is comparable to the Nursing Facility LOC clinical coverage with the following exclusions:
 - Have a completed comprehensive assessment that finds there is a reasonable indication the individual needs CAP services in order to remain in the community due to risk of institutionalization;
 - Be able to have his or her health, safety and well-being maintained at their primary private residence or approved location of service for CAP with the use of formal and informal supports;
 - Be able to have medical needs met within the establish amount of the average per capital cost.
 - Able to have an assigned waiver slot for waiver entry contingent to waiver allocations.

- Use waiver services during each continuous 90 consecutive day time period of CAP participation, require and utilize waiver services which is directly related to a documented medical diagnosis(es) and identified medical care needs;
- Have an emergency back-up plan with adequate formal and informal support to meet the basic needs outlined in the CAP assessment and service plan to maintain their health, safety and well-being.

When average per capita cost is 75% of the average cost each quarter of assessment:

To ensure cost neutrality of the waiver, a cost analysis of the total waiver budget and each individual's cost expenditure will be conducted quarterly. When the average per capita cost of the waiver budget is over the identified budget limit, DMA will do the following:

- a. Develop a cost utilization plan with a timeline of 90 calendar days to align the care needs within the CAP budgetary limits;
- b. implement a 60 calendar-day cost adjustment plan if the 90 calendar-day cost utilization plan is not able to align with the established budgetary limits; and

At end of the 60 calendar days, if the cost adjustment plan fails to align the waiver budget with the established budgetary limit, service utilization limits shall be implemented until the waiver is within the cost neutrality limits.

Upon the discovery of out layers (waiver participants exceeding the average per capital cost by 75% in each assessment quarter) in each quarter of analysis, the case manager is informed in conjunction with the waiver beneficiary of the out layer in an attempt to reassess needs or to identify other formal or informal services to meet care needs in an attempt to reduce the average per capital cost of care. If the average per capita cost to care for the waiver beneficiary is 100% over the average per capita cost of institutional care, an evaluation will be conducted to determine the suitability of waiver participation. If it is determined that care needs are more costly than the average per capita cost of institutional care, a conference meeting will be convened to identify a health, safety and well-being plan for the waiver beneficiary.

If a waiver beneficiary's needs increases, the case manager will implement services to meet the need through programming called short-term intensive. These services are able to be prorated across the annual cycle of the waiver year so to maintain the average per capita cost. Each waiver beneficiary is entitled to Due Process when a service is denied, suspended or terminated or when the waiver beneficiary is disenrolled from the program. The beneficiary is mailed a letter by trackable mail to inform of the adverse decision. The beneficiary has 30 calendar days from the date of the letter to request an appeal. If the appeal is requested within 10 business days, services remain as planned without interruptions. If the appeal is requested after the 10 business day, services can be reinstated on the date in which the appeal was requested. Services remain in place while the decision is under appeal until the final disposition.

The targeted population choosing consumer-direction must meet the above additional criteria and the following:

- Understands the rights and responsibilities of directing one's own care;
- Willing and capable to assume the responsibilities for waiver beneficiary (self)-directed care, or selects a representative who is willing and capable to assume the responsibilities to direct the waiver beneficiary's care; and
- Complete a self-assessment questionnaire to determine ability to direct care or identify training opportunities to build competencies to aid in self-direction

Waiver services are limited to individuals residing in private primary residential settings. The State defines primary private residence as a traditional home that is not licensed or regulated as any kind of group home or other board and care facility. No more than four unrelated people may live in the home. Individuals may be living in licensed facilities or nursing facilities at the time of application, but must be discharged to a private residence before they can actually begin participating in the waiver program. A foster home is considered a private primary resident for children experiencing in foster care.

The State Medicaid Agency actively seeks to ensure participant's safeguards while participating in the waiver. A waiver beneficiary may be denied based health, safety, and well-being eligibility requirements. These requirements include when can't be mitigated:

- a. The waiver beneficiary is considered to be at risk of health, safety and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a Personal Emergency Response System; waiver beneficiaries under the age of 18 is considered to be at risk of health, safety and well-being when their parents or responsible party cannot cognitively and physically devise and execute a plan to safety;
- b. The waiver beneficiary, lacks the emotional, physical and protective support of a willing and capable caregiver, who must provide adequate care to oversee 24-hour hands-on support or supervision, to ensure the health, safety, and well-being of the individual with debilitating medical and functional needs; or
- c. The waiver beneficiary's needs cannot be risk stratified and maintained by the system of services that is currently available to ensure the health, safety, and well-being despite an individualized risk agreement.
- d. The waiver beneficiary's primary private residence, is not reasonably considered safe to meet the health, safety and well-being in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the waiver beneficiary's safety, and these issues cannot be resolved through waiver services or other means;
- e. The waiver beneficiary's residential environment, would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager/care advisor, presents a physical or health threat, due to the proven evidence of unlawful activity conducted in the primary private residence; threatening or physically or verbally abusive behavior, by the waiver beneficiary or family member exhibited on more than two incidences physically and verbally abusive behavior or threatening language; or present of a health hazard due to pest infestation.
- f. The waiver beneficiary's continuous intrusive and oppositional behavior, impedes the safety of self and others by attempts of

suicide, injurious to self or others, verbally abusive or aggressive, destructive of physical environment, or repeated noncompliance of service plan and written or verbal directives; or g. The waiver beneficiary's primary caregiver or responsible party, continuously impedes the health, safety and well-being of the waiver beneficiary, by refusing to comply with the terms of the service plan, refusal to sign a plan, and other required documents; when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal), refuse to keep the care manager or care advisor informed of changes in the status of the waiver beneficiary; h. The waiver beneficiary chooses to remain in a living situation, where there is a high risk or an existing condition of abuse, neglect, or exploitation as evidenced by an Adult Protective Services assessment or care plan or the parent or responsible party refused to comply with Children Protective Services where there is a high risk factors of existing conditions of abuse, neglect, or exploitation.

- c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

- Not applicable. There is no maximum age limit**
- The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

Six (6) months prior to the 21st birthdate, the case manager assists the waiver beneficiary to identify community options and other services to meet care needs due to reaching the maximum age limit of this waiver. This meeting is called the aging-out transitional planning meeting. Priority transition (no wait time) is granted into the State's 1915(c) HCBS Adult Waiver to all waiver beneficiaries participating in this waiver. Three (3) months prior to the 21st birthdate, the case manager revisits the aging-out transition plan with the waiver beneficiary to ensure person-centeredness and previously identified community connections and resources are still able to meet needs. The case manager will initiate referrals and linkages to the identified resources. One month prior to the 21st birthdate, the case manager confirms connection to identified community resources as listed in the 3-month plan and there is a confirmed enrollment date that occurs on or prior to the 21st birthdate.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*). Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

The limit specified by the State is (*select one*)

- A level higher than 100% of the institutional average.**

Specify the percentage:

- Other**

Specify:

- Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- Cost Limit Lower Than Institutional Costs.** The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver.

Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the State is (select one):

The following dollar amount:

Specify dollar amount:

The dollar amount (select one)

Is adjusted each year that the waiver is in effect by applying the following formula:

Specify the formula:

May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

The following percentage that is less than 100% of the institutional average:

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

The data elements retrieved from the service request form and the comprehensive assessment provide assurances of ability to meet waiver participant's needs within the average cost limits of the waiver.

Beneficiary's medical, functional, behavioral, mental and social information will be assessed utilizing a screening tool (Service Request Form). This screening tool will establish initial basic eligibility determination of nursing LOC. This screening tool provides for a comprehensive medical overview and information to help determine intensity of support needs as well as risk factors that may impede health, safety and well-being. This screening tool has a built-in smart logic mechanism that auto-fills the assessment to reduce data entry errors.

An interdisciplinary comprehensive needs assessment is conducted by Lead Agency's social worker and registered nurse initially and annually on each beneficiary to determine medical, functional and social acuity level to plan for all the beneficiary's assessed needs to assure health safety and well-being. The interdisciplinary comprehensive assessment addresses the following areas to assure health, safety and well-being can be maintained within the cost limit:

- a. Personal health information;
- b. Caregiver information;
- c. Medical diagnoses;
- d. Medication and precautions;
- e. Skin;
- f. Neurological;
- g. Sensory and communication;
- h. Pain;
- i. Musculoskeletal;
- j. Cardio-Respiratory;
- k. Nutritional;
- l. Elimination;
- m. Mental Health;
- n. Informal support; and
- o. Housing and finances.

The individual cost limit is a combination of nursing facility care and hospital level of care.

The assessment has a scoring logic which yields acuity of care needs. There are two levels of needs that an individual is categorized: high (skilled) and hospital.

If program admission is denied due to needs cannot be safely met under the waiver, when all resources are explored and exhausted, referrals to other services are made and the waiver beneficiary is offered due process rights. After admission to the waiver, QA activities related to health, safety and well-being beneficiary's outcomes are performed by the case management entity and DMA. Program growth will be closely monitored by the Medicaid agency to determine need for a waitlist or amendment to the waiver to increase number of unduplicated recipient to be served based on State budgetary limits.

- c. **Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

- The participant is referred to another waiver that can accommodate the individual's needs.**
 Additional services in excess of the individual cost limit may be authorized.

Specify the procedures for authorizing additional services, including the amount that may be authorized:

Each waiver beneficiary is assigned an acuity level based on their assessed needs. The results of the acuity level identifies utilization of waiver services to ensure health and safety as well as per capita cost for each waiver beneficiary. As an additional safeguard, each waiver beneficiary is required to implement an emergency back-up plan. An emergency back-up plan is the provision for alternative arrangements for the delivery of services that are critical to a waiver beneficiary's well-being. In the event the formal supports are temporarily unavailable or the services are at its maximum limits due to a change of status, the emergency back-up plan is activated along with an over per average capita cost transition plan. The over average capita cost transition plan consist of: The wavier beneficiary being granted up to five months to align within the established average capita cost. Every opportunity will be utilized such as annual proration of service(s) or intervention from community resources before a decision is made to disenrollment the waiver beneficiary. The waiver beneficiary will be carefully transition in a coordinated process to another community resources with the support of informal caregivers to avert placement in an institution if the average capita cost of care cannot align within the planned over average capita cost planning period of five months is reached.

To further assist in augmenting waiver utilization limits due to a change in status, each waiver beneficiaries is allowed to practice assumed risk through an individual risk agreement. An individual risk agreement outlines the risks and benefits to the waiver beneficiary of a particular course of action that might involve risk to the waiver beneficiary, the conditions under which the waiver beneficiary assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement allows a waiver beneficiary or responsible party to assume responsibility for his or her personal choices, through surrogate decision makers, or through planning team consensus. This practice promotes continuous participation in the waiver.

On a monthly basis, the assigned case manager or care advisor will assess the beneficiary's needs and service provision to assure health, safety and well-being are maintained within the waiver average cost limit. Every three months, the case manager or care advisors is required to conduct a home visit to observe hand-on assistance of service to ensure amount, frequency and duration are sufficient to needs and health, safety and well-being is maintained in the average cost limits.

Upon discovery or by request, adjustments are made to the POC or level of care. The case manager or care advisor must review supporting documentations to determine the need for a reassessment to determine a change in the beneficiary's level of acuity. A reassessment is performed within 30 days of the request or discovery to review personal health information; caregiver information; medical diagnoses; medication and precautions; skin; neurological; sensory and communication; pain; musculoskeletal; cardio-respiratory; nutritional; elimination; mental health; informal support; and housing and finances to identify medical, functional and social needs. The new assessment is scored through the scoring algorithm that determines the level of acuity. The beneficiary's POC is planned based on the identified LOC identified in the reassessment. If beneficiary is not in agreement with the results of the reassessment, an appeal can be requested by the beneficiary/responsible care giver

After admission to the waiver, QA activities related to health, safety and well-being and cost limits are performed by the CWE and local lead agencies, and DMA for continuous quality improvement.

The case manager or care advisor corresponds with the beneficiary and service providers within 30-days of the change in the participant's condition to identify an alternative care plan to meet the beneficiary's current needs. A reassessment of needs is performed through a comprehensive interdisciplinary assessment conducted by both the social worker and nurse. Adjustments are made to the POC or level of care based upon the summary of findings. An assessment will be conducted on a quarterly basis to assess average cost of care needs. When average cost of care needs are 75% of the average at two consecutive quarters, DMA will work with the family and the case manager to assess the appropriateness of waiver services, to identify alternative resources to augment expenditures. When cost of care needs are 100% of the average cost, arrangements must be made to access appropriateness of waiver participation to assure cost neutrality of service provision. If an adverse decision is made, the waiver beneficiary is granted an appeal.

- Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

- a. Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	4000
Year 2	4000
Year 3	4000
Year 4	4000
Year 5	4000

- b. Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:
- The State does not limit the number of participants that it serves at any point in time during a waiver year.
 - The State limits the number of participants that it serves at any point in time during a waiver year.

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	3950
Year 2	3950
Year 3	3950
Year 4	3950
Year 5	3950

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

- c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:
- Not applicable. The state does not reserve capacity.
 - The State reserves capacity for the following purpose(s).

Purpose(s) the State reserves capacity for:

Purposes	
Emergency	
Money Follows the Person	
Military	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

Emergency

Purpose (describe):

Reserved capacity is for emergency needs in which the individual is at risk of imminent, significant harm if services form the waiver is not available. Individuals in the following category are eligible for emergency reserve:

- Individuals with an active AIDS diagnosis with a T-Count of 200.
- Individuals transitioning from a nursing facility or hospital utilizing service of Community Transition.
- Individuals whose third party insurance is terminating and the beneficiary needs HCBS for health, safety and well-being.
- Previously eligible waiver beneficiaries who are transitioning from a short-term rehabilitation placement within 90 days of the placement.
- Individuals identified at risk by their local Department of Social Services or federally recognized Tribes who has a need for protection by Child Protective Services for abuse, neglect and exploitation.

Describe how the amount of reserved capacity was determined:

The reserve figure is based on historical numbers of participants statewide who were determined to be in an emergency situation requiring immediate admission to waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	30
Year 2	30
Year 3	30
Year 4	30
Year 5	30

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

Money Follows the Person

Purpose (describe):

To assist individual to transition out of a facility into a home and community-based setting.

Describe how the amount of reserved capacity was determined:

Reserved capacity for these selected individuals is a percentage of the total past utilization and the number of participants approved for waiver participation in the State.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	5
Year 2	5
Year 3	5
Year 4	5
Year 5	5

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose (provide a title or short description to use for lookup):

Military

Purpose (describe):

To allow previously eligible Military dependents who are transferring back to North Carolina after an out-of-State military assignment to re-enter into the waiver without wait.

Describe how the amount of reserved capacity was determined:

Reserved capacity is an estimate based on the number of requests of continued services from military families transferring to NC with children on similar waivers in other states.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15
Year 3	15
Year 4	15
Year 5	15

Appendix B: Participant Access and Eligibility**B-3: Number of Individuals Served (3 of 4)**

- d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):
- The waiver is not subject to a phase-in or a phase-out schedule.**
 - The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**
- e. Allocation of Waiver Capacity.**

Select one:

- Waiver capacity is allocated/managed on a statewide basis.**
- Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

- f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

Due to similar acuity needs of individuals applying for participation in the waiver, this waiver arranges for service consideration on a first-come first-serve basis.

The State will reserve 50 slots per waiver year to meet the needs of individuals transitioning into the waiver program utilizing money follows the person, are determined to meet the established priority list (emergency waiver need) or is a displaced military family member. The State will also use a methodology referred to as borrowed against slot management which allows the temporary overage of slot capacity for a temporary period of time until a slot becomes available.

Individuals meeting specific criteria shall be prioritized for immediate consideration of waiver participation. If there is not an available slot or reserved slots are at its maximum, the individual shall be placed first in line on an existing statewide waitlist. Prioritization criteria apply to individuals meeting the following:

- a. Individuals transitioning from a facility with Money Follows the Person (MFP) designation.
- b. Individuals transitioning from a facility utilizing services of community transition.
- c. Eligible CAP beneficiaries who are transferring to another county or case management entity.

- d. Previously eligible CAP beneficiaries who are transitioning from a short-term rehabilitation placement within 90 calendar days of the placement.
 - e. Individuals identified at risk by their local Department of Social Services (DSS) who have an order of protection by Child Protective Service (CPS) for abuse, neglect or exploitation, and the CAP program is able to mitigate risk; or
 - f. Medicaid beneficiaries with active Medicaid who are temporary out of the State due to a military assignment of their primary caregiver.
 - g. Individuals who were receiving personal care-type services through private health insurance plan and the policy is terminating.
- The following items must be in place prior to waiver entrance:
- Service Request Form to determine basic level of care eligibility
 - Availability of a waiver slot and assignment of a waiver slot
 - Coordinated service/transition plan

The CAP IT system receives referral for individual interested in participating in the waiver. When a referral is made, a service request form is completed to determine eligibility for level of care. If eligibility is determined, and there are no available slots (assigned or reserved, when appropriate), the individual is placed on a waitlist. Data analytic is able to separate the waittime to reflect county specific, agency specific and statewide. The State Medicaid Agency utilizes the data of the CAP IT system to track waiver slot utilization statewide, to ensure established utilization limits are maintained as well as to track demographic of the referrals and approval, population universe and wait time. Each appointed case management entity must adopt the State Medicaid Agency's Waiting List Policy in approving, accepting and processing referrals.

Transfer Policy:

The case manager or care advisor shall coordinate the transfer of an eligible waiver beneficiary to another county, agency or program within 30 calendar days upon a request. Each case manager or care advisor of their respective county or agency shall coordinate the seamless transfer to prevent gaps in service provisions.

The following steps must be completed prior to the transition:

The following steps must be completed prior to the transfer:

1. The identification of the waiver beneficiary's anticipated start date of service;
2. A completed coordinated transition plan between provider agencies;
3. A written narrative of how to plan for the health, safety and well-being of the beneficiary;
4. A transfer request to e-CAP to have record electronically transferred to the receiving county;
5. A confirmed appointment for a home visit by the receiving entity to assess the home environment identifying any health and welfare concerns and planning for mitigation and safety; and
6. An update service plan that informs of the start on the first date of service provisions.

If the beneficiary is aging out of CAP/C

The case management entity shall assist a CAP beneficiary three months prior to their 21st birthday with completing the following:

- The development of a comprehensive adult transition plan.

Coordination activities shall include:

- A. conference between both entities to derive a comprehensive transition plan that outlines timelines and case management needs;
- B. the transferring entity to provide a breakdown of case management utilization activities to ensure appropriate case management time to manage the beneficiary's need by the new entity;
- C. an established date to conduct a home visit by the receiving entity to assure health, safety and well-being as well as to review the service plan to determine accuracy and need for revision;
- D. consultation with the CAP waiver beneficiary and primary caregiver to provide policy information about the new case management entity.
- E. Transfer of the electronic record to the receiving entity at least 10 days prior to the transfer.

The State Medicaid agency will assessment the remaining case management hours and the utilization of the case management hours by the referring case management agency before An assessment of case final approval of the transfer is granted. This process is necessary to ensure the health, safety and well-being of the waiver beneficiary in terms of access to ongoing case management services.

To coordinate the transition of children's Medicaid to adult Medicaid at age 17.75, the case manager or care advisor will assist the family to file a Medicaid application 90 days prior to the 18th birthday to ensure appropriate Medicaid eligibility prior to the 18th birthday.

For CAP beneficiaries transferring to a different county:

- A. conference between both counties to derive a comprehensive transfer plan that outlines timelines and case management needs;
- B. The case manager or care advisor of the transferring county shall coordinate the transfer with the case manager or the care advisor of the receiving county at least 30 calendar days prior to the anticipated transfer.
- C. The case managers or care advisors of the transferring and receiving counties shall discuss and plan for the health, safety and well-being of the waiver beneficiary.
- D. The electronic health record is transferred to the receiving county at least 10 business days prior to the transfer.
- E. The case manager or care advisor of the receiving county shall arrange for a home visit to assess the home environment to identify any health and welfare concerns to plan for mitigation and safety.

F. The case manager or care advisor shall coordinate the provision of services to start on the first date of the transfer into the receiving county.

A transferring waiver beneficiary is considered under the priority category and is guaranteed a slot in the receiving county, agency or program. Waiver participation will continue under the current Medicaid eligibility until the next Medicaid certification period (Medicaid eligibility and waiver annual reassessment).

Waiver beneficiary requesting to transfer from one case management entity to another and the case management utilization rate is near the maximum allowable or the newly requested case management entity has a waiver compliance a score of 89% or less, the waiver beneficiary will be provided education and consultation of what this means and how these issues may cause concern with health, safety and well-being. Education will also be provided about the possibility that the transfer may not be to grant as a result current performance issues or over the maximum utilization limits. Close monitoring of utilization of case management hours will be carefully analyzed to ensure appropriate use. When data from the CAP IT system identifies inappropriate use of case management time, a root cause analysis will be conducted to validate misappropriation. If evidence warrants misappropriate a corrective action plan will be implement to request Medicaid reimbursement for the miss use of management hours.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a (*select one*):

- §1634 State
 SSI Criteria State
 209(b) State

2. **Miller Trust State.**

Indicate whether the State is a Miller Trust State (*select one*):

- No
 Yes

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- Low income families with children as provided in §1931 of the Act
 SSI recipients
 Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
 Optional State supplement recipients
 Optional categorically needy aged and/or disabled individuals who have income at:

Select one:

- 100% of the Federal poverty level (FPL)
 % of FPL, which is lower than 100% of FPL.

Specify percentage:

- Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
 Working individuals with disabilities who buy into Medicaid (TWWIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
 Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
 Medically needy in 209(b) States (42 CFR §435.330)

- Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Children receiving foster care or adoption assistance who are covered under 42 CFR 435.145.
Individuals receiving services under 42 CFR 435.135

Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed

- No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.**
- Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

Select one and complete Appendix B-5.

- All individuals in the special home and community-based waiver group under 42 CFR §435.217**
- Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

- A special income level equal to:**

Select one:

- 300% of the SSI Federal Benefit Rate (FBR)**
- A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

- A dollar amount which is lower than 300%.**

Specify dollar amount:

- Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- Aged and disabled individuals who have income at:**

Select one:

- 100% of FPL**
- % of FPL, which is lower than 100%.**

Specify percentage amount:

- Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver)**

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

- a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217:

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- b. **Regular Post-Eligibility Treatment of Income: SSI State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- c. **Regular Post-Eligibility Treatment of Income: 209(B) State.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

- d. **Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules**

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- e. **Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

- f. **Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.**

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-4 indicate that you do not need to submit Appendix B-5 and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is:

ii. Frequency of services. The State requires (select one):

- The provision of waiver services at least monthly**
 Monthly monitoring of the individual when services are furnished on a less than monthly basis

If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

- Directly by the Medicaid agency**
 By the operating agency specified in Appendix A
 By an entity under contract with the Medicaid agency.

Specify the entity:

Case management entity will submit the completed physician-attested Service Request Form to CAP IT system for processing and analysis of level of care and medically fragility. The CAP IT system performs data algorithm to evaluate medical, functional and health information in the SRF to determine LOC and medically fragile. A nurse reviewer will review all SRFs analyzed by the IT system when a negative result is identified. The nurse reviewer will review the SRF and request any additional information before an adverse decision is made. The waiver beneficiary will be provided appeal rights if an adverse decision is reached. The result of LOC decision will be forwarded to DMA's MMIS for accuracy of claim processing.

- Other**
Specify:

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Bachelor's degree in social work from an accredited school of social work, and one (1) year of directly related experience of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or

personal care and the completion of a DMA-certified training program within 90 calendar days of employment;

Bachelor's degree in a human services or equivalent field from an accredited college or university with two (2) or more years of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA certified training program within 90 calendar days of employment;

Bachelor's degree in a non-human services field from an accredited college or university with two (2) or more years of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA certified training program within 90 calendar days of employment; or

Registered nurse who holds a current North Carolina license, two (2) year or four (4) year degree, one (1) year case management in homecare, long-term care, personal care or related work experience and the completion of a DMA certified training program within 90 calendar days of employment.

The case manager or care advisor shall complete nine (9) contact hours or continuing education hours per calendar year, of which person-centered training; legislation training related to health care disability and reimbursement strategies; abuse, neglect, exploitation, and program integrity (PI) are mandatory (refer to Subsection 6.3).

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The definition of level of care for this HCBS waiver includes:

A disability of medical and physical condition that includes a primary medical diagnosis (es) that is chronic in nature. The overriding medical condition is primarily physical rather than psychological, behavioral, or developmental. The individual needs in-home supports and services similar to that provided in an institution. The individual require modifications 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.

Professional judgment and a thorough evaluation of the beneficiary's medical condition and psychosocial needs are required to differentiate between the need for nursing facility care and other health care alternatives. The HCBS LOC must address interventions, safeguards (health, safety and well-being) and the stability of each beneficiary to ensure community integration and prevention of institutionalization as a result of chronic medical and physical disabilities.

Qualifying Conditions

HCBS Nursing Facility Level of Care Criteria must require a need for any one of the following:

1. Services required by a physician's judgment require:
 - A. supervision of a registered nurse or licensed practical nurse; and
 - B. other personnel working under the direct supervision of a registered nurse or licensed practical nurse.
2. Observation and assessment of beneficiary needs by a registered nurse or licensed practical nurse. The nursing services must be intensive and directed to an acute episode or a change in the treatment plan that would require such concentrated monitoring.
3. Restorative nursing measures once a beneficiary's treatment plan becomes stable. Restorative nursing measures are used to maintain or restore maximum function or to prevent advancement of progressive disability as much as possible. Such measures are:
 - A. Encouraging and assisting a beneficiary to achieve independence in activities of daily living (i.e. bathing, eating, toileting, dressing, transfer and ambulation);
 - B. Use of preventive measures or devices to prevent or delay the development of contractures, such as positioning, alignment, range of motion, and use of pillows;
 - C. Ambulation and gait training with or without assistive devices; or
 - D. Assistance with or supervision of transfer so, the beneficiary would not necessarily require skilled nursing care.
4. Dialysis (hemodialysis or peritoneal dialysis) as part of a maintenance treatment plan.
5. Treatment for a specialized therapeutic diet (physician prescribed). Documentation must address the specific plan of treatment such as the use of dietary supplements, therapeutic diets, and frequent recording of the beneficiary's nutritional status.
6. Administration or control of medication as required by state law to be the exclusive responsibility of licensed nurses:
 - A. Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration;
 - B. The use of drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgment on a continuous basis; or
 - C. Frequent injections requiring nursing skills or professional judgment.
7. Nasogastric or gastrostomy feedings requiring supervision and observation by an RN or LPN:
 - A. Primary source of nutrition by daily bolus or continuous feedings;
 - B. Medications per tube when beneficiary on dysphagia diet, pureed diet or soft diet with thickening liquids; and
 - C. Tube with flushes.
8. Respiratory therapy: oxygen as a temporary or intermittent therapy or for a beneficiary who receives oxygen continuously as a component to a stable treatment plan:
 - A. Nebulizer usage;
 - B. Nasopharyngeal or tracheal suctioning;
 - C. Oral suctioning;
 - D. Pulse oximetry.

9. Isolation: when medically necessary as a limited measure because of contagious or infectious disease.
10. Wound care of decubitus ulcers or open areas.
11. Hemodialysis or peritoneal dialysis as part of a maintenance treatment plan.
12. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan.

b. Conditions That Must be Present in Combination to Justify HCBS Nursing Level of Care

The following, when in combination (two or more), may justify HCBS nursing facility level of care placement:

1. Need for teaching and counseling related to a disease process, disability, diet, or medication.
2. Adaptive programs: training the beneficiary to reach their maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the beneficiary's participation in the program and the beneficiary's progress.
3. Ancillary therapies: supervision of beneficiary's performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of plaster casts.
4. Injections: requiring administration or professional judgment by an RN or LPN or a trained personal assistance.
5. Diabetes: when daily observation of dietary intake or medication administration is required for proper physiological control:
 - A. Vision, dexterity and cognitive deficiencies; or
 - B. Frequent hypoglycemic and diabetic ketoacidosis (DKA) (high blood sugar) episodes with documentation requiring intravenous or intramuscular (IV or IM) or oral intervention.
6. Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction.
7. Psychosocial considerations: psychosocial condition of each beneficiary must be evaluated in relation to their medical condition when determining the need for nursing facility level of care. Factors to consider along with the beneficiary's medical needs are:
 - A. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes and/or by nursing or therapy notes);
 - B. Age;
 - C. Length of stay in current placement;
 - D. Location and condition of spouse;
 - E. Proximity of social support; or
 - F. Effect of transfer on resident, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning helps alleviate the fear and worry of transfer).
8. Blindness.
9. Behavioral problems, such as:
 - A. Wandering;
 - B. Verbal disruptiveness;
 - C. Combativeness;
 - D. Verbal or physical abusiveness; or
 - E. Inappropriate behavior (when it can be properly managed at the nursing facility level of care);
10. Frequent falls; or
11. Chronic recurrent medical problems that require daily observation by licensed personnel for prevention and treatment.

A LOC determination using the SRF must be completed at initial enrollment. Annual reevaluation of LOC is performed through a needs assessment that determines ongoing nursing facility equivalent LOC and acuity level. A favorable change to a waiver beneficiary's condition that improves functionality and mobility to the point waiver services are no longer needed to support community inclusion may result in a dis-enrollment from waiver participation.

The functional acuity levels of skilled and hospital are established through a comprehensive assessment that covers the following areas:

The interdisciplinary assessment includes the following functioning areas to ensure waiver beneficiary access and eligibility:

- a. Personal health information;
- b. Caregiver information;
- c. Medical diagnoses;
- d. Medication and precautions;
- e. Skin;
- f. Neurological;
- g. Sensory and communication;
- h. Pain;
- i. Musculoskeletal;
- j. Cardio-Respiratory;
- k. Nutritional;
- l. Elimination;
- m. Education
- n. Mental Health;
- o. Informal support; and
- p. Housing and finances.

When the LOC is determined, an assessment is completed to identify the functioning acuity level. The information obtained from the LOC instrument informs of the nursing facility LOC. The CAP IT system has acuity functionality programmed to identify the identified acuity levels of skilled and hospital.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

- The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

A different instrument is used to determine the level of care for waiver beneficiary than the FL-2, used by the State Medicaid Plan. This tool is referred to as a Service Request Form (SRF). The SRF tool is equivalent to the State instrument and is statistically valid. The Service Request Form captures a comprehensive overview of medical, functional, behavioral and social needs of an individual that allows for an accurate assessment of nursing facility equivalent level of care for community-dwelling individuals.

The Service Request Form is the first eligibility consideration for participation in the waiver. The SRF establishes the basic eligibility criteria for nursing or hospital facility level of care for all waiver beneficiaries.

The SRF must be completed to its entity and signed by a designated clinician and must have clear indication of nursing facility level of care needs in order to initiate the scoring algorithm to determine nursing or hospital facility level of care. The following required fields on the form include:

- o Program request.
- o Waiver beneficiary demographics.
- o Waiver beneficiary conditions and related support needs.
- o Informal caregiver availability.
- o Physician Attestation.
- o Date of LOC request and determination.

When nursing or hospital facility LOC is established through the SRF, the CAP IT system electronically transmits to the Medicaid's Fiscal Agent the level of care decision to enter the prior approval eligibility in the Medicaid Management System. A prior approved LOC is one of two components required in the State's MMIS in order to adjudicate waiver claims. The second component is the assignment of a waiver special coverage code.

- f. **Process for Level of Care Evaluation/Reevaluation:** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Upon an initial referral for waiver participation, a Service Request Form (SRF) is completed to determine eligibility. The SRF evaluates the participant's medical, functional, psychosocial and behavioral needs and evaluate those needs against an established level of care that is equivalent to nursing facility or hospital level of care. The data gathered on the SRF is aggregated and scored through a LOC algorithm to yield an approval or denial of LOC. If the SRF is approved for LOC, the potential waiver participant is placed in an assessment queue. Activities that must be conducted prior to waiver entrance include a needs assessment and a service plan. The needs assessment will confirm the need for waiver intervention. The needs assessment includes the following which validates LOC:

- Personal health information.
- Caregiver information.
- Medical diagnoses.
- Medication and precautions.
- Skin.
- Neurological.
- Sensory and communication.
- Pain.
- Musculoskeletal.
- Cardio-Respiratory.
- Nutritional.
- Elimination.
- Mental Health.
- Informal support.
- Housing and finances.

The approval of LOC is transmitted to the State Medicaid MMIS for the management of waiver eligibility, claim processing and utilization limits.

An annual SRF is not completed. The ongoing and continuous LOC is established through an assessment of need. The assessment has logic to evaluate one's ongoing level of care through entries of medical, functional, behavioral, and psychosocial characteristics.

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

- Every three months
 Every six months
 Every twelve months
 Other schedule

Specify the other schedule:

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

- The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
 The qualifications are different.

Specify the qualifications:

- i. Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

A LOC determination is completed initially. An annual reevaluation of LOC is performed annually through a comprehensive needs assessment that aggregates the data and compares it against the scoring logic of the initial SRF. The results of the comprehensive needs assessment yield LOC comparability and the functioning acuity level (skilled or hospital).

The CAP IT system provides monthly reminders of the need to complete the reevaluation. The CAP IT system has trigger-logic to alert the case managers of:

- when plans are due
- when a case management agency are 30 days past the plan renewal period, and
- non-changing personal health and historical information to allow for auto-fill and generation to the service plan.

The CAP IT system provides real time reports on all performance measures for LOC assurance. It provides alerts to the family and case manager of formal intervention that are needed to build an array of home and community-based services while ensuring service utilization limits and health and safety are adequately planned. The system also provides the State Medicaid Agency, in real time, performance summaries for all case management activities such as the workflow progression of assessments and service plans, timely and untimely filing of critical incident reports, timely and untimely responses to required monitoring tasks and corresponding documentation. The CAP IT system also has the capacity to track and trend complaint reports, satisfaction surveys and case management documentation. These summaries allow the State Medicaid Agency to identify each case management agency's compliance to policy for tracking and trending purposes as well as remediation, if required. Non-compliance issues are able to be quickly remediated based on the daily and monthly data reports generated through the CAP IT system.

For continuous quality of the waiver, the CAP IT system is evaluated quarterly to identify quality improvement strategies for the waiver as well as system improvements for more efficient case management functions.

- j. Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The CAP IT system and the CSRA/NCTracks are electronic system and will maintain waiver documentations that are consistent with the State's retention policy.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery: Level of Care Assurance/Sub-assurances**

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

- i. Sub-Assurances:**

- a. **Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver beneficiaries who had a level of care indicating need for institutional level of care prior to waiver participation. Numerator: number of waiver beneficiaries who had a level of care indicating need for institutional LOC prior to waiver participation Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and DMA's MMIS managed by CSRA	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> Other Specify: IT Contractor	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. **Sub-assurance:** *The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. **Sub-assurance:** *The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of new enrollees who received a level of care determination using the Service Request Form (SRF). Numerator: number of new enrollees who received a LOC determination using SRF **Denominator:** number of new enrollees

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and DMA's MMIS managed by CSRA	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CAP IT system for the waiver is designed to evaluate all waiver beneficiaries and provider agencies in the processing and performance of waiver activities which is a critical component of the success of this waiver. To validate the efficiency and capacity of the CAP IT system programmed to support DMA administrative operation on this waiver, the sampling methodology will be 100% sampling for waiver year one.

The State Medicaid Agency has established mandatory requirements for waiver participation. A waiver beneficiary must meet the criteria for HCBS nursing facility level of care criteria and be at risk of institutionalization. Risk of institutionalization is defined as a participant who meet nursing facility level of care (LOC) criteria with assessed acuity of needs ranging from skilled to hospital level of acuity and who do not have available resources to meet immediate needs-medical, psychosocial and functional. Resources include both formal and informal (including willing and able family members).

A level of care (LOC) decision is determined on all potential waiver beneficiaries prior to approval of waiver participation. A standardized prior approval tool known as the Service Request Form (SRF) is used to determine the HCBS level of care. The SRF is a comprehensive tool that captures medical, behavioral and social information to clearly identify the functional level of the individual. All requests for waiver participation are initiated through data uploaded in the IT system. The requester of this service type will enter the supporting medical, functioning, behavioral and psychosocial information electronically in the SRF module of IT system. The completed form is attested to by the applicant's primary physician to recommend and validate the need for this level of care and the service intervention. This safeguard assures each waiver beneficiary meets the basic eligibility criteria and current needs cannot be met by existing support systems. A second safeguard, to assure medical, behavioral and functional needs are consistent with nursing facility level of care. Data from the SRF is analyzed to generate a score that ties to the algorithms for nursing facility level of care. The scoring logic has an exhaustive approach in that all functional areas are carefully scrutinized and if one area does not present with

the LOC criteria identified, the system automatically checks the next qualifying condition(s). When LOC cannot be determined in the first analytic process, the SRF is returned to the requester for additional supporting information. If the additional information does not yield LOC, and RN reviews the SRF to make a final decision.

The IT system automatically tracks and counts the number of new enrollees with a request for whom a LOC is determined. Data queries will be obtained from the fiscal agent for all LOCs on a quarterly basis. The Service Request Form and the comprehensive assessment will assure the beneficiary meets and needs the required LOC.

The IT system provides an automated assessment and service plan that captures data on all waiver beneficiaries. The IT tool reviews 100 percent of level of care determinations. Monthly to quarterly reports are generated through the IT system for review and analysis by State Medicaid Agency to assist with the monitoring of assurances and performance measures. The State Medicaid Agency will use this information to provide feedback to the case management entities, and when necessary, establish a corrective action plan to ensure performance measures are met in all cases.

Every 12 months, the case manager or care advisor is required to complete a Continued Need Review (CNR) to determine if the enrolled beneficiary continues to meet the established LOC requirements. The CNR must be completed during the month of the initial waiver entry, referred to as the CAP effective date. The local authority reviewer must approve and sign the plan by the first day of the month following the CNR. There are prompting questions to serve as a safeguard to assist the reviewer in analyzing the assessment and service plan to assure compliance of waiver assurances. The annual reassessment process consists of the following:

1. Home visit to the waiver beneficiary’s home by the assessment team to conduct the assessment of needs.
2. Collaboration with care providers to validate the information obtained during the home assessment.
3. Overview of the completed assessment to confirm continued need of LOC and waiver participation. An affirmative assessment leads the case manager to initiate the family/person-centered service plan. An assessment that does not validate LOC and the need for waiver participation, the case manager assists the waiver beneficiary in developing and transition plan and works with that waiver beneficiary to transition to other community services that are more in line with their care needs. The IT system will aggregate the data automatically and provide reports to support waiver performance measures. Special queries are generated quarterly in the IT system and provided to State Medicaid Agency to meet this performance measure.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Upon discovery of noncompliance, the State Medicaid Agency notifies the offending case management entity of the non-complaint area(s) and requests an immediate remediation plan to be completed within 30 calendar days. The remediation plan should consist of the following: obtain a LOC determination for the impacted waiver participant, if the LOC meets eligibility requirements, the waiver participant continues to receive waiver services. If the LOC is found ineligible, the waiver beneficiary is dis-enrolled from waiver participation and issued appeal rights in accordance with Medicaid policy. The case management entity also assists the individual in identifying other Medicaid and non-Medicaid supports and services. The first occurrence of this incident, the case management entity is restricted from enrolling new enrollees until the remediation plan has been satisfied. The case management entity will be required to reimburse Medicaid for services rendered when waiver beneficiaries do not have a validate LOC on file. If there is a second and third occurrence, the case management entity will pay an assessment penalty. Repeated findings of non-compliance in this area by the case management entity will result in termination as a case management entity.

The case management entity will be provided technical guidance and training to build competencies in this area(s) when non-compliance is found.

Upon discovery of an annual reassessment of waiver needs not completed, the case management entity is provided a corrective action plan/ an official remediation plan for immediate action within 30 calendar days. The reassessment must be completed within that timeframe and the waiver beneficiary and service providers must be notified. The first occurrence of this type of incident, the case management entity is restricted from enrolling new enrollees until the remediation plan has been satisfied. The case management entity will be required to reimburse Medicaid for services rendered when waiver beneficiaries do not have a validate reassessment of needs on file. The second and third occurrence, the case management entity will pay an assessment penalty. Repeated findings of non-compliance by the case management entity will result in termination as a case management entity.

The case management entity will be provided technical guidance and training to build competencies non-compliance is found.

Upon discovery of non-compliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within 3 business days. Repeated findings of non-compliance by a CAP IT contractor results in in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

The CAP IT system acts as a medical record and stamp-dates and archive all case management activities and corrective action plans.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Individuals seeking Medicaid services and have an indication to meet the basic eligibility criteria of the waiver, a service provider, a case management entity and the county department of social services or Tribal Nation may provides general information about the waiver and a referral is made by the individual upon an agreement of a selected case management entity in their service area. Each waiver beneficiary is informed of the case management entities in his or her catchment area and of case management entities' roles and responsibilities. Upon the approval of waiver entry and at the approval of annual waiver renewal, each waiver beneficiary is mailed a CAP Introductory Letter that outlines the purpose of the waiver, services available through the waiver, what freedom of choice is and how to exercise their choice of services, providers and participation in the waiver. This letter also includes information about abuse, neglect and exploitation. During the assessment and planning phases of waiver enrollment and renewal, the waiver beneficiary is required to select an agency of their choice to perform the four core functions of case management (assessing, care planning, monitoring, linking and follow-up) for the purpose waiver care management - participant, provider and financial management. During the assessment phase, the waiver beneficiary is informed of their rights and responsibilities as a waiver participant and how he or she has the right to select any provider (freedom of choice) at any time including another case management entity to render approved waiver and non-waiver services.

There are at least two case management entities per county to enable choice of provider for the waiver beneficiary. If a designated case management entity in a county is not able to provide case management services for any reason, to offer choice, another case management entity, within a 30-60 miles radius, will be permitted to serve that service area. The beneficiary has a choice of providers. DMA will also solicit a case management provider through a Request for Providers posted to the DMA's website, to ensure there are at least two case management providers in each catchment area.

DMA utilizes the services of local agencies, referred to as case management entities (CME), to perform administrative responsibilities of the waiver that comports with freedom of choice. During the service plan development phase, the waiver beneficiary is provided a list of Medicaid-approved agencies in his or her catchment area to select and exercise freedom of choice. This list of agencies is referred to as Freedom of Choice of providers. The waiver beneficiary selects a provider independent of the

case management entity agency. Upon selection, a referral is forwarded to the Medicaid provider for initiation of services. Upon the completion of the service plan, a service authorization is forwarded to the provider, selected by the waiver beneficiary to render the waiver or non-waiver service(s). The waiver beneficiary can choose any provider at any time without forfeiting or experiencing a gap in service provision.

The CAP Introductory Letter informs of what Freedom of Choice is and how to select an agency of their choice at any given time. Once a selection is made, a referral by DMA is made to the chosen CME to initiate case management activities. Even though the referral for waiver participation can be initiated from the local entry point in the beneficiary's catchment area, each approved individual who meets the basic eligibility requirements to participate in the waiver is required to verify the CME of their choice by selecting an entity approved in their catchment area. Services are prohibited by the referring CME until DMA receives the signed Freedom of Choice document from the waiver beneficiary that clearly identifies the chosen CME.

To ensure conflict free case management, DMA will appointment case management agencies to be solely responsible to complete independent assessment.

- b. Maintenance of Forms.** Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Waiver Freedom of Choice forms are maintained in CAP IT system and in the case management entity's file.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Federal law requires that all Medicaid providers in North Carolina comply with the Americans with Disabilities Act (ADA), Title VI of the Civil Rights Act of 1964 (Title VI), Section 504 of the Rehabilitation Act (Section 504), and Section 1557 of the Affordable Care Act (Section 1557).

The ADA requires the provision of reasonable accommodations. Such accommodations may include providing individuals who are deaf, deaf-blind, or hard of hearing with auxiliary aids and services, such as sign language interpreters, to achieve effective communication. The State uses services from the sister Divisions to make accommodations for individuals who may be blind, blind-deaf and hard of hearing. This accommodation is made on an individual basis when a request is made or when these disabilities are realized.

The Division of Medical Assistance translates documents according to Title VI of the Civil Rights Act of 1964 which requires us to translate all vital documents. Vital documents contain information that is critical for obtaining federal services and/or benefits, or is required by law. Some examples of vital documents:

1. Applications
2. Consent forms
3. Notices of rights
4. Notice advising individuals of free language assistance
5. Letters or notices that require a response from the beneficiary or client

DMA has no-cost language services available for non/limited English speaking individuals.

Title VI prohibits discrimination on the basis of race, color, or national origin in any program or activity that receives Federal funds or other Federal financial assistance. Programs that receive Federal funds cannot distinguish among individuals on the basis of race, color or national origin, either directly or indirectly, in the types, quantity, quality or timeliness of program services, aids or benefits that they provide or the manner in which they provide them. The courts have held that Title VI prohibits recipients of Federal financial assistance from denying limited English proficient (LEP) persons access to programs, based on their national origin.

Section 1557 builds upon already existing federal laws and prohibits discrimination on the basis of sex in any health programs and activities receiving federal financial assistance, such as Medicaid providers and the state Medicaid program. In general, the requirements adopted under Section 1557 include equal treatment of men and women with respect to health coverage and prohibitions against discrimination based on pregnancy, gender identity, and sex stereotyping. This section also updated notice requirements to ensure access to individuals with limited English proficiency (LEP).

Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

- a. Waiver Services Summary.** List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:

Service Type	Service		
Statutory Service	In-Home Care Aide Service		
Supports for Participant Direction	Financial Management		
Other Service	Assistive Technology		
Other Service	Case Management		
Other Service	Community Transition		
Other Service	Home Accessibility and Adaptation		
Other Service	Institutional and Non-Institutional Respite		
Other Service	Participant Goods and Services		
Other Service	Pediatric Nurse Aide Services		
Other Service	Specialized Medical Equipment and Supplies		
Other Service	Training, Education and Consultative Services		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

In-Home Care Aide Service

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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.

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.

Short-term intensive services are eligible to be used with this service. Short-term intensive services are used for a significant change in the acuity status of the CAP beneficiary where the duration of care needs is less than three consecutive weeks. Short-term intensive services are listed in the service plan. Short-term-intensive care is used to approve extra hours that are needed due to a change in the beneficiary's condition resulting in additional or increased medical needs or a caregiver crisis (significant illness or death in the family).

A spouse, parent, step-parent, 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 spouse, parent, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if:

- a. CAP beneficiary and provider are 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 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 spouse, parent, step-parent, 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 spouse, parent, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if:

- a. CAP beneficiary and provider are 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 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.

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

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.

Parents, step-parents, loco parentis, legal guardian, or significant others to a parent shall not be hired to provide personal care services to CAP beneficiaries under the age of 18. This applies for both traditional and consumer-directed services.

A spouse, parent, step-parent, child, sibling, or other relatives is eligible for hire as the employee when a CAP beneficiary is 18 years of age or older. 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 beneficiary and provider are 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:

- undergo a criminal background and registry check prior to hire; and
- demonstrate competencies and skill sets to care for the CAP beneficiary as documented by the consumer-directed participant or responsible party through the self-assessment questionnaire 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:

- Felonies related to manufacture, distribution, prescription, or dispensing of a controlled substance;
- Felony health care fraud;
- More than one felony conviction;
- Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
- Felony or misdemeanor patient abuse;
- Felony or misdemeanor involving cruelty or torture;
- Misdemeanor healthcare fraud;
- Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
- Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
- 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.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E**
 Provider managed

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Individual	Direct Staff
Agency	In-Home Aide Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: In-Home Care Aide Service

Provider Category:

Individual

Provider Type:

Direct Staff

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and educational services are needed and documentation is available to support training needs were met. Must be CPR certified.

Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Verification of Provider Qualifications

Entity Responsible for Verification:

It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Frequency of Verification:

initially and annually

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service

Service Name: In-Home Care Aide Service

Provider Category:

Agency

Provider Type:

In-Home Aide Providers

Provider Qualifications

License (specify):

Services are provided by a home care agency licensed by the DHSR under 10A NCAC 13J.

An individual licensed by the NCBON as a Registered Nurse provides supervision of the Nurse Aide as under 10A NCAC 13J.1110.

The Nurse Aide providing direct care is registered as a Nurse Aide I + or Nurse Aide II with DHSR and the NCBON.

Medicare certified home health agency.

Certificate (specify):

The nurse aide providing direct care is certified in CPR. It is recommended that (s)he also be certified in First Aid.

Other Standard (specify):

Staff shall obtain licensure or certification according to all applicable laws and regulations, and practice within the scope of practice as defined by the individual practice board.

DMA requires the following provider qualifications and training be completed before staff is assigned to provide person care to the CAP beneficiary:

- a. Criminal background checks, which must be repeated every two (2) years, at the time of licensure renewal (refer to Subsection 6.6);
- b. Verification of cardiopulmonary resuscitation (CPR) certification and every two (2) years, coinciding with expiration dates;
- c. Review of trainings and beneficiary-specific competencies at each job performance review as per agency policy;
- d. Pediatric nursing experience or completion of DMA pediatric training, such as
 1. growth and development;
 2. pediatric beneficiary interactions;
 3. and home care of pediatric beneficiary;

Verification of Provider Qualifications

Entity Responsible for Verification:

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and education services are needed and documentation is available to support training needs were met.

Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Frequency of Verification:

The verification of provider qualification is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12010 financial management services in support of self-directi

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Financial management services are provided for CAP beneficiaries who are directing their own care to ensure that consumer-directed funds outlined in the service plan are managed and distributed as intended. An approved financial manager performs financial intermediary (FI) services to reimburse the personal assistant(s) and designated providers.

The FI:

- deducts all required federal, state taxes, including insurance, prior to issuing reimbursement or paychecks;
- is responsible for maintaining separate accounts on each beneficiary's services, and producing expenditure reports as required by the state Medicaid agency;
- provides payroll statements on at least a monthly basis to the personal assistant(s) and the case management entity; and
- conducts necessary background checks (criminals and registry) and age verification on personal assistants.

The FMS must have experience and knowledge of the following:

- Automated standard application of payment;
- Check Claims;
- Electronic Fund Transfer;
- Electronic Fund Account;
- International Treasury Service;
- Invoice processing platform;
- Judgment Fund;
- Payment Application Modernization;
- Prompt Payment;
- Automated Clearing House;
- Cash Management Improvement Act;
- GFRS/FACTS I;
- Government wide Accounting;

- n. Intergovernmental Reconciliation;
- o. Standard General Ledger;
- p. Tax Payer Identification Number

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

Financial management services are billed in 15 minute increments as per the established and approved CAP Choice Fee Schedule.

Start-up fee must be assessed the first month of enrollment and shall not exceed 4 units (1 hour). Monthly management fees shall be assessed each month and shall not exceed 4 units (1 hour) per month.

Initial transfer, start-up fee shall not exceed 4 units.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal Management Agency

Appendix C: Participant Services**C-1/C-3: Provider Specifications for Service**

Service Type: Supports for Participant Direction
Service Name: Financial Management

Provider Category:

Agency

Provider Type:

Fiscal Management Agency

Provider Qualifications**License** (specify):

Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications of financial management.

Certificate (specify):
Other Standard (specify):

The FMS shall have a minimum of three (3) years of experience in developing, implementing and maintaining a record management process that includes written policies and procedures for establishing and maintaining current and archived participant, attendant, service vendors and FMS files in a secure and confidential manner and for the prescribed period of time as required by Federal and State rules and regulations, including HIPAA requirements. Internal controls for monitoring this process must be included in the system and described in the policies and procedures. The FMS will also have the capacity to provide Financial Management Services through both the Agency with Choice (AwC) and Fiscal/Employer Agent (F/EA) models. Be authorized to transact business in the State of North Carolina, pursuant to all State laws and regulations. Be approved as a Medicaid Provider for Financial Management Services.

Verification of Provider Qualifications**Entity Responsible for Verification:**

DHHS fiscal agent (CSRA/NCTracks) – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General website to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Assistive Technology

HCBS Taxonomy:**Category 1:**

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Assistive technology for CAP beneficiaries excludes items that are covered under the Home Health Final Rule. Examples of assistive technology includes product systems and equipment, acquired commercially, modified, or customized, and used for

- improving or maximizing the functional capabilities of the beneficiary;
- improving the accessibility and use of the beneficiary's environment; or
- addressing 24/7 beneficiary coverage issues.

This service shall be used for:

- adaptive or therapeutic equipment designed to enable beneficiaries to increase, maintain, or improve functional capacity in performing daily life tasks that would not be possible otherwise;
- specialized monitoring systems; and
- specialized accessibility and safety adaptations or additions.

This service includes technical assistance in device selection and training in device used by a qualified assistive technology professional, assessment and evaluation, purchases, shipping costs, and as necessary, the repair of such devices.

This CAP service also includes a plan for training the CAP beneficiary, family, primary caregiver, personal aides, or assistants who will assist in the application or use of the device(s).

Repairs of assistive technology are covered as long as the cost of the repairs does not exceed cost of purchasing a new piece of equipment. CAP funding must not be used to replace equipment or devices that have not been reasonably cared for and maintained.

In some cases, the use of assistive technology may reduce the number of hours of personal care that the beneficiary needs. Professional consultation must be accessed to ensure that the equipment or supply meet the needs of the 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 total cost of modifications such as home, vehicle and assistive technology can not exceed \$28,000 per Beneficiary per the life of the waiver, which is renewed every five years.

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.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial
Individual	Specialized Therapist

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License (specify):

Qualified assistive technology professionals, nursing facility (rehab), hospital, or certified home health agency (ies), state licensed occupational therapist, physical therapist, and speech therapist can provide this service through consultation, education, repairs, and technical assistance on devices to the beneficiary, family, caregiver, personal aides, and assistance who will assist the beneficiary with application or use of device(s).

Certificate (specify):

Certification- An Assistive Technology Practitioner (ATP) or Assistive Technology Supplier (ATS) certified by RESNA

Other Standard (specify):

Assistive Technology Professionals, Nursing Facility (Rehab), Hospital, or Certified Home Health Agency that are State licensed Occupational Therapists, Physical Therapists or Speech Language Pathologists (Licensure to include certification of clinical competency which is required for augmentative communication evaluations) shall provide assistive technology. Additional provider qualifications may include Assistive Technology Practitioners (ATP) or Assistive Technology Suppliers (ATS) certified by RENSA. Assistive Technologists shall hold a bachelor's degree in a human services field, special education or related degree, and two years of experience working with assistive technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

CSRA/NCTracks for provider enrollment

Frequency of Verification:

Initially, at time of waiver service provision and every five years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Specialized Therapist

Provider Qualifications

License (specify):

Qualified assistive technology professionals, nursing facility (rehab), hospital, or certified home health agency(s), state licensed occupational therapist, physical therapist, and speech therapist can provide this service through consultation, education, repairs, and technical assistance on devices to the beneficiary, family, caregiver, personal aides, and assistance who will assist the beneficiary with application or use of device(s).

Certificate (specify):

Certification- An Assistive Technology Practitioner (ATP) or Assistive Technology Supplier (ATS) certified by RESNA

Other Standard (specify):

Assistive Technology Professionals, Nursing Facility (Rehab), Hospital, or Certified Home Health Agency that are State licensed Occupational Therapists, Physical Therapists or Speech Language Pathologists (Licensure to include certification of clinical competency which is required for augmentative communication evaluations) shall provide assistive technology. Additional provider qualifications may include Assistive Technology Practitioners (ATP) or Assistive Technology Suppliers (ATS) certified by RENSA. Assistive Technologists shall hold a bachelor's degree in a human services field, special education or related degree, and two years of experience working with assistive technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

At time of waiver service provision

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Case Management

HCBS Taxonomy:

Category 1:

01 Case Management

Sub-Category 1:

01010 case management

Category 2:

01 Case Management

Sub-Category 2:

01010 case management

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.**
- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

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.

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; and
- h. related correspondence in compliance with all applicable federal and state laws, rules and regulations.

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.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Entity
Individual	Federally Recognized Tribes

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Case Management Entity

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The case management entity is an agency approved by DMA to act as the lead entity in a service region. The approved entity is the lead local entry point and approval authority for CAP services. The lead entity is responsible for the day-to-day case management activities for potential and eligible CAP beneficiaries. These agencies can be county departments of social services, county health departments, hospitals, or qualified case management agencies. The case management entity shall provide case management and lead entity services. The case management entity is responsible for issuing the service authorization to authorize a provider to render specialized medical equipment and supplies, as appropriate.

a. The case management entity shall be an organization with three (3) or more years of direct service experience in providing case management to individuals at risk of institutionalization and receiving home and community-based services.

b. Each case management entity shall enroll as a NC Medicaid provider and be approved through an agreement by the State Medicaid Agency to provide lead entity CAP services. Every three years, the case management entity shall recertify as a Medicaid provider.

Qualified Case Management Entities shall have:

a. Resource connection to the service area to provide continuity and appropriateness of care;

b. Experience in pediatrics, medical fragility and physical disabilities;

c. Policies and procedures in place that align with the governance of the state and federal laws and statutes;

d. Three (3) years of progressive and consistent home and community-based experience;

e. Ability to provide case management by both a social worker and a nurse;

f. Physical location;

g. Computer technology and IT web-based connectivity to support the requirement of current and future automated programs;

h. Met the regulatory criteria under DHHS or DHHSR, if applicable; This requirement waived for federally approved organizations.

i. Appropriate staff to participant ratio; and

j. Ability to authorize services within 48 hours of the approved service plan.

The case manager or care advisor shall meet one of the following qualifications:

- a. Bachelor's degree in social work from an accredited school of social work, and (1) year of directly related community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA- certified training program within three (3) consecutive months of employment;
- b. Bachelor's degree in a human services or equivalent field from an accredited college or university with two (2) or more years of community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA-certified training program within three (3) consecutive months;
- c. Bachelor's degree in a non-human services field from an accredited college or university with two (2) or more years of community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA-certified training program within three (3) consecutive months; or
- d. Registered nurse who holds a current North Carolina license, two (2) year or four (4) year degree, one (1) year case management experience in homecare, long-term care, personal care or related work and the completion of a DMA-certified training program within three (3) consecutive months.

The case manager or care advisor shall complete nine (9) contact or continuing education hours per year of which person-centered training; legislative training related to health care disability and reimbursement strategies; recognition and reporting of abuse, neglect and exploitation; and program integrity (PI) are mandatory.

Verification of Provider Qualifications

Entity Responsible for Verification:

The State Medicaid Agency for appointment and annual monitoring
DHHS fiscal agent (CSRA/NCTracks) – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years

Frequency of Verification:

DMA- Initially and Annually

DHHS- Every five years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Case Management

Provider Category:

Individual

Provider Type:

Federally Recognized Tribes

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The case management entity is an agency approved by DMA to act as the lead entity in a county. The approved entity is the lead local entry point and approval authority for CAP services. The lead entity is responsible for the day-to-day case management activities for potential and eligible CAP beneficiaries. These agencies can be county departments of social services, county health departments, hospitals, or qualified case management agencies. The case management entity shall provide case management and lead entity services. The case management entity is responsible for issuing the service authorization to authorize a provider to render specialized medical equipment and supplies, as appropriate.

a. The case management entity shall be an organization with three (3) or more years of direct service experience in providing case management to individuals at risk of institutionalization and receiving home and community-based services.

b. Each case management entity shall enroll as a NC Medicaid provider and be approved through an agreement by the State Medicaid Agency to provide lead entity CAP services. Every three years, the case management entity shall recertify as a Medicaid provider.

Qualified Case Management Entities shall have:

a. Resource connection to the service area to provide continuity and appropriateness of care;

b. Experience in pediatrics, medical fragility and physical disabilities;

- c. Policies and procedures in place that align with the governance of the state and federal laws and statutes;
- d. Three (3) years of progressive and consistent home and community-based experience;
- e. Ability to provide case management by both a social worker and a nurse;
- f. Physical location;
- g. Computer technology and IT web-based connectivity to support the requirement of current and future automated programs;
- h. Met the regulatory criteria under DHHS or DHSR, if applicable;
- i. Appropriate staff to participant ratio; and
- j. Ability to authorize services within 48 hours of the approved service plan .

The case manager or care advisor shall meet one of the following qualifications:

- a. Bachelor's degree in social work from an accredited school of social work, and (1) year of directly related community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA- certified training program within three (3) consecutive months of employment;
- b. Bachelor's degree in a human services or equivalent field from an accredited college or university with two (2) or more years of community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA-certified training program within three (3) consecutive months;
- c. Bachelor's degree in a non-human services field from an accredited college or university with two (2) or more years of community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA-certified training program within three (3) consecutive months; or
- d. Registered nurse who holds a current North Carolina license, two (2) year or four (4) year degree, one (1) year case management experience in homecare, long-term care, personal care or related work and the completion of a DMA-certified training program within three (3) consecutive months.

The case manager or care advisor shall complete nine (9) contact or continuing education hours per year of which person-centered training; legislative training related to health care disability and reimbursement strategies; recognition and reporting of abuse, neglect and exploitation; and program integrity (PI) are mandatory.

Verification of Provider Qualifications

Entity Responsible for Verification:

The State Medicaid Agency for appointment and annual monitoring
DHHS fiscal agent (CSRA/NCTracks) – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years

Frequency of Verification:

DMA- Initially and Annually
DHHS- Every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:

16 Community Transition Services

Sub-Category 1:

16010 community transition services

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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

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, not to 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.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Entity

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Case Management Entity

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The case management entity will authorize this service and assures business or Medicaid providers have the capacity and ability as verified by the case manager/care advisor to provide items and services of sufficient quality to meet the need for which they are intended.

2. Items/services (including rental housing) must be of sufficient quality and appropriate to the needs of the participant. The participant must provide a receipt for each purchase or invoice for each payment.

3. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management Entity and The State Medicaid Agency

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home Accessibility and Adaptation

HCBS Taxonomy:

Category 1:

14 Equipment, Technology, and Modifications

Sub-Category 1:

14020 home and/or vehicle accessibility adaptations

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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 residences 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.

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 authorize 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 is \$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.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home Accessibility and Adaptation

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License (specify):

Local business licensure requirement specific to business entity

Certificate (specify):

Other Standard (specify):

Case Management Entity must approve and authorize the service and the provider.
 The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license. Licensed contractors are preferred.

Enrolled Medicaid providers who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer’s specifications and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent (CSRA/NC Tracks) – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Institutional and Non-Institutional Respite

HCBS Taxonomy:

Category 1:

Sub-Category 1:

09 Caregiver Support

09012 respite, in-home

Category 2:

09 Caregiver Support

Sub-Category 2:

09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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.

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.

Respite, total to 720 hours/fiscal year, can 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:

720 hours/fiscal year

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

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
 Provider managed

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

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Institutional and Non-Institutional Respite

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License (specify):

10A NCAC 13J .1107 IN-HOME AIDE SERVICES

Licensure: TITLE 10: CH22, 0.0100; 10 NCAC 06B .0101- Institution: settings of a hospital or a nursing facility or similar setting.

Agencies and organizations providing nutrition services shall meet Division of Aging and Adults Services (DAAS) requirements for home delivered meals in compliance with 10A NCAC 06K.0101. Federally Recognized Tribes- Any requirement for participation as a provider of health care services under a Federal health care program that an entity be licensed or recognized under the State or local law where the entity is located to furnish health care services shall be deemed to have been met in the case of an entity operated by the Service, an Indian tribe, tribal organization, or urban Indian organization if the entity meets all the applicable standards for such licensure or recognition, regardless of whether the entity obtains a license or other documentation under such State or local law. In accordance with section 221, the absence of the licensure of a health professional employed by such an entity under the State or local law where the entity is located shall not be taken into account for purposes of determining whether the entity meets such standards, if the professional is licensed in another State.

Certificate (specify):

Other Standard (specify):

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent (CSRA/NCTracks) – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years.

NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

Initially,
 monthly and
 every five years for purpose of Medicaid Enrollment status

Appendix C: Participant Services**C-1/C-3: Service Specification**

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Participant Goods and Services

HCBS Taxonomy:**Category 1:**

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:**Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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

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

The cost of participant goods and services for each beneficiary must not exceed \$800.00 annually (July –June). Any item over \$200.00 must be approved by a DMA consultant. Products and items listed on the State Medicaid Plan is prohibited from being reimbursed by this service unless approved by the State Medicaid Agency.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative

Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Participant Goods and Services

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

The Case Management entity must approve and authorize the service.
 The commercial/retail business that obtains and/or installs the equipment or modification must hold an applicable state/local business license. Licensed contractors are preferred.
 Enrolled Medicaid providers who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer's specifications and requirements.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent (CSRA/NCTracks) – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years
 NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

Initially and at time of service provision

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Pediatric Nurse Aide Services

HCBS Taxonomy:

Category 1:

Sub-Category 1:

08 Home-Based Services

08030 personal care

Category 2:**Sub-Category 2:**

Category 3:**Sub-Category 3:**

Category 4:**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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.

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.

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:

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

Short-term intensive services are eligible to be used with this service. Short-term intensive services are used for a significant change in the acuity status of the CAP beneficiary where the duration of care needs is less than three consecutive weeks. Short-term intensive services are listed in the service plan. Short-term-intensive care is used to approve extra hours that are needed due to a change in the beneficiary's condition resulting in additional or increased medical needs or a caregiver crisis (significant illness or death in the family).

Unexpected hours are used when the caregiver needs an adjustment to the approved weekly hours due to an unexpected event. The adjustment is planned per day. reoccurring unexpected hours within a calendar monitoring period may warrant a POC revision to reflect the actual hours of need.

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.

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.

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

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.

Parents, step-parents, loco parentis, legal guardian, or significant others to a parent shall not be hired to provide personal care services to CAP beneficiaries under the age of 21. This applies for both traditional and consumer-directed services.

A spouse, parent, step-parent, grandparent, child, sibling, or other relative is eligible for hire as the employee when a CAP beneficiary is 18 years of age or older. 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 beneficiary and provider are 18 years of age or older; and
- b. Meets the qualifications to perform the level of personal care determined by the CAP assessment and plan of care.

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 successfully pass a background check.

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Agencies

Provider Category	Provider Type Title
Individual	Direct Staff

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Pediatric Nurse Aide Services

Provider Category:

Agency

Provider Type:

Home Care Agencies

Provider Qualifications

License (specify):

Services are provided by a home care agency licensed by the DHSR under 10A NCAC 13J.

An individual licensed by the NCBON as a Registered Nurse provides supervision of the Nurse Aide as under 10A NCAC 13J.1110.

The Nurse Aide providing direct care is registered as a Nurse Aide I + or Nurse Aide II with DHSR and the NCBON.

Medicare certified home health agency.

Certificate (specify):

The nurse aide providing direct care is certified in CPR. It is recommended that (s)he also be certified in First Aid.

Other Standard (specify):

Staff shall obtain licensure or certification according to all applicable laws and regulations, and practice within the scope of practice as defined by the individual practice board.

DMA requires the following provider qualifications and training be completed before staff is assigned to provide person care to the CAP beneficiary:

- Criminal background checks, which must be repeated every two (2) years, at the time of licensure renewal (refer to Subsection 6.6);
- Verification of cardiopulmonary resuscitation (CPR) certification and every two (2) years, coinciding with expiration dates;
- Review of trainings and beneficiary-specific competencies at each job performance review as per agency policy;
- Pediatric nursing experience or completion of DMA pediatric training, such as
 - growth and development;
 - pediatric beneficiary interactions;
 - and home care of pediatric beneficiary;

Verification of Provider Qualifications

Entity Responsible for Verification:

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and education services are needed and documentation is available to support training needs were met.

Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Frequency of Verification:

The verification of provider qualification is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Pediatric Nurse Aide Services

Provider Category:

Individual

Provider Type:

Direct Staff

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Must undergo a criminal background and registry check prior to hire. Must also demonstrate competencies and skill sets to care for the waiver beneficiary as documented by the consumer-directed waiver participant/responsible party and uploaded to case file. Documentation must be provided when training and educational services are needed and documentation is available to support training needs were met. Must be CPR certified.

Waiver beneficiaries between ages of 0-17- Parents, step parents, loco parentis, legal guardian, or significant others to a parent are prohibited from being hired to provide personal care services.

Verification of Provider Qualifications

Entity Responsible for Verification:

It is the responsibility of the financial manager to verify the provider, hired employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

Frequency of Verification:

initially and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Specialized Medical Equipment and Supplies

HCBS Taxonomy:

Category 1:

Sub-Category 1:

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.

- Service is included in approved waiver. The service specifications have been modified.**
- Service is not included in the approved waiver.**

Service Definition (Scope):

- a. Adaptive Tricycles: A durable medical equipment used for the development of gross motor skills, range of motion, improved endurance, improved circulation, trunk stabilization and balance, or as an adjunct to gait training.
- b. Vehicular transport vest: A durable medical equipment for safe transport.

Specialized medical equipment and supplies consists of the following:

- 1. The performance of assessments to identify the type of equipment needed by the participant.
- 2. Training the participant or caregivers in the operation and/or maintenance of the equipment or use of the supply.
- 3. Repair of the equipment is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment.

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

Adaptive tricycles for individuals: - \$ 3,000 over the cycle of the waiver

Adaptive car seats or vehicular transport for individuals between the ages of 0-20- children weighing over 30 pounds or with a seat to crown height that is longer than the back height of the largest safety car seat if the child weighs less than the upper weight limit of the current car seat. As priced per plan year.

A physician's signature certifying medical necessity for the supply is required

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E**
- Provider managed**

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

- Legally Responsible Person**
- Relative**
- Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Financial Management Provider
Agency	DME Supplier

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Individual

Provider Type:

Financial Management Provider

Provider Qualifications

License (specify):

Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications of financial management.

Certificate (specify):

Other Standard (specify):

The FMS shall have a minimum of three (3) years of experience in developing, implementing and maintaining a record management process that includes written policies and procedures for establishing and maintaining current and archived participant, attendant, service vendors and FMS files in a secure and confidential manner and for the prescribed period of time as required by Federal and State rules and regulations, including HIPAA requirements. Internal controls for monitoring this process must be included in the system and described in the policies and procedures. The FMS will also have the capacity to provide Financial Management Services through both the Agency with Choice (AwC) and Fiscal/Employer Agent (F/EA) models. Be authorized to transact business in the

State of North Carolina, pursuant to all State laws and regulations. Be approved as a Medicaid Provider for Financial Management Services (or in the process of applying for such approval).

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent (CSRA/NCTracks) – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and re-certify Medicaid provider status every three years

Frequency of Verification:

Annually and every five years thereafter

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Specialized Medical Equipment and Supplies

Provider Category:

Agency

Provider Type:

DME Supplier

Provider Qualifications

License (specify):

Certificate (specify):

Other Standard (specify):

Enrolled as a Medicaid provider as a DME provider

Verification of Provider Qualifications

Entity Responsible for Verification:

DHHS fiscal agent (CSRA/NCTracks) – approves the Medicaid application to provide Medicaid services, monitors Office of Inspector General to assure appropriateness as a Medicaid/Medicare provider and recertify Medicaid provider status every three years,

NC Division of Health Service Regulation – provides initial and ongoing licensure and monitors compliance to policies and procedures.

Frequency of Verification:

Initially and every five years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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 Type:

Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Training, Education and Consultative Services

HCBS Taxonomy:

Category 1:

13 Participant Training

Sub-Category 1:

13010 participant training

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

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 her self, 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. 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 DMA.

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 is limited to \$500 per fiscal year (July 1- June 30).

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.

Service Delivery Method (check each that applies):

- Participant-directed as specified in Appendix E
- Provider managed

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

- Legally Responsible Person
- Relative
- Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial/Educational Settings

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service

Service Name: Training, Education and Consultative Services

Provider Category:

Agency

Provider Type:

Business/Commercial/Educational Settings

Provider Qualifications**License (specify):**

- 1) Universities, Colleges, and Community Colleges
- 2) An organization with a training/class curriculum approved by the Division of Medical Assistance.

Certificate (specify):

- 1) Universities, Colleges, and Community Colleges
- 2) An organization with a training/class curriculum approved by the Division of Medical Assistance.

Other Standard (specify):

The case management entity must approve and authorize the service.

Verification of Provider Qualifications**Entity Responsible for Verification:**

Case Management Entity

Frequency of Verification:

prior to service provision

Appendix C: Participant Services**C-1/C-3: Service Specification**

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 Type:Other Service

As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Vehicle Modifications

HCBS Taxonomy:**Category 1:**14 Equipment, Technology, and Modifications **Sub-Category 1:**14020 home and/or vehicle accessibility adaptations **Category 2:****Sub-Category 2:****Category 3:****Sub-Category 3:****Category 4:****Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one :

- Service is included in approved waiver. There is no change in service specifications.
- Service is included in approved waiver. The service specifications have been modified.
- Service is not included in the approved waiver.

Service Definition (Scope):

Vehicle modification is a service for a CAP beneficiary that enables increased independence and physical safety through safe transport. Vehicle modifications are adaptations, alterations, installation, service, controls, repairs or maintenance to a motor vehicle such as an automobile or van that is the CAP beneficiary's primary means of transportation. The vehicle must be owned by the CAP beneficiary or the primary caregiver. Vehicle adaptations are specified by the service plan as necessary to

accommodate the special needs of the beneficiary to enable the beneficiary to integrate more fully into the community and to ensure the health, safety, and well-being. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the modification in the event of an accident. Modifications do not include the cost of the vehicle or lease.

The following is coverage vehicle modifications:

- a. Door handle replacements;
- b. Door modifications;
- c. Installation of raised roof or related alterations to existing raised roof system to approve head clearance;
- d. Lifting devices;
- e. Devices for securing wheelchairs or scooters;
- f. Adapted steering, acceleration, signaling and breaking devices only when recommended a by physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel;
- g. Handrails and grab bars;
- h. Seating modifications;
- i. Lowering of the floor of the vehicle;
- j. Transfer assistances;
- k. 4-point wheelchair tie-down;
- l. Wheelchair/scooter hoist;
- m. Cushions;
- n. Wheelchair or scooter lift;
- o. Ramp; and
- p. Devices for securing oxygen tanks.

The CAP program is the payer of last resort for items that are covered through the Durable Medical (DME), Orthotics and Prosthetics, and Home Health Supply Programs and EPSDT prior to requesting from the CAP program.

An assessment must be completed by a Physical Therapist or Occupational Therapist specializing in vehicle modifications, or a Rehabilitation Engineer or Vehicle Adaptation Specialist certifying medical necessity. All vehicles must be evaluated with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications. A copy of the assessment must be submitted with the request for Vehicle Modifications. A physician's signed order may be needed to certify that the requested adaptation is medically necessary. The physician's signed order must be on file with the case manager's records. When feasible there must be up to two competitive quotes with an emphasis on the safety and "life expectancy" of the vehicle in relationship to the modifications to determine the most efficient method to complete the request.

Documentation regarding each of the requirements for modification must be included in the waiver beneficiary file.

The vehicle that is adapted must belong to the individual, to a primary caregiver or a member of the family.

The service does not cover the purchase or lease of the vehicle itself. Vehicle modification may in some cases be used to pay for a lift that is existing on a previously modified van. All the following information must be submitted to DMA when approval for an existing lift is being requested:

- a. The age of the lift;
- b. The original price of the lift and the assessed condition;
- c. The current value of the lift;
- d. The age of the vehicle; and
- e. The current appraised condition and value of the vehicle.

Approval for vehicle modifications is based upon medical need; there is no entitlement of services up to the program limit. All equipment purchased through the CAP program uses a selection process to insure the most efficient use of Medicaid funds. Motor vehicle modifications are provided and installed according to applicable standards and safety codes such as manufacturer's installation instructions, National Mobility Equipment Dealer's Association guidelines, Society of Automotive Engineers guidelines, and National Highway and Traffic Safety Administration guidelines.

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:

A combined budget will be used for vehicle and home modifications and assistive technology. The combined budget must not exceed \$28,000. The case management entity shall track all costs of vehicle modifications billed and paid, in order to avoid exceeding the \$28,000 limit over the lifetime limit of CAP waiver.

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.

The cost of renting or leasing a vehicle with adaptations, service and maintenance contracts and extended warranties and adaptations purchased for exclusive use at the school or home school are not covered. Items that are not of direct or remedial benefit to the CAP beneficiary are excluded from this service. Case management entity shall authorize vehicle

modification through service authorization prior to the initiation of the modification.

A vehicle inspection must be completed on vehicles that are 7 years or older or for vehicles with 80,000 or more miles.

Exclusions:

- a. Items that are not of direct or remedial benefit to the participant are excluded from this service.
- b. This service does not include the purchase or lease of the vehicle itself.
- c. Regularly scheduled upkeep and maintenance of a vehicle is excluded
- d. The cost of renting a vehicle with adaptations;
- e. Service and maintenance contracts and extended warranties;
- f. Adaptations purchased for exclusive use at the school/home school;
- g. Replacement of a vehicle adaptation if the participant/family fails to keep their automobile insurance policy current when the repair would have been covered by the insurance is not covered.
- h. Vehicles over ten (10) years old are excluded from complete modification
- i. Vehicles with 200, 000 or more miles are excluded from complete modification

Service Delivery Method (*check each that applies*):

- Participant-directed as specified in Appendix E
 Provider managed

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

- Legally Responsible Person
 Relative
 Legal Guardian

Provider Specifications:

Provider Category	Provider Type Title
Agency	Business/Commercial

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Business/Commercial

Provider Qualifications

License (*specify*):

Certificate (*specify*):

Other Standard (*specify*):

Meets applicable state and local requirements for type of device that the vendor is providing.

All vehicles must be evaluated by an adapted vehicle supplier.

Motor vehicle modifications are provided and installed in accordance with applicable standards and safety codes including manufacturer's installation instructions, National Mobility Equipment Dealer's Association guidelines, Society of Automotive Engineers guidelines, and National Highway and Traffic Safety Administration guidelines.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management Entity, if the case management agency bills for the modifications on behalf of the vehicle adapter.

Frequency of Verification:

Prior to service delivery.

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- As an administrative activity.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (*select one*):

- No. Criminal history and/or background investigations are not required.**
- Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Criminal Background checks are conducted in accordance with GS 131 E255 and NCAC 27G.0202.

Criminal background checks and registry checks are conducted on all personnel providing waiver services. For case management staff, the appointed case management entity is required to perform a state background check and a national background check if lived outside of North Carolina within five years. The record of this background check is kept on file at the provider agency and uploaded in the IT system.

For all personal care assistants who are providing hands-on waiver services, the In-Home Aide Agency or the Home Health Agency is required to perform a criminal background and registry check on all hired employees prior to assignment to a waiver beneficiary. The record of this background check is kept on file at the provider agency and must be produced upon demand.

For all Medicaid enrolled providers, the State's contracted vendor, conducts a background check to include an OIG search on all applicants prior to the assignment of a National Provider Number. If the background check is not favorable, the applicant is not granted a Medicaid enrollment status.

For direct hire employees, the financial management entity is mandated to conduct a SBI background check on all employees to include a registry and Registry check. The results of the background check are filed in the waiver beneficiary's file.

The verification of criminal history and background check is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. The financial manager is required to verify criminal history and background check of the provider, hire employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis. This section has been updated.

The case manager verifies that this has been completed before waiver services and participation are approved. DMA conducts annual audits to ensure compliance of waiver assurances and performance measures in regard to criminal history and background checks. The DMA's Program Integrity Unit conducts post audit reviews, criminal history and background investigation are included in their reviews.

The DMA's Program Integrity Unit conducts post audit reviews, criminal history and background investigation are included in their reviews.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

- No. The State does not conduct abuse registry screening.**

Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Division of Health Services Regulation (DHSR) maintains the North Carolina Health Care Personnel Registry. This registry may include information about any unlicensed staff of a health care facility that has direct access to residents, clients, or their property. The registry includes data regarding abuse, neglect, and misappropriation. 10A NCAC 13j .1003 (c) states: The agency shall not hire any individual either directly or by contract who has a substantiated finding on the North Carolina Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

Registry checks are conducted on all personnel providing waiver services. For case management staff, the appointed case management entity is required to perform a registry check on all hired staff. The record of this background check is kept on file at the provider agency and uploaded in the IT system.

For all personal care assistants who are providing hands-on waiver services, the In-Home Aide Agency or the Home Health Agency conducts a registry check on all hired employees prior to assignment to a waiver beneficiary. The record of this background check is kept on file at the provider agency and must be produced upon demand.

For all Medicaid enrolled providers, the State's contracted vendor conducts a registry search on all applicants prior to the assignment of a National Provider Number. If the background check is not favorable, the applicant is not granted a Medicaid enrollment status.

For direct hire employees, the financial management entity is mandated to conduct a registry on all employees. The results of the background check are filed in the waiver beneficiary's file.

The verification of Abuse Registry Screening is performed by an approved, licensed Home Health or In-Home provider when the waiver beneficiary is receiving services from a direct provider. The financial manager is required to verify Abuse Registry Screening of the provider, hire employee, when the waiver beneficiary is directing his or her care. The verification process is completed on an annual basis.

The case manager verifies that this has been completed before waiver services and participation are approved. DMA conducts annual audits to assure compliance of waiver assurances and performance measures in regard to Abuse Registry Screening. The DMA's Program Integrity Unit conducts post audit reviews, criminal history and background investigation are included in their reviews.

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. **Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:***

- No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. **Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

- No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of *extraordinary care* by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

Personal care services may be provided by a relative or legally responsible party who is an employee of an In-Home Care Agency or Home Health Agency as long as qualifications and criminal background checks are met. Parents, step parents, legal guardians or responsible parties of a child, an individual under the age of 18 are not able to be hired or provide personal care and receive reimbursement.

The qualified individual approved to provide and receive payment for personal care services are included below:

a. Must be 18 years of age or older;

b. Meets the aide qualifications; or deemed competent by the appropriate licensed supervisory professional of the In-Home Care agency/Home Health agency to provide the personal care task at that level as defined in 10A NCAC 13J.110; and

Note: Employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the waiver beneficiary. This requirement also applies to other relatives and hired personnel.

Under consumer-direction option, the directly hired staff cannot provide non-Institutional Respite Services, and may NOT also be the legally responsible person, the legal guardian or the person making the day-to-day decision for the consumer. Parents, step parents, legal guardians, responsible parties, significant others or live-in mates are not able to be hired as the direct staff due to a shared responsibility of decision-making when the waiver beneficiary is under the age of 18.

Training and education about health, safety and well-being is provided to the case management entity to empower the case manager to look for signs and risk indicators by a legally responsible individual when that individual is assigned to provide personal care. The case management entity monitors appropriateness of services from all levels. The waiver beneficiary is also provided training and education about how to report abuse, neglect and exploitation. The comprehensive assessment has logic that provides data about the informal support system which aids in identifying potential risk(s) and ways to mitigate risk (s). When a health, safety and well-being issue presents through data discovery or during regular and routine monitoring, a risk agreement is implemented to quickly mitigate the risk.

The Case Manager / Care Advisor plays a major role, along with the beneficiary and/or representative in assessing and determining need for personal care. The Case Manager / Care Advisor also assists in monitoring the service plan, tasks and time records to ensure appropriate provision and utilization of these services. Additional safeguards include post-payment reviews conducted by DMA consultants.

- e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

The State does not make payment to relatives/legal guardians for furnishing waiver services.

The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

Relatives/legal guardian under specific circumstances and only when the relative/guardian is qualified to furnish services may be paid for furnishing waiver services. The qualified individuals approved to provide and receive payment for personal care services are included below:

a. Must be 18 years of age or older;

b. Meets the aide qualifications; or deemed competent by the appropriate licensed supervisory professional of the In-Home Care agency/Home Health agency to provide the personal care task at that level as defined in 10A NCAC 13J.110; and

Note; Employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the waiver beneficiary. This requirement also applies to other relatives and hired personnel.

The State allows relatives OTHER than the following for waiver beneficiaries under the age of 18 when still under the care of their parents:

1. The child's parent, step-parent, foster parent, or adoptive parent and parent's significant other.

2. Any one that has legal responsibility for the minor child.

3. Grandparents of the waiver beneficiary when the grandparent is acting in the role of parent.

4. Siblings of the waiver beneficiary who are not 18 and who are acting in the role of parent.

5. The spouse of an adult (18 and older) waiver beneficiary when the spouse is responsible for all decisions.

6. Anyone that has legal responsibility/POA/HPOA for the waiver beneficiary to provide the waiver services specified in section C1/C3, when those relatives meet the applicable provider qualifications.

Safeguards utilized by the State to assure payments were made only for services rendered include:

A service plan is created that outlines the waiver services in the amount, frequency and duration based on a needs assessment.

These limits are made available to the service providers through a service authorization to ensure compliance of the service plan.

Prior approval limits of the amount, frequency and duration is entered into the State's Medicaid Management system to ensure utilization is not exceeded.

On a monthly basis, the case manager or care advisor corresponds with the waiver beneficiary and service providers to ensure that the services authorized in the service plan were provided in the amount,

frequency and duration. This monitoring task includes a discussion with the waiver beneficiary and service providers.

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- Other policy.**

Specify:

- f. Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

DMA maintains a web-based provider application portal, tutorial and FAQs for parties interested in becoming a Medicaid provider. Any provider who meets the qualifications specified by each service can apply and enroll to become a Medicaid provider. Applicants must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as a waiver provider. Specific qualifications for each provider types are listed in the Provider Qualifications and Requirements Checklist. Once participation as a Medicaid provider has been approved, providers are assigned an NPI with an effective date. To be approved to provide waiver services, a provider must complete a Manage Change request to add waiver services to their benefit plan. The requested waiver services are placed in a workbasket that must be reviewed and approved by the State Medicaid Agency. The State Medicaid Agency approves or denies all requests to provide waiver services. A provider must be qualified in the areas of which a request is made. Each waiver provider must complete a CAP overview training prior to rendering CAP services and annually thereafter.

DMA utilizes the services of local agencies to perform administrative responsibilities of the waiver that comports with freedom of choice. During the service plan development phase, the waiver beneficiary is provided a list of Medicaid-approved providers in his or her catchment area to select and exercise freedom of choice. This list of providers is referred to as Freedom of Choice of providers. The waiver beneficiary selects a provider, independent of the case management entity agency, a referral is forwarded to the Medicaid provider for initiation of services. Upon the completion of the service plan, a service authorization is forwarded to the provider, selected by the waiver beneficiary to render the waiver or non-waiver service(s). The waiver beneficiary can choose any provider including the case management entity at any time without forfeiting or experiencing a gap in service provision. Case management is a service within the waiver, however to be approved to be a provider for case management, a provider must have been appointed by the State Medicaid Agency as a designated case management entity, the lead agency for the State in a particular catchment area. The State Medicaid Agency provides close monitoring and supervision over these agencies as they are responsible for core functions under the administrative authority. All appointed agencies must meet an established threshold to include financial stability and meet all requirements/qualification set forth by the State Medicaid Agency and the Division of Health Services Regulations. The following requirements are mandatory:

- A resource connection of the service area as to provide continuity and appropriateness of care;
- Experience in Pediatric, medical fragility and physical disabilities;
- Policies/procedures in place that aligns with the governance of the state and federal laws and statutes;
- 3 years of progressive and consistent home and community base experience;
- Ability to provide case management by both social worker and Nurse;
- 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);
- Implementation of services within 5 days of service plan approval;
- A clear understand of person-centered planning;
- Participate in peer reviews; and
- Sufficient cash revenue or reserve.

Case Management entities are prohibited from providing case management services and other waiver and non-waiver services to a CAP beneficiary.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

- a. **Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver providers who met the required provider requirements to provide waiver services. Requirements: active NPI, Medicaid enrollment status annually, complete trainings annually and render services as per service plan. Numerator: number of waiver providers who meet requirements to provide waiver services Denominator: number of waiver providers

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and DMA's MMIS managed by CSRA	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input checked="" type="checkbox"/> Other Specify: Random	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver providers whose name were listed on OIG registry and continued to provide waiver services. Numerator: number of waiver providers whose name were listed on OIG registry and continued to provide waiver services Denominator: number of waiver providers

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and DMA's MMIS managed by CSRA	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of case management entities monitored quarterly through audits (desktop, site, or an analysis of data) that maintained a 90% compliance score. Numerator: number of case management entities with a compliance score of 90% or better Denominator: number of case management entities

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

Reports of assessments, service plans, level of care determinations, service authorizations, criminal incident reports and monthly and quarterly monitoring documentation uploaded in CAP IT system.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT system	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver beneficiaries who selected consumer-direction where all staff had the required criminal/registry checks, prior to the receipt of waiver services. Numerator: number of consumer-direct waiver beneficiaries where all staff had the required criminal/registry checks, prior to the receipt of services Denominator: number of consumer-direct beneficiaries of overall staff

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and DMA's MMIS managed by CSRA	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
		<input type="checkbox"/> Other

	<input type="checkbox"/> Continuously and Ongoing	Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- c. **Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.**

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver providers who received a service authorization that completed the CAP specific waiver overview and orientation training module, initially and annually.

Numerator: number of waiver providers who completed CAP training initially and annually

Denominator: number of waiver providers

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Material will be uploaded in the CAP IT system by the case management entity annually and continuously and ongoing.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample

		Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT system	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of consumer-directed waiver beneficiaries whose direct support completed all required trainings identified during the self-assessment questionnaire.
Numerator: number of consumer-directed waiver beneficiaries taff completed all required trainings **Denominator: number of consumer-directed waiver beneficiaries**

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and DMA's MMIS managed by CSRA	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: [Dropdown]
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: [Dropdown]
	<input type="checkbox"/> Other Specify: [Dropdown]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: [Dropdown]	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: [Dropdown]

Performance Measure:

Number and percent of appointed case management entity's staff who completed annual mandatory training requirements
 Numerator: number of appointed case management entity's staff who completed annual mandatory training requirements
 Denominator: number of case management entities

Data Source (Select one):

Training verification records

If 'Other' is selected, specify:

Material will be uploaded in the CAP IT system by the case management entity annually.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: CAP IT system by the case management entity	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The CAP IT system evaluates waiver activities. To validate the efficiency and capacity of the IT system, the sampling methodology will be 100% for waiver year one. DMA verifies all Medicaid providers are licensed or certified, as required, and properly enrolled as a Medicaid provider by the State Medicaid Agency fiscal agent for each type of service furnished. A rigorous process that includes submitting a complete copy of the applicable criminal complaint, consent order, documentation of license, suspension, penalty notice, and/or final disposition. The provider application, has the following questions that must be answered: Have you ever been convicted of any criminal offense, had adjudication withheld on any criminal offense, plead no contest to any criminal offense or entered into a pre-trial agreement for any criminal offense? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had disciplinary action taken against any business or professional license held in this or any other State, including licenses issued by the North Carolina Division of Health Service Regulation and endorsements issued by any Local Management Entity as that term is defined in N.C.G.S. 122C-115.4? Has your license to practice ever been restricted, reduced/revoked in this or any other State or been previously found by a licensing, certifying or professional standards board or agency. Have you or any entity you are or were either an agent, owner, or managing employee of, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any State? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had payments suspended by Medicare or Medicaid in any State? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had civil monetary penalties levied by Medicare, Medicaid or other State or Federal agency or program, including NC DHSR, even if the fine(s) have been paid in full? Have Medicare or Medicaid in any State ever taken recoupment actions against you or any entity you are or were an agent, owner, or managing employee of? Do you or any entity you are or were either an agent, owner, or

managing employee of, owe money to Medicare or Medicaid that has not been paid in full? Have you ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services? Have you ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? Have you ever been convicted under federal or state law of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct? Have you or any entity you are or were either an agent, owner, or managing employee of, ever been found to have violated federal or state laws, rules or regulations governing North Carolina's Medicaid program or any other State's Medicaid program or any other publicly funded federal or state health care or health insurance program? Applicants must meet all program requirements and qualifications, for which they are seeking enrollment, before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once participation as a Medicaid provider has been approved, providers are assigned an NPI with an effective date and are notified by mail. Providers may begin submitting claims to Medicaid, upon receipt of their NPI. An active Medicaid Provider must be reassessed, a minimum of every three years to, ensure the provider's credentials and qualifications continue to meet N.C. standards.

Addition to this rigorous state licensure/certification standards, a Medicaid provider must demonstrate competency to perform services. The State Medicaid Agency approves each provider to provide waiver services. After approval to provide the service and before services may be rendered, each approved provider must complete a Provider CAP Training Overview module.

The case management entity will provide the Medicaid provider a service authorization initially, annually, and as needed, so to initiate approved waiver services.

Waiver beneficiaries have the freedom to choose to receive waiver services from any active credentialed Medicaid provider that serves their county. A waiver participant may switch providers without any restrictions. The only restrictions that will be imposed is a 5-day delay to the switch between case management entities within a county. Because of the appointment of lead entity and the utilization limitation of case management hours annually, when a request is made to switch a case management entity, the case manager will notify the State Medicaid Agency to initiate a root cause analysis to identify reason, current utilization limits and the performance of the previous and newly selected case management entity. The State Medicaid Agency will provide technical guidance for the approval and transfer of the case management entity.

Medicaid providers that provide personal care services and other in-home type services, must ensure the following activities to comply with state laws: 1. background checks are completed on all employees; 2. competency evaluations and trainings are conducted for in-home aide staff; 3. Monitor quality of care; 4. Handle Workers Compensation; 5. Manage the payment of income and Social Security taxes; 6. Ensure that in-home aides work under the supervision of a Registered Nurse, and 7. Abide by the waiver policy of no seclusion and restraints. FMS will conduct background/registry checks on all direct support staff.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Upon discovery of non-compliance, The State Medicaid Agency appointed fiscal agent notifies the provider via letter and electronically to inform of the return of the provider application. The returned application will highlight the areas of non-compliance along with information in how to re-submit the application. The provider must comply with all required timelines. If the timeline is not met, the provider application will be voided. A provider must document and provide a record of provision of services before seeking Medicaid payment. The record must provide an audit trail for services billed to Medicaid. Submitting a written explanation in lieu of supporting documentation may result in the denial of the application. Each provider must notify the State Medicaid Agency fiscal agent within thirty (30) calendar days of learning of any adverse action initiated against the license, certification, registration, accreditation and/or endorsement of the provider or any of its officers, agents, or employees.

Upon non-compliance of CAP specific guidelines, the CAP Medicaid provider will be notified via written correspondence detailing the non-compliant area(s). The provider will be given a specified period of time to comply. If compliance is not reached, depending on the occurrence, a referral will be made to Program Integrity with a recommendation of termination or pay back.

Upon discovery of non-compliance of the FMS, the State Medicaid Agency notifies the FMS of the noncompliance and gives the FMS 30 calendars days to correct the noncompliance areas. Technical Assistance is provided to the FMS. Persistent non-compliance will result in a sanction of a civil financial penalty. Three incidences of a civil financial penalty will result in the termination of the provider as a fiscal intermediary. Any direct support staff without a criminal background and registry check will not be allowed to provide services until verification is confirmed that the checks were complete.

Upon discovery of non-compliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within 3 business days. Repeated findings of non-compliance by a CAP IT contractor results in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

The State Medicaid Agency will ensure that provider training is conducted in accordance with state licensure/certification requirements, DMA clinical policy and waiver requirements. The appointed case management entity staff, are required to have mandatory annual trainings as specified by the waiver. Upon discovery of non-compliance, case management entities will be required to attend an ad-hoc mandatory training session in person or by webinar. Persistent non-compliance will

result in suspension of new enrollment until compliance is maintained. Failure to meet annual training requirements for all staff for two consecutive waiver years will result in provider termination as a case management entity.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

- Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

- Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

- Other Type of Limit.** The State employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCBS Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

See Attachment #2, HCB Settings Waiver Transition Plan, for a description of how the state will achieve compliance with the HCB settings requirements of the final rule for both residential and non-residential settings.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person/Family-Centered Plan of Care

- a. Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*select each that applies*):

- Registered nurse, licensed to practice in the State**
- Licensed practical or vocational nurse, acting within the scope of practice under State law**
- Licensed physician (M.D. or D.O)**
- Case Manager** (qualifications specified in Appendix C-1/C-3)
- Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- Social Worker**

Specify qualifications:

- Other**

Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

- Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**
- Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

- c. Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

DMA engages the waiver beneficiary in a interactive discussion during service plan development to ensure best interest, support, cultural influences, holistic overview of assessed needs, and pro-active planning for the health, safety and well-being. Service plan development is encapsulated in two phases. The assessment phases must be completed to determine participation in the CAP waiver within 45-calendar days of the assignment and 15 calendar days when an expedited consideration is required (need services immediately).

Phase 1, referral for waiver consideration and Phase 2, performance of the comprehensive assessment are performed separately to determine risk factors and need for waiver participation. During each of these phases, supportive information is made available to the waiver beneficiary/primary caregiver directly by DMA through a notice letter to beneficiary (referral) and introductory letter (comprehensive assessment and notice of approval). This information clearly outlines of the following:

Eligibility criteria- the clinical criteria of medically fragile and needs based eligibility of at-risk of institutionalization and how each component of the criteria are met. The participant is provided information on the three qualifying conditions for medically fragile, see Appendix B-1b and how needs-based eligibility is gathered from the information obtained during the comprehensive assessment, see Appendix B-2b. The participant is provided summary information after the completion of each step to explain how he or she met each of the qualifying criteria.

Waiver benefit package - the names of each waiver service and its definition are provided to the waiver participant. Additional information is provided on how one qualifies for a particular waiver services, the utilization limits and how the services may prevent institutional placement. Freedom of choice of provider is also explained.

Person-centered planning – information is provided to describe the definition of person-centered planning and how the participant is entitled to determine who should be involved in decision-making and who may attend planning meetings. The participant is also provided information about how to ensure his or her likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity are included in the plan. The participant is also informed about assumed risk when choosing to participate in a home and community-based program,

Freedom of Choice – information is provided to describe what freedom of choice is and how the participant is able to exercise his or her freedom of choice when selecting to participate in the waiver, how to select waiver services and providers to provide services which also includes the case management agency for management of the day-to-day oversight during waiver participation. A participant may select a different provider at any time, for any reason.

Due process- information is provided on how to request an appeal when an adverse decision is made and the timeline granted to file an appeal.

Complaints and Grievances- information is provided that describes what is a complaint and grievance and how to lodge a complaint and grievance. The timeline is provided on how the complaint and grievance is to be addressed.

Abuse, Neglect and Exploitation (ANE) - information is provided on what ANE means, ways to identify concerns and how to report suspensions. This information also states the obligation by DMA as well as the case management entity to report concerns of ANE to the appropriate officials.

Resources available in the community- a list of resources is provided to the participant that describes Medicaid services and other community resources potentially available to the participant while the participant completes through the eligibility steps.

Additional supportive information that is provided to the participant is an analysis of the information obtained during each phase of eligibility. The CAP IT system analyzes all data received and entered in the electronic medical record to ensure sections correspond with each other and the health information depicts the needs of the participant in order to assist in the development of the person-centered plan of care. Once the data is validated, the CME meets with the participant/primary caregiver to review the findings of the

assessment for the cooperative development of the service plan. The participant/primary caregiver signs the service plan to acknowledge understanding and their choice to participate in the waiver and their selection of waiver services and providers. If there is a change in the waiver beneficiary's status, a revision to the service plan is initiated. Depending on the urgency of the need, revised service plans may be approved retroactively for up to 30 calendar days, prior to the date that the service plan is needed. The process, as discussed above, for constructing a family/person-centered service plan, remains the same for service plan revisions.

Documenting a change in services: The Waiver case manager or care advisor shall revise the service plan as the waiver beneficiary's needs change. Changes to the service plan are submitted in the web-based case management tool within 30-days of identified needs for a case management entity and approved within five (5) business days.

Documenting a change of provider agency: A service plan update is required for a change in provider agency, but the change is not considered a revision. The case manager or care advisor will obtain a signed agreement from the waiver beneficiary or the responsible party consenting to the change in providers.

For occasions when a service is denied, reduced or terminated due to not medically necessary, needs not being met, the case management entity shall send a written adverse notice in accordance with DMA's due process policy to the waiver beneficiary or responsible party. The adverse notice will provide specific information about the process to ensure support to the waiver beneficiary.

To support the waiver beneficiary on a day-to-day basis, a case management entity is assigned to provide some administrative oversight as described in Appendix A-4 and A-5. The waiver beneficiary voluntarily selects the case management entity of his or her choice. The chosen case management entity acts in the role of lead navigator for the waiver beneficiary to provide support and guidance during the service plan development. The navigator's role includes a process that emphasizes a strength-based, collaborative problem-solving and decision making approach with the waiver beneficiary and those persons, who are most important in his or her life. The case management entity provides the waiver beneficiary with educational information when requested and on monthly basis. The educational information provides the waiver beneficiary with helpful information in monitoring his or her assessed needs and that services are provided as listed on his or her service plan. The following are activities the case management entity conducts with the waiver beneficiary as a means of support:

- monthly contact (by phone or in person) and mandatory quarterly face-to-face contact or as often as the service plan informs due to risk factors to review the findings collected data. The potential waiver beneficiary/primary caregiver uses this information to begin the construction of a family/person-centered service plan.
- assists with identifying strengths, obstacles, strategies, and opportunities to develop a care plan that incorporates opportunities for inclusion in community events, work, education, church/faith, physical activity, family and friends.

The assigned case manager ensures the supportive engagement will achieve the following:

- Identification of waiver beneficiary's strengths and needs;
- Assessment of needs and strategies to meet identified needs in the amount, frequency and duration of acuity;
- Confirmation of right to choose among waiver and institutionalization and providers as evidenced by a signed provider freedom of choice form;

The educational material also informs of the service plan development process, the timeframe to complete and implement service plan.

For those choosing consumer-directed care, orientation and training in consumer direction are provided to the beneficiary, beneficiary's representative, and family members, to ensure understanding and to build competencies in service plan development. The fiscal intermediary also provides the waiver beneficiary and their hired worker additional training and one-on-one support through the enrollment process and monthly thereafter.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

- d. Service Plan Development Process.** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Service Plan Development Process is completed in multiple phases. The first phase is to establish the level of care. The LOC is the first determinant or first phase of waiver eligibility. The next phase is determination of at-risk of institutionalization based on functional needs and psychosocial factors identified in a comprehensive assessment. At-Risk of institutionalization is defined as participants who meet nursing facility level of care (LOC) criteria with assessed acuity of needs ranging from skilled to hospital level of care and who do not have available resources to meet immediate needs- medical, psychosocial and functional. Resources consist of both formal and informal such as willing and able family members. The affirmative results of being at-risk of institutionalization leads to the last phase of eligibility, the service plan development.

At the first phase of eligibility, if LOC is met, each waiver beneficiary is mailed an introductory letter that provides supportive information about the waiver. The letter also introduces the waiver beneficiary to home and community-based planning; the roles and responsibility of DMA and the case management entity, freedom of choice and services available to his or her while participating in the waiver. Refer to Appendix D-1c. The letter also provides a description of the next phase of eligibility and what

qualifying criteria are needed.

The second phase of the service plan development process is to conduct an interdisciplinary comprehensive assessment. A social worker and registered nurse, are teamed to determine medical, functional, behavioral and social needs, for the purpose of developing a family/person-centered service plan to meet all assessed needs. The comprehensive assessment includes multiple functioning areas to ensure the holistic needs of the waiver beneficiary. These functioning areas include:

- Personal health information.
- Caregiver information.
- Medical diagnoses.
- Medication and precautions.
- Skin.
- Neurological.
- Sensory and communication.
- Pain.
- Musculoskeletal.
- Cardio-Respiratory.
- Nutritional.
- Elimination.
- Mental Health.
- Informal support.
- Housing and finances.

This assessment team meets with the potential waiver beneficiary/primary caregiver and others at his or her request in their primary residence, to initiate the interdisciplinary comprehensive assessment that includes a historical overview of potential waiver beneficiary's life. The assessment team collects and enters the data in the CAP IT system to initiate the analysis of health care needs. During this process, the assessment team collaborates with current providers and the primary physician to confirm assessed needs to further validate functional level.

The development of a family/person-centered service plans is triggered by various assessment questions/answer combinations that the CAP IT system automatically generates from critical components of the service plan. The assessment will identify medical, behavioral, social and functional needs that must be addressed in the service plan whether formally or informally. These identified needs will auto-populate to the service plan worksheet, for consideration and planning. The CAP IT system will not allow a service plan to be completed until there is a plan for each identified service need. Provisions are made for identification of personal goals in the assessment. These are automatically transferred to the service plan template to ensure an activity/task plan for each goal is developed. The CAP IT system allows the State Medicaid Agency to review an individual service plan in order to evaluate if the selected service(s) and proposed service(s) intervention are adequate (proposed hours, schedule and skilled level). The service plan can also be reviewed by type and can be reviewed for adequacy and appropriateness through ad-hoc data queries.

Upon the completion of the assessment, the CAP IT system provides the assigned case manager an overview of assessed needs and areas that are critical to consider during the service plan development phase. The assigned case manager meets with the potential waiver beneficiary/primary caregiver and others at his or her request, to review the findings of the assessment, to begin the discussion of a family/person-centered plan, the potential waiver beneficiary/primary caregiver uses this information to begin the construction of a family/person-centered service plan. The case manager collaborates with the waiver beneficiary to develop the plan of care that will consist of both waiver and non-waiver services. A referral is made to non-waiver services upon the identification of a need during the first two phases of eligibility.

The completed assessment must be approved by designated personnel within the Case management entity. The assessment must be completed and approved within 45-calendar days of assignment that is tracked by the CAP IT system. Once all needs are identified and the data analysis is received, the service plan may be initiated.

An annual, every 12 months, reassessment is required during the month of the original waiver entry date. The annual re-assessment is called a Continued Need Review (CNR) assessment. The CAP IT system tracks all Continued Need Review and reassessments.

The CAP IT system provides monthly alerts to all case managers of when their annual reassessments are due. The CAP IT system captures all assessment information and automatically generates a service plan revision recommendation. The CNR assessment includes the following:

- a. An interdisciplinary comprehensive assessment that identifies LOC, the waiver beneficiary's preferences, strengths, needs, and ability to live safely in the community; and
- b. an approved person-centered service plan developed in coordination with the waiver beneficiary/primary caregiver that outlines cultural influences, likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity and services in the amount and duration of acuity of need. The services documented on the service plan must address the needs identified in the assessment. Case managers and Care Advisors use the service plan to achieve the following:
 - a. Summarize the evaluation and assessment information to highlight the waiver beneficiary's strengths and needs;
 - b. Outline family/person-centered goals and objectives based on the assessment and identified needs;
 - c. Develop a comprehensive list of waiver services, medical supplies and durable medical equipment (DME), including provider name, amount, frequency and duration of each service;
 - d. Calculate the monthly waiver beneficiary cost of care including waiver services and other State Plan services;
 - e. Ensure the waiver beneficiary's right to choose among providers as evidence a signed provider freedom of choice form;
 - f. Assure the waiver beneficiary's right to choose between waiver and institutionalization and from among Medicaid-enrolled providers by signature of the service plan; and
 - g. Develop service plan annually and update when warranted due to status changes in the waiver participant condition.

The service plan is initiated after the completion of the interdisciplinary comprehensive assessment and must be completed within 5 business days of the approved assessment.

The annual service plan must be approved by the first day of the month following the waiver beneficiary's identified CAP effective date. The CNR service plan is effective the first day of the month following the CAP effective date and expires one year later. The CNR family/person-centered service plan achieves the following for the waiver beneficiary and service providers:

- Summarizes the evaluation and assessment information to highlight the waiver beneficiary's strengths and needs;
- Outlines goals and objectives based on the assessment and identified needs; and
- Ensures the waiver beneficiary's right to choose between waiver participation and institutionalization and from among Medicaid-enrolled providers. Obtain the signature of the waiver beneficiary or responsible party on the Freedom of Choice form.

Changes and Revision to the Service plan

The Waiver case manager or care advisor shall revise the service plan as the waiver beneficiary's needs change. Changes to the service plan are submitted in the CAP IT system within 30-days of identified needs and approved within five (5) business days. The assigned case manager or care advisor determines whether to revise the service plan when there is a change in the waiver beneficiary's needs. A service plan revision is required when a waiver or Medicaid State Plan service is added, reduced, increased, deleted or when there are changes in amount, duration or frequency of a waiver service. A service plan update is required for a change in provider agency, but the change is not considered a revision. The case manager or care advisor will obtain a signed agreement from the waiver beneficiary or the responsible party consenting to the change in providers.

Service plan revisions are approved by an approval authority of the Case management entity. Revisions may be approved retroactively for up to 30 calendar days prior to the date that the plan is revised. The waiver beneficiary or the primary caregiver shall agree to and sign service plan changes for all waiver services.

The Case management entity shall send a written adverse notice in accordance with DMA's Due Process policy to the waiver beneficiary or responsible party if a service is denied, reduced, terminated, or disenrollment from the program.

The CAP IT system places prior approval limits on all authorized waiver services to ensure accurate reimbursement. The assigned case manager monitors the services monthly with the waiver beneficiary and authorized waiver providers to identify deviations from the providers and review provision of services. If there are consistent deviations and the service is authorized on the service plan, the case manager must review this with the waiver beneficiary and discuss a possible change in providers. If the waiver beneficiary's needs may be maintained at the deviated service(s) level, a service plan revision must be completed.

A beneficiary may exercise his or her freedom of choice of provider(s) at any time. If a request is made to change from one case management entity to another, a State representative will review the reason for the request to ensure care needs were not neglected as well as to identify the current utilization of all waiver services to assure health, safety and well-being of care needs.

When CAP participation is approved, the case management entity will notify the beneficiary in writing of the approval through a Welcome Letter. The Welcome letter outlines the following:

Waiver benefit package - the names of each waiver service and its definition. Additional information is provided on how one qualifies for a particular waiver services, the utilization limits and how the services may prevent institutional placement. Freedom of choice of provider is also explained.

Person-centered planning – information is provided to describe the definition of person-centered planning and how the participant is entitled to determine who should be involved in decision-making and at planning meetings. The participant is also provided information about how to ensure his or her cultural influences, likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity are included in the plan. The participant is also informed about assumed risk when choosing to participate in a home and community-based program,

Freedom of Choice – information is provided to describe what freedom of choice is and how the participation is able to exercise his or her freedom of choice when selecting to participation in the waiver, choosing waiver services and providers that also includes the case management to manage the day-to-day oversight during waiver participation. A participant may select a different provider at any time, for any reason.

Due process- information is provided of how to request an appeal when an adverse decision is made and the timeline granted to file an appeal.

Complaints and Grievances- information is provided that describes what is a complaint and a grievance and how to lodge a complaint or grievance. The timeline is provided on how the complaint and grievance is to be addressed.

Abuse, Neglect and Exploitation (ANE) - information is provided on what ANE means, ways to identify concerns and how to report suspensions. This information also states the obligation by DMA as well as the case management to report concerns of ANE to the appropriate officials.

Resources available in the community- a list of resources is provided to the participant that describes Medicaid services and other community resources potentially available to the participant while the participant goes through the eligibility steps.

The local department of social services is provided an official letter of notification of waiver approval. The notice informs of the CAP effective date and the special coverage code to enter into the eligibility system to ensure the adjudication of all CAP claims that are submitted.

Each service provider is provided an official notice called a service authorization to authorize the waiver service that is listed on the service plan. In addition, Medicaid provider of other Medicaid services are provided a participation letter to acknowledge approval of receipt of other Medicaid services.

The CAP IT system forwards electronic files to DMA's Medicaid's Fiscal Agent to validate the prior approval of LOC as well the prior approval of waiver services in the amount and frequency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The State has procedures to promote individual and family preferences and selections for care and services. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences and goals of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts). To ensure that family or individual decisions are honored, an individual risk assessment tool is used to help provide a framework for supporting individuals to remain in their homes despite identified risk of health, safety and well-being. This tool helps the case manager, care advisor or the waiver beneficiary to think through risks and identify ways to minimize them. Risk and outcomes are identified to develop a risk plan and service plan to monitor and control the probability and effects of unfortunate events, or to maximize the realization of opportunities for ongoing community living.

Risk Assessment and Mitigation begins during the interdisciplinary comprehensive assessment. Each waiver beneficiary, will be carefully assessed for health and well-being to plan for safe living in the community. Upon the completion of the assessment, the CAP IT system analyzes the data fields to identify areas that could be a potential risk for the waiver beneficiary. Data from the assessment generated by CAP IT system informs the potential waiver beneficiary/primary caregivers and the assessment team of risk factors to consider during the service plan development to keep the waiver beneficiary safely in the community. During the development of the service plan the assigned case manager meets with the potential waiver beneficiary/primary caregiver and other of his or her choice to review assessed risks to develop a plan of action to address each risk factor. Waiver and non-waiver services, assistance from the informal supports system are included in the service plan to aid in mitigating risk factors.

When waiver services, the informal supports system and regular Medicaid Services are not able to fully address the risk factors, a waiver beneficiary has the discretion to enter into an Individual Risk Agreement (IRA) to assume responsibility and accountability of decisions. A risk agreement permits waiver beneficiaries to assume responsibility for their personal choices through surrogate decision makers or through planning team consensus. This agreement outlines the risks and course of action.

The individual risk assessment tool:

Ensure full understanding of assumed risk through:

- A written and signed statement to negotiate risks

The tool identifies real or potential risks by:

- Fostering communication, discussing and setting expectations
- Describing service delivery plan
- Acknowledging Participant's Right to make choices involving risks
- Assigning responsibilities

This tool on an ongoing basis:

- Addresses changing risks over time.
- Evaluates how are things going?
- Adjusts the outcomes
- Provides Remediation

Enrollment and continuous participation in the waiver may be denied based upon the inability of the program to ensure the health, safety, and well-being of the waiver beneficiary despite the implementation of an individual risk agreement. Based on the evaluation of the risk agreement and the assessment of the waiver beneficiary's medical, mental, psychosocial, physical condition and functional capabilities may warrant inability to participate in the waiver when the following conditions cannot be mitigated:

- a. The waiver beneficiary is considered to be at risk of health, safety and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a Personal Emergency Response System; waiver beneficiaries under the age of 18 is considered to be at risk of health, safety and well-being when their parents or responsible party cannot cognitively and physically devise and execute a plan to safety;
- b. The waiver beneficiary, lacks the emotional, physical and protective support of a willing and capable caregiver, who must provide adequate care to oversee 24-hour hands-on support or supervision, to ensure the health, safety, and well-being of the individual with debilitating medical and functional needs; or
- c. The waiver beneficiary's needs cannot be risk stratified and maintained by the system of services that is currently available to ensure the health, safety, and well-being despite an individualized risk agreement.
- d. The waiver beneficiary's primary private residence, is not reasonably considered safe to meet the health, safety and well-being in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the waiver beneficiary's safety, and these issues cannot be resolved through waiver services or other means;
- e. The waiver beneficiary's residential environment, would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager/care advisor, presents a physical or health threat, due to the proven evidence of unlawful activity conducted in the primary private residence; threatening or physically or verbally abusive behavior, by the waiver beneficiary or family member exhibited on more than two incidences physically and verbally abusive behavior or threatening language; or present of a health hazard due to pest infestation.
- f. The waiver beneficiary's continuous intrusive and oppositional behavior, impedes the safety of self and others by attempts of suicide, injurious to self or others, verbally abusive or aggressive, destructive of physical environment, or repeated noncompliance of service plan and written or verbal directives; or
- g. The waiver beneficiary's primary caregiver or responsible party, continuously impedes the health, safety and well-being of the

waiver beneficiary, by refusing to comply with the terms of the service plan, refusal to sign a plan, and other required documents; when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal), refuse to keep the care manager or care advisor informed of changes in the status of the waiver beneficiary.

h. The waiver beneficiary chooses to remain in a living situation, where there is a high risk or an existing condition of abuse, neglect, or exploitation as evidenced by an Child Protective Services assessment or care plan or the parent or responsible party refused to comply with Children Protective Services where there is a high risk factors of existing conditions of abuse, neglect, or exploitation.

In addition to Risk Assessment and Mitigation, each waiver beneficiary will be required to have an emergency back-up plan. The emergency back-up plan is created by the waiver beneficiary with the assistance of the case manager/care advisor. This plan specifies who will provide care when key direct care staff cannot provide services or tasks as indicated in the current service plan. Because both personal and home maintenance tasks are essential to the well-being of the beneficiary, the case manager/care advisor is responsible for ensuring that an adequate emergency back-up plan is in place. In the event of an emergency or an unplanned occurrence, the plan can include family, friends, neighbors, community volunteers and licensed home care agencies when possible. An emergency back-up plan is necessary for times when the personal care aide or personal assistant is unavailable during regularly scheduled work hours and when the unpaid informal support is unavailable for the balance of the remaining 24-hour coverage period. The emergency back-up is also necessary to inform of what the care needs are during a disaster.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

- f. Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Each waiver beneficiary is informed of choice of providers for all waiver and non-waiver services. During the referral and basic eligibility process, the CAP IT generates information for the waiver beneficiary about freedom of choice. This information informs of their right to choose any provider to render waiver and non-waiver services listed on the service plan. When the waiver beneficiary meets the basic criteria for waiver participation and is at the point to be assessed, a freedom of choice form is signed by the waiver beneficiary to identify the providers of choice.

Providing each waiver beneficiary with an Introductory or Annual Letter welcoming them to the CAP program and providing an overview of the CAP program offers a safeguard in the area of informed consent. Refer to Appendix D-1d.

Case management/care advisement is a waiver service offered to waiver beneficiaries to assist the beneficiary to navigate systems and to gain access to Medicaid services to meet their identified needs. The cohesiveness of the informal support system and the need for the intervention by a case manager is clearly identified through the comprehensive interdisciplinary assessment. When the assessment identifies a direct need for a case manager, this service will be included in the service plan on a monthly ongoing basis and the waiver beneficiary will be given the option to select the case management provider. The selected case management entity will be locked in as the sole lead case management provider for the waiver beneficiary due to the appointment of Case Management Entities, their role and responsibility to waiver administration and limited number of case management hours that are allotted annually. If a request is made to transfer to another case management entity, a root-cause analysis will be conducted by DMA within 5 days of the request to identify reasons, assure the health and well-being of the waiver beneficiary and obtain service utilization limits. DMA will provide technical guidance to assist with the transfer from one entity to the other.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

- g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

On an ongoing basis, DMA uses a representative sample when reviewing case management service plans and assessments for auditing and compliance purposes on a quarterly basis. The representative sample consists of .95 confidence interval with a margin of error of 5%.

The State Medicaid agency will conduct service plan quality assurance (QA) reviews quarterly. When a case management entity has two (2) consecutive quarters with a less than an 89% compliance rate of service plan development and approval as per waiver policies and procedures, the State Medicaid Agency will implement a corrective action plan and remove this activity from the case management entity until successful remediation and quality improvement.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

- h. Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

Every three months or more frequently when necessary

- Every six months or more frequently when necessary
- Every twelve months or more frequently when necessary
- Other schedule

Specify the other schedule:

- i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following (*check each that applies*):

- Medicaid agency
- Operating agency
- Case manager
- Other

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The service plan implementation and monitoring are performed at the local case management entity's level. The appointed case management entity initiates a family/person-centered service plan with the waiver beneficiary and monitors the plan. The State Medicaid agency ensures conflict-free case management through checks and balances managed by State staff. The checks and balances in place include assignment of an independent case management entity selected by the waiver beneficiary to complete the eligibility phases of waiver consideration and the development of the service plan. Upon the approval of waiver participation, the day-to-day ongoing case management needs are provided by a case management entity the waiver beneficiary/primary caregiver selects through freedom of choice.

Upon an approved service plan, the case management entity authorizes or acknowledges the waiver and non-waiver services within 5 business days to qualified Medicaid providers in the amount, duration and frequency listed in the service plan. Prior to authorizing or acknowledging waiver services to a Medicaid provider, the assigned case manager confirms that the provider is able to provide the services within a reasonable timeframe (within five days).

Each waiver beneficiary is contacted monthly by the case management entity to undergo an assessment of his or her care needs and changes to medical condition, functioning level and social support system. Quarterly multidisciplinary team meetings are held with the waiver beneficiary and all care providers to review the service plan, person-centered goals and desired outcomes to ensure the health and well-being of the beneficiary. If during these scheduled times, a need is identified to revise the service plan or to conduct a new assessment of needs, the case management entity will initiate that process. The waiver beneficiary also has the autonomy to reach out to the assigned case management entity, State staff or a representative from a provider to inform of concern(s) or a change in status in an attempt to assure health and safety. DMA staff has access to data that informs of hospitalizations, ER visits and CPS referrals which is monitored regularly to allow for quick intervention to avert health and well-being issues.

Monitoring tasks include assessing, planning, referring, linkage and follow-up. Upon the implementation of waiver services, the assigned case manager monitors the delivery, effectiveness and efficiency of all waiver services monthly with the waiver beneficiary/responsible party. On a quarterly basis and as needed, the assigned case manager conducts home visits and on-site agency visits to monitor and observe the provision of waiver services. During these monitoring visits, the assigned case manager assesses medical, social, behavioral and functional areas to identify a change in status which may warrant a services plan revision. The CAP IT system provides the quality assurance for service plan implementation and monitoring. Monthly reports and alerts are provided to the case manager/care advisor to ensure appropriate implementation of the service plan as per policy. Real time reports and data are made available to the State Medicaid Agency to monitor the compliance rate and performance of all case management entities to ensure services are implemented within 5 business days of a services plan approval. The QIS is monitored monthly to ensure the safety and well-being of each waiver beneficiary. The data analytic of service utilization, risks factors, incident reports and complaints and grievances for the CAP QIS framework also allows for quick remediation.

- b. **Monitoring Safeguards.** *Select one:*

- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.
- Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. Specify:

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

- a. Sub-assurance: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver beneficiaries who had an Individual Risk Agreement (IRA), when indicated, to mitigate serious health and safety risk factors identified in the assessment. Numerator: number of waiver beneficiaries who had an IRA Denominator: number of waiver beneficiaries who had serious health/safety risk factors identified in the initial, annual or Change in status assessment

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and APS and CPS data reports.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and APS and CPS data reports	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver beneficiaries who had a signed service plan that identified person-centered goals and strategies to meet those goals. Numerator: number of waiver beneficiaries who had a signed service plan that identified person-centered goals and strategies to meet those goals Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entity's file.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entity's file	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>

	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. *Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver beneficiaries who had a service plan updated within 12 months of the initial waiver enrollment date. Numerator: number of waiver beneficiaries who had a service plan updated within 12 months of the initial waiver enrollment date Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entity's file.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entity's file	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of waiver beneficiaries who had a revised SP, when indicated, to meet needs, based on monthly monitoring and CI reports. Numerator: number of waiver beneficiaries who had a revised SP, when indicated, to meet needs, based on monthly monitoring and CI reports
Denominator: number of waiver beneficiaries who needed a revised service plan based on monthly monitoring and CI reports

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entity's file.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entity's file	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. **Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver beneficiaries whose files were transmitted to NCTracks with PA waiver service limits in the amount, frequency, and duration authorized in the service plan. Numerator: number of beneficiaries whose files were transmitted to NCTracks with PA

waiver service limits in the amount, frequency and duration of service approvals
Denominator: number of waiver beneficiaries

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

The source of these reports are from CAP IT system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT system and DMA's MMIS managed by CSRA	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number/percent of beneficiaries who had a current service auth. on file that authorized services to a waiver provider in the amt, freq, and duration approved in the SP. Numerator: number of beneficiaries who had a current service auth on file that authorized services to a

waiver provider in the amt, freq, and duration approved in the SP Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entity's file.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entity's file	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver beneficiaries who report overall waiver services were adequately assessed and planned for in the amount, frequency, and duration of their needs.

Numerator: number of waiver beneficiaries who report overall waiver services were adequately assessed and planned for in the amt/freq/duration of their needs. **Denominator:** number of experience respondents

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system retrieved from survey respondents.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system retrieved from survey respondents	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- d. **Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number/percent of waiver beneficiaries who received an introductory/annual packet informing of waiver services and freedom of choice of waiver services and providers
Numerator: number of waiver beneficiaries who received an introductory/annual packet informing of waiver services and freedom of choice of waiver services and providers
Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entity's file.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entity's file	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver beneficiaries who had services that were received as authorized in the approved service plan
Numerator: Number of wavier beneficiaries who had services that were received as authorized in the approved service plan
Denominator: Number of wavier beneficiaries

Data Source (Select one):

Record reviews, on-site

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system, MMIS system and case management entity's file.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and MMIS	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input checked="" type="checkbox"/> Other Specify: CAP It case management system and MMIS	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

e. **Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver beneficiaries’ records who had a signed freedom of choice form that specified the waiver provider of choice. Numerator: number of waiver beneficiaries’ records who had a signed freedom of choice form that specified the waiver provider of choice. Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entity's file.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: CAP IT case management system and case management entity's file	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:

	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The State reviews each service plan that is developed by the case management entity to validate the accuracy of the information. To monitor compliance and conflict-free, the e-CAP system performs a compliance audit monthly to validate each report. A quality data report is provided to DMA and outliers are carefully reviewed and assessed by DMA for discovery, remediation and continuous quality improvement.

The CAP IT system for the waiver is designed to evaluate all waiver beneficiaries and provider agencies in the implementation and performance in the service plan development which is a critical component of health, safety and well-being of waiver beneficiary. Staff at DMA reviews each service plan or other waiver activities that is developed and created by the case management entity to validate the accuracy of the information. A quality data report is provided to DMA and outliers are carefully reviewed and assessed by DMA for discovery, remediation and continuous quality improvement.

To validate the efficiency and capacity of the CAP IT system programmed to support DMA administrative operation on this waiver, the sampling methodology will be 100% for waiver year one.

The CAP IT system has service plan functionality that produces data reports during each stage of eligibility and through the implementation of the service plan to ensure approve waiver services are rendered and billed in the amount, frequency and duration specified on the service plan to selected providers. A selected provider will receive a service authorization with the amount, frequency and duration authorized by the case management entity. NC Medicaid fiscal agent (CSRA/NCTracks) will only reimburse the prior approved limits and deny any claims over the approved limits.

The CAP IT system reviews 100% of cases monthly to determine errors in service plan development. These reviews assist to remediate deficiencies that result from failure to complete the care planning assessment tool accurately. Each case management entity has access to these quality assurance reports to track their performance and identify non-compliance areas that may require remediation.

Monthly, annual and ad-hoc audits, desktop or on-site, are conducted to monitor the safeguards established for service plan development.

b. Methods for Remediation/Fixing Individual Problems

- i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Upon discovery of non-compliance of the case management entity, a corrective action plan is developed to remediate the noncompliance with a completion date within 30 days. Repeated findings of non-compliance by a Case management entity

results in termination of new enrollment until compliance is achieved. Staff training and technical support are also provided. If waiver services are authorized by the case management entity outside of policy, the case management entity will be fined the amount of the unauthorized waiver services. Continued noncompliance in this assurance area for three consecutive reporting quarters will result in termination of provider's rights as a case management entity. Upon discovery of non-compliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within 3 business days. Repeated findings of non-compliance by a CAP IT contractor results in in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

No

Yes

Please provide a detailed strategy for assuring Service Plans, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix E: Participant Direction of Services

Applicability (from Application Section 3, Components of the Waiver Request):

Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.

No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested (select one):

Yes. The State requests that this waiver be considered for Independence Plus designation.

No. Independence Plus designation is not requested.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver is designed to afford every waiver beneficiary (or the legally responsible party), the opportunity to elect to direct care using consumer-directed services. The program affords increased beneficiary's choice and independence in meeting home care needs and increasing satisfaction with long term supports. This waiver offers both provider-lead and direct-led service options. Waiver services may be directed by the waiver beneficiary or a legally responsible party of the waiver beneficiary. Waiver services may also be directed by a representative freely chosen by an adult beneficiary or a legally appointed representative.

Description of Consumer Direction for the purpose of this waiver; consumer-direction, waiver beneficiary will be able to:

- Choose (hire), the personal assistant who will provide their care;
- Train, supervise, and evaluate the worker;
- Negotiate the rate of pay and other benefits;
- Release (terminate) the worker should this become necessary;
- Select individual providers and direct reimbursement for several other waiver services (identified previously in Appendix C-1/C-3); and
- Engage in a cooperative working arrangement, with a financial manager who will pay the beneficiary's worker, handle federal and state taxes and other payroll or benefits related to the employment of the worker, and reimburse other service providers under the direction of the waiver beneficiary.

To be eligible for consumer-direction, a waiver beneficiary or designated responsible party must:

Meet basic criteria to be assessed for HCBS waiver participation (e.g., at risk of institutional care; be eligible for Medicaid); Understand the rights and responsibilities of directing one's own plan of care; be willing and able to self-direct or select a representative who is willing and capable of assuming this responsibility. A self-assessment questionnaire must be completed to assess ability of the waiver beneficiary/primary caregiver to direct care. If there are areas for improvement or additional support, the case advisor works with the waiver beneficiary/primary caregiver to build these competencies. Approval to direct care is not approved until the waiver beneficiary/primary caregiver shows evidence of competencies in all areas.

The State Medicaid agency, case management entities, financial management agencies, waiver service providers and other providers interacts with and participate in the beneficiary's service plan.

The Case management entity provides care advisement to the beneficiary on a monthly and quarterly basis. The care advisor is a specialized case manager from a case management entity, with an understanding of consumer direction. The care advisor focuses on empowering waiver beneficiaries to define and direct their own direct staff and services. The care advisor guides and supports the waiver beneficiary, rather than directing and managing the waiver beneficiary throughout the service planning and delivery process. The care advisor provides four basic functions of case management (assessing, care planning, referral/linkage, and monitoring/follow-up). These functions are done under the guidance and direction of the consumer-directed beneficiary.

The Fiscal Intermediary (FI), through financial management services (FMS), provides financial services to the waiver beneficiary. Financial management services are provided to ensure that consumer-directed funds outlined in the family/person-centered service plan are managed and distributed as intended. The FI files claims through CSRA/NCTracks and reimburses the direct staff and individual providers. The FI deducts all required federal, state taxes, including insurance prior to issuing reimbursement or paychecks. The FI entity is responsible for maintaining, separate accounts on each beneficiary's services, and producing expenditure reports as required by the State Medicaid agency. The FI also provides payroll statements, on at least a monthly basis, to the direct staff and the case management entity. The FI must conduct background checks and age verification on all direct staff.

The CAP IT system has a knowledge exchange that provides additional education and resource materials about consumer-directed services which is readily available to the case management entity for self-use and distribution to the waiver participant.

Waiver beneficiaries selecting consumer-directed care are able to direct the personal care type services and participant goods and services.

Training requirements are required for direct staff who are caring for waiver beneficiaries who are medically fragile and with special care needs. Training and Education is a waiver service and may be included in the service plan to arrange for mandatory training. The direct staff must exhibit core competencies in the specialized areas which are checked off by the waiver beneficiary or responsible party and reviewed by the care advisor before services are authorized.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

- Participant: Employer Authority.** As specified in *Appendix E-2, Item a*, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- Participant: Budget Authority.** As specified in *Appendix E-2, Item b*, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- Both Authorities.** The waiver provides for both participant direction opportunities as specified in *Appendix E-2*. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

- Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**

- Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
- The participant direction opportunities are available to persons in the following other living arrangements

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. **Election of Participant Direction.** Election of participant direction is subject to the following policy (*select one*):

- Waiver is designed to support only individuals who want to direct their services.
- The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
- The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.

Specify the criteria

The CAP waiver has two options, CAP (traditional option) and consumer-directed option. A waiver beneficiary has the opportunity to select either option during the initial or annual assessment; or any time during waiver participation. To be eligible for consumer-directed care, a waiver beneficiary, responsible party, or legally appointed representative, must meet all of the following criteria: 1. Understands the rights and responsibilities of directing one's own care; 2. Willing and intellectually capable to assume the responsibilities for directing care, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care; and 3. Complete a self-assessment questionnaire to determine ability to direct care or identify training opportunities to build competencies to aid in self-direction. At any given time, a waiver beneficiary directing his own care can request to return to the traditional option of the waiver. The care advisor will work with the waiver beneficiary for a smooth transition back to the traditional option.

The following conditions are carefully analyzed prior to approval of consumer-direction:

1. Decline in mental or physical health and/or loss of informal support that would affect the ability of the beneficiary to self-direct. If this occurs, care advisors will reassess the beneficiary's situation, to determine whether the consumer-directed option continues to be appropriate for the individual. Personal care assistants and other direct care workers, who are in touch with the beneficiary on a daily or regular basis, are instructed to report problems in these areas to the care advisor;
2. Consistent misappropriation of previous Medicaid services
3. Past and present criminal involvement; and
4. Violation of the Beneficiary Rights and Responsibilities, while participating in the waiver.

The Beneficiary Rights and Responsibilities is listed below:

Beneficiary Rights and Responsibilities

By signing the form, I, as the waiver beneficiary or the responsible party (parent, legally responsible party, or designated caregiver) for [name of waiver beneficiary], MID# [insert MID #] acknowledge my understanding of the Community Alternatives Program (CAP) and my rights and responsibilities as a waiver beneficiary.

I understand:

1. The CAP Waiver is an alternative option to institutionalization. I must meet a nursing facility LOC initially and annually to participate in this program.
2. I agree to select this program as an option to institutionalization.
3. The CAP Waiver waives some Medicaid requirements to allow in-home care services (institutional-like services) to be provided and received in my home and community.
4. This CAP Waiver supplements rather than replaces the formal and informal services already available to me and my family.
5. The CAP Waiver has two service options, direct-lead (in-home aide and home health providers), and consumer-lead (consumer-directed), from which to receive my services. To qualify for and maintain qualification for consumer-directed care, I or my designated representative must be intellectually able and willing to direct my care as evidenced by a self-assessment tool. Quarterly reviews of performance are conducted by the care advisor and financial manager to ensure ongoing competencies.
6. The CAP Waiver provides an array of services, known as waiver services, to meet my assessed needs to keep me integrated in the community.
7. The CAP Waiver allows me the right to select any of the available waiver services to meet my assessed needs and any provider to provide those services.
8. The waiver services I select to meet my needs will be listed on a service plan in the correct amount, frequency, and duration

that are consistent with my assessed needs. The service plan will be assessed quarterly and can be revised at any time based on my changing needs.

9. If I have a concern, complaint or grievance, I can notify my case management entity, State staff or my provider agency to assist with my concerns. I also understand that a grievance or complaint does not result in a fair hearing.

10. If a waiver service I request is denied, reduced, terminated or suspended, I will be notified in writing and be given instructions on how to appeal the denial.

11. The CAP Waiver requires work verification documentation and a listing of household members to assist in planning for my care needs. Work time and family support must be reported accurately to prevent a program integrity review.

12. If I have a Medicaid spend down, deductible or premium, I must incur the established medical expenses before my CAP Medicaid is made available. I must also pay my identified providers the cost of these incurred medical expenses to prevent a gap in my care provision.

13. The CAP Waiver allows my waiver services to be provided by individuals and agencies of my choosing. However, waiver beneficiaries between the ages of 0-17, the following identified parties cannot directly provide waiver services and receive payment through payroll: a parent; stepparent, parent's spouse/significant other (live-in or not), foster parent, custodial parent or adoptive parent, sibling under the age of 18, anyone acting as "loco parentis". The following identified parties cannot directly provide waiver services for waiver beneficiaries 0-18 years of age or older and received payment through payroll: an appointed guardian appointed Health Power of Attorney or Power of Attorney or executor the estate.

14. The CAP Waiver is required to protect my health, safety, and well-being, at all times, while I participate in the program, I am able to assume some risks in my decisions making. This assumed risk must be outlined in an Individual Risk Agreement or emergency back-up plan. When choices are made that expose me to abusive situation, cause me to be neglected, abused, or exploited, the IRA may be terminated and a referral will be made to Adult or Child Protective Services. An assessment of my continued eligibility to participate in the waiver will be conducted.

15. The CAP Waiver may initiate disenrollment from the waiver when any one of the following occurs:

- The beneficiary's Medicaid eligibility is terminated;
- The beneficiary's physician does not recommend nursing facility;
- The SRF is not approved for nursing facility LOC;
- DSS removes the CAP evidence code;
- The CAP case management entity has been unable to establish contact with the beneficiary or the primary caregiver(s) for more than 60 calendar days despite two written and two verbal attempts;
- The beneficiary fails to use CAP services as listed in the service plan during a 90 consecutive day time period of CAP participation despite case management coordination;
- The beneficiary's health, safety, and well-being cannot be mitigate through a risk agreement and other interventions;
- The beneficiary or primary caregiver will not participate in development of or sign the service plan;
- The beneficiary or primary caregiver(s) fail to comply with all program requirements, such failure to arrive home at the end of the approved hours of service, or manipulation of the coverage schedule without contacting the case management entity for approval; or
- The beneficiary demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of CAP as outlined in the "Beneficiary Rights and Responsibilities" form, and signed by the CAP beneficiary.

16. I or the primary responsible party must maintain monthly telephone contact and monthly-to- quarterly face-to-face contact with the assigned case manager for the purpose of monitoring health and well-being and coordinating to include referrals, linkage, assessments and care planning.

17. I or the primary responsible party will receive an annual letter of appointment to complete my annual continued need review for going participation in the waiver program. Failure to comply or keep the arranged appointment may interrupt the provision of my services or initiate disenrollment from the CAP waiver.

18. The Division of Medical Assistance (DMA) has sole approval authority over the administration of the CAP waiver.

I have read and understand the above information. By signing this document, I willingly accept to participate in the CAP Waiver and agree to abide by the policies and procedures of the CAP Waiver. I also understand my rights and responsibility as a waiver beneficiary.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

- e. Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The case management entity is responsible for providing waiver beneficiary/primary caregivers/legally responsible party sufficient information to ensure informed decision-making and understanding of the consumer-directed service option and of the traditional provider-managed service delivery option. The information includes the responsibilities and choices individuals may make with the election of the consumer-directed service option. The assigned case manager reviews the consumer-directed services option at program enrollment, at least annually, or upon request. This information is provided orally and in writing to the waiver beneficiary, and the legally authorized representative by the case management entity. The information that is provided includes:

- An overview of the consumer-directed services option;
- Explanation of responsibilities of the individual or individual's legally authorized representative and the consumer- directed

service agency in the consumer-directed service option;

- Explanation of benefits and risks of participating in the consumer- directed services option;
- Self-assessment questionnaire requirement for participation in the consumer-directed services option;
- Explanation of required minimum qualifications of service providers through the consumer-directed services option; and
- Explanation of employee/employer relationships, that prohibit employment under the consumer-directed services option.

During the initial enrollment, the Financial Management Services (FMS) performed by a financial intermediary (FI) organization will be responsible for providing the following:

- Information, training and outreach;
- Information in completing and filing IRS tax forms;
- What are the roles and responsibilities of FI?
- What are the roles and responsibilities of the waiver participant?
- Conducting criminal background checks and explaining the criminal background that is identified during the check;
- Processing referral applications;
- How applicants must complete the employment application;
- How to submit Medicaid personal care claims for reimbursement;
- An explanation of Bill of Rights;
- How to contact a representative of the FI contractor; and
- Access to customer services to submit claims and guidance for technical problems or concerns.

On an ongoing monthly basis, the FMS is responsible for the following:

- Filing Medicaid claims for reimbursement of personal care claims;
- Managing and paying payroll;
- Arranging to reimburse hired assistants when payroll is missed;
- Trouble shooting concerns or problems;
- Conducting criminal background checks on newly hired personal care assistants;
- Maintaining monthly contact with the care advisor; and
- Assuring accessibility to customer service for waiver participants to submit claims and seek guidance for technical problems or concerns.

The FI and the case management entity will monitor the compliance of all self-assessment tools to ensure appropriateness of directing care.

The care advisor will inform roles and responsibilities associated with a self-directed model, explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual/representative to modify individual budget. The care advisor will also provide:

- Assessment of individual risk;
- Assessment of health, safety, and well-being of the person as well as the continued appropriateness of services and supports;
- Identification of the need for a representative for the waiver beneficiary, who desires to direct his/her own services and supports, and ensures that the representative, meets established criteria to assist the participant to self-direct their supports/services;
- Quality assurance of the person-centered plan, identifies how emergency back-up services will be furnished for workers employed by the individual, and authorizes the provision of on-call emergency back-up services;
- Report critical incidents; and
- Addresses complaints, grievances and appeals.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

- The State does not provide for the direction of waiver services by a representative.**
- The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: (*check each that applies*):

- Waiver services may be directed by a legal representative of the participant.**
- Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

A representative is appointed when the waiver beneficiary or legal guardian request assistance or has demonstrated a need for assistance. The financial manager works with the beneficiary to identify an individual who will be appointed as the representative. The legal representative is a neutral party. The care advisor plays a significant role in identifying the need for a representative and ensuring that the representative meets the criteria outlined above. Additionally, the care advisor, as part of ongoing monitoring activities, ensures that the representative continues to act in the best interest of the waiver beneficiary.

The representative may NOT be the paid hired staff (i.e. personal assistant) for the waiver beneficiary. The following requirements must be met prior to approval of designating a representative:

- Demonstrated knowledge and understanding of the beneficiary's needs and preferences;
- Agreement to a predetermined level of contact with the beneficiary;
- Willingness to comply with program requirements;
- 18 years of age or older; and,
- Agreement by the waiver beneficiary/ primary caregiver for someone to act in that capacity

A parent/legal guardian, significant other to a parent of an individual 0-17 is not eligible to be the representative if a representative is designate by DMA. The representative may be a family member, friend, someone who has power of attorney, income payee, or another person, who willingly accepts responsibility for performing tasks that the waiver beneficiary or legal guardian is unable to perform and must be at least 18 years old. The representative must be committed to follow the waiver beneficiary or legal guardian's needs and preferences while using sound judgment to act on the waiver beneficiary or legal guardian's behalf.

The representative may NOT be paid to be the representative or to provide any other service to the participant with the exception of guardianship services.

If a representative is identified, the representative will be asked to sign the "Representative Agreement" provided by the FI. This agreement outlines the requirements and expectations of the representative, and explains that the representative may be removed for not complying with the agreement. The assigned care advisor monitors the delivery of services monthly and reports any concerns to the FI and the State Medicaid Agency. In addition, any concerns about the well-being of a waiver beneficiary or legal guardian must be reported through a critical incident report.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

- g. Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Participant Goods and Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Pediatric Nurse Aide Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
In-Home Care Aide Service	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Institutional and Non-Institutional Respite	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

- Yes. Financial Management Services are furnished through a third party entity.** (Complete item E-1-i).

Specify whether governmental and/or private entities furnish these services. *Check each that applies:*

- Governmental entities
 Private entities

- No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

- FMS are covered as the waiver service specified in Appendix C-1/C-3**

**The waiver service entitled:
 Financial Management Services**

- FMS are provided as an administrative activity.**

Provide the following information

- i. Types of Entities:** Specify the types of entities that furnish FMS and the method of procuring these services:

Public or private entities are eligible to provide FMS as long as they meet the required credential to enroll as a Medicaid provider of this service. The provider credential is as follows:

The vendor shall have a minimum of two (2) years similar project experience with other departments or divisions of state government, county government, municipal governments, or large corporation employers in North Carolina, or in other States with similar projects. The vendor must be authorized to transact business in North Carolina and be approved as a Medicaid provider.

A solicitation for vendors is posted to the Division of Medicaid Assistance website to procure vendors for this service.

Waiver beneficiaries are informed of the providers of this service and given a choice of providers to select.

- ii. Payment for FMS.** Specify how FMS entities are compensated for the administrative activities that they perform:

The payment for FMS is a waiver service which is added to the cost budget of the waiver beneficiary. The FMS files claims to Medicaid for reimbursement of FMS fees. The case management entity closely monitors the FMS to ensure services were rendered in the amount, duration and frequency. The CAP IT system will also submit prior approval claims directly to CSRA/NCTrack for reimbursement of FMS. The case management entity will also monitor customer service to address any concerns, complaint or grievance the waiver beneficiary may have.

- iii. Scope of FMS.** Specify the scope of the supports that FMS entities provide (*check each that applies*):

Supports furnished when the participant is the employer of direct support workers:

- Assist participant in verifying support worker citizenship status**
 Collect and process timesheets of support workers
 Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
 Other

Specify:

Supports furnished when the participant exercises budget authority:

- Maintain a separate account for each participant's participant-directed budget**
 Track and report participant funds, disbursements and the balance of participant funds
 Process and pay invoices for goods and services approved in the service plan
 Provide participant with periodic reports of expenditures and the status of the participant-directed budget
 Other services and supports

Specify:

Additional functions/activities:

- Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
 Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
 Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
 Other

Specify:

- iv. **Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The FMS must enroll as a Medicaid provider and meet all provider credentials as established by the State Medicaid Agency. The State Medicaid's Fiscal Agent, CSRA oversees provider enrollment to ensure enrollment is consistent with the State's policies and procedures, monthly and on an ongoing basis. The fiscal agent conducts and OIG checks regularly to ensure good standing with Medicare and Medicaid. A provider application recertification is required every five(5) years.

The State Medicaid Agency and the case management entities monitor closely the execution of FMS services to ensure the health, safety and well-being of the waiver beneficiary. The case management entity reviews monthly budget summary sheets provided by the FMS and also address concerns of service utilization, both over and under.

The CAP IT system provides the case management entity and the State Medicaid Agency real time reports to assist in the monitoring of the FMS to ensure criminal and registry background checks are conducted and that enrollment paperwork is completed and the rate is within the approved Medicaid limits.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

- j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

- Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Information and assistance are available to support the waiver beneficiary when participating in consumer-direction. This support is provided through a care advisor. Care advisors will inform waiver beneficiaries and families of the option to self-direct prior to and during the assessment and person centered planning process. Waiver beneficiaries and family members are provided information by the care advisor as well as the FI of their roles and responsibilities in directing care. The care advisor's role is to empower the beneficiary to define and direct their own personal assistance needs and services. Those services and functions assist participating families and individuals to make informed decisions about what will work best for them, services consistent with their needs and reflect their individual circumstances. Those services are available to assist in identifying immediate and long-term needs, developing options to meet those needs, and accessing identified supports and services. A person-centered approach is used. Care advice offers practical skills training to enable waiver beneficiary and primary caregiver to remain independent. The service and function of consumer-direction include providing sufficient information to ensure waiver beneficiary and the primary caregiver understand the responsibilities involved with consumer-direction and assist in the development of an effective back-up and emergency plan.

The care advisor will also provide information and assistance with the following:

- Explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual/representative to modify their individual budget.
- Assessments of individual risks.
- Assessment of health, safety, and well-being of the waiver beneficiary as well as the continued appropriateness of services and supports.
- Identification of the need for a representative for the beneficiary who desires to direct his or her own services and supports, and ensures that the representative meets established criteria to assist the beneficiary to self-direct his or her supports and services
- Assurance that the Person-Centered Plan identifies how emergency back-up services will be implemented and how and when to authorize the provision of on-call emergency back-up services.
- Assessment of critical incidents and completing necessary reports and referrals
- Assistance with grievances and appeals
- Assist and support the waiver beneficiary/primary caregiver in transitioning to the provider-lead model of the supports if the waiver beneficiary/primary caregiver decides that he or she no longer desires to continue to self-direct; or for those beneficiaries who have been unable to maintain budget authority.
- Notification of any concerns with implementation and on-going utilization of the consumer-direction option.

This waiver will provide financial management services as a waiver service for a waiver beneficiary choosing to direct their care. This service will be included in the waiver benefit packet as a fee-for-service item.

- Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service Information and Assistance Provided through this Waiver Service Coverage
--

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Assistive Technology	<input type="checkbox"/>
Home Accessibility and Adaptation	<input type="checkbox"/>
Specialized Medical Equipment and Supplies	<input type="checkbox"/>
Vehicle Modifications	<input type="checkbox"/>
Training, Education and Consultative Services	<input type="checkbox"/>
Financial Management	<input type="checkbox"/>
Participant Goods and Services	<input type="checkbox"/>
Pediatric Nurse Aide Services	<input type="checkbox"/>
In-Home Care Aide Service	<input type="checkbox"/>
Case Management	<input type="checkbox"/>
Institutional and Non-Institutional Respite	<input type="checkbox"/>
Community Transition	<input type="checkbox"/>

Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

- No. Arrangements have not been made for independent advocacy.**
- Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Waiver beneficiaries choosing consumer-directed care are provided information on opportunities to access independent advocacy. This information is provided during screening and referral for support planning and during the enrollment process for ongoing support. The Division of Vocational Rehabilitation Services provides education, information and training in consumer-direction and how to efficiently arrange and access services in community. The Department of Health and Human Services (DHHS) has a Customer Service Center to provide information, referrals, education and outreach to individuals choosing to direct their own care. The DHHS Customer Service Center can be reached by dialing 1-800-662-7030. The DHHS Customer Service Center is available 24-hours, 7-days per week and includes interpretive services for non-English speaking callers. Vocational Rehabilitation Services are available Monday-Friday from 8am -5pm for direct assistance in person, in writing or by telephone. There is no fee for accessing and using these advocacy programs. Waiver beneficiaries seeking legal guidance are able to access services from NC Legal Aide Services.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A waiver beneficiary selecting consumer-directed care may withdraw from the option at any time by notifying the assigned care advisor. The assigned care advisor prepares a revision to the service plan, so provider-directed services are authorized for the waiver beneficiary with no service lapse.

The following steps are followed:

- (1) Beneficiary or legally responsible party requests that the assigned care advisor terminates the consumer-direction option and

returns the beneficiary back to the traditional waiver services.

(2) Care advisor asks the beneficiary or legally responsible party to select a provider and updates the service plan to reflect termination of the consumer-direction option and the provider agency selected by the beneficiary or legally responsible party to provide provider-directed services.

(3) The legally responsible person signs the service plan and the care advisor upload to the CAP IT system.

(4) The CAP IT system analyzes the service plan for accuracy and the case management entity or the State Medicaid Agency approves the service plan, authorizes provider-directed services and terminates participant-direction option.

(5) The assigned case manager sends a letter to the beneficiary or legally responsible party and all providers notifying of the termination of consumer-direction option per the request that includes the date of the termination of payroll for employees. The letter is copied to the care advisor.

(6) The Employer of Record or Agency with Choice notifies staff that they are no longer employed under the consumer-direction option.

A Care advisor works with the waiver beneficiary to transfer to regular waiver services or other State plan service(s) and monitors health and safety until the new service is fully implemented.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

- m. Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

This waiver will allow for both provider-lead and direct-lead services. Provider-lead services are referred to as the traditional agency oversight. If a waiver beneficiary is not successful in directing own care and continues to need the intervention of this waiver, arrangements will be made to transition this waiver beneficiary to a provider-lead agency for waiver planning. Upon the transition, the beneficiary will receive all services from a provider agency and the assigned case management entity will take a more active role in directing the care needs of the waiver beneficiary.

When a waiver beneficiary demonstrates the inability to self-direct waiver services, whether due to misuse of funds, consistent non-adherence to program rules, or an ongoing health and safety risk, he or she will be required to select a representative to assist them with the responsibilities of self-direction. If a waiver beneficiary refuses to select a representative or if waiver beneficiary loses a representative and cannot locate a replacement, the waiver beneficiary will be required to transfer to traditional programming of the waiver for closer oversight. Care advisors will assist the waiver beneficiary with the transition. Waiver beneficiaries are given Due Process rights for any changes, termination or removal of a service or program.

The State Medicaid Agency will initiate an involuntary termination from consumer-directed care under the following circumstances:

- (1) Immediate health and safety concern including maltreatment of the waiver beneficiary;
- (2) Repeated unapproved expenditures and misuse of waiver funds;
- (3) No approved representative available when deemed necessary;
- (4) Refusal to accept the necessary care advisement and training service when deemed necessary;
- (5) Refusal to allow care advisor to monitor services;
- (6) Refusal to participate in mandatory monthly and quarterly monitoring requirements, state or federal monitoring;
- (7) Non-compliance with individual and family supports, Financial Supports Agency, Agency with Choice or employee support agreements;
- (8) Inability to implement the approved service plan or comply with waiver requirements despite reasonable efforts to provide additional training assistance and support.

The State Medicaid Agency will dis-enroll a waiver beneficiary from consumer-direction if the same major mistakes occur more than three times in a twelve-month period. However, the recommendation to termination from consumer-direction may occur immediately if the waiver beneficiary's health and safety are at risk or misuse of funds is suspected. For example, an incident of substantiated abuse by a paid employee could lead to termination if a plan cannot be implemented to ensure health and safety. Prior to considering a termination from consumer-direction, the case management entity will report concerns and allegations of major problems with the implementation of consumer-direction to each State Medicaid Agency. The State Medicaid Agency consultant investigates the concerns or allegations. The consultant will review all available plans of correction and documentation.

The termination date from the consumer-direction program will occur on the last day of a given month. When the termination is due to a threat to the waiver beneficiary's health and safety, such as physical abuse, termination occurs immediately and traditional waiver participation resumes immediately.

If the employer/Agency with Choice disagrees with the decision of the State Medicaid Agency, the employer/Agency with Choice may file a reconsideration request or a grievance.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

- n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

Waiver Year	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority	
	Number of Participants	Number of Participants	
Year 1			500
Year 2			575
Year 3			650
Year 4			725
Year 5			800

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

- a. **Participant - Employer Authority** Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:

- i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both:*

- Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

- Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

- ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise:*

- Recruit staff**
 Refer staff to agency for hiring (co-employer)
 Select staff from worker registry
 Hire staff common law employer
 Verify staff qualifications
 Obtain criminal history and/or background investigation of staff

Specify how the costs of such investigations are compensated:

- Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
 Determine staff duties consistent with the service specifications in Appendix C-1/C-3.
 Determine staff wages and benefits subject to State limits
 Schedule staff
 Orient and instruct staff in duties
 Supervise staff
 Evaluate staff performance
 Verify time worked by staff and approve time sheets
 Discharge staff (common law employer)

- Discharge staff from providing services (co-employer)
 Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more:*

- Reallocate funds among services included in the budget
 Determine the amount paid for services within the State's established limits
 Substitute service providers
 Schedule the provision of services
 Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3
 Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3
 Identify service providers and refer for provider enrollment
 Authorize payment for waiver goods and services
 Review and approve provider invoices for services rendered
 Other

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Each waiver beneficiary is provided a Welcome Letter initially and annually that identifies the average per capita cost. The case management entity also provides training and orientation to the waiver beneficiary about the budget and budget management when directing care.

Budgets will be calculated based on the methodology currently in place for the waiver. The process involves an assessment to identify needs; development of person-centered goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. The estimated monthly cost of each waiver service is calculated based on approved waiver Fee Schedules. The costs of waiver and non-waiver services cannot exceed the average per capita cost as established for this waiver. The waiver beneficiary is informed by the financial manager about the IRS process and how taxes and insurances are calculated and how those taxes need to be considered when negotiating a rate. The waiver beneficiary is also informed of the need to set the rate at a medium range, but not less than minimum wage, in order to plan for unexpected changes and to also plan for rate increases for worker to compensate for longevity or tasks that require extensive assistance.

A rate fee range is provided to the waiver beneficiary for consideration of hire. The waiver beneficiary is counseled by the care advisor as well as the FI on how to set that rate that allows for flexibility and maximal utilization of waiver services. The waiver beneficiary is also provided information and education about the Department of Labor Final Rule regarding overtime pay, maintaining task sheets and assigning pay wages at or above minimum wage. This information is available to the public by accessing the information on the Division's website.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Upon approval of waiver participation, a waiver beneficiary is provided a Welcome Letter that informs of the waiver services, resources and utilization limits provided under the waiver. The waiver beneficiary is informed of acuity level he or she is assessed based on the results of the comprehensive assessment. The acuity level identifies the average per capita cost of service provision based on assessed needs. When developing the service plan to ensure budget management, the care advisor and the financial manager assist the waiver beneficiary in strategizing and structuring services at a negotiated rate. This budget is based on the number of support hours needed during the day, the utilization of other waiver and non-waiver services and the hourly wages to be paid to the employee. The FI takes this information and creates a budget to ensure the services and pay rate are within the average per capita cost and the pay rate including all taxes, insurances and overtime is within the Medicaid maximum reimbursement. Upon the completion of this budget, the FI reviews and explains to the waiver beneficiary for understating and agreement. The approved budget by the waiver beneficiary is shared with the care advisor to finalize the service plan. If an adjustment is need during the annual participation in consumer-direction, the waiver beneficiary is able to negotiate additional services using the same methods described above that continues to align within the average per capita cost.

A change to the waiver beneficiary's status may warrant a change in the acuity level of care, thus changing the average per capita cost. The beneficiary, the care advisors, physician or provider agencies can request a change in status assessment to identify an adjustment in the care needs. If the acuity level increases, the waiver beneficiary has more negotiation power and resources to plan care. If the acuity level decreases, the care advisor and financial manager assist the waiver beneficiary in realigning their service needs to ensure service provision is within average per capita cost. The care advisor assists the waiver beneficiary to develop a 90-day transition plan to align waiver services as to not create a health and safety risk factor. Each waiver beneficiary is given a total of 6 months to align within the average per capita cost upon the discovery of exceeding the average per capita cost. When the discovery is made, the waiver beneficiary is informed and the case manager works with the beneficiary to identify other formal or informal services to align within the average per capita cost. If after the third month of intervention, the cost of care is significantly over the average per capita cost and the cost of care will not align because of the severity of care needs, a transition plan will be created for a three-month transitioned to traditional Medicaid services and other community services where an average per capita cost is not a factor in planning the care needs. The waiver beneficiary is provided Due Process rights. Medicaid beneficiaries or their personal representatives have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 et seq. and N.C.G.S. §108A-70.9.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

- iv. **Participant Exercise of Budget Flexibility.** *Select one:*

- Modifications to the participant directed budget must be preceded by a change in the service plan.**
- The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

A change to the waiver beneficiary's status may warrant a "change in status assessment" to reassess needs and level of acuity and the consumer-directed budget. This reassessment may change the maximum average per capita cost of the budget. When a change in status is identified or a request to reevaluate the service plan is made, the care advisor meets with the waiver beneficiary to assess needs and to determine the validity of revising the service plan. Evidence to support the reassessment or a revision to the service plan prepares the care advisor to initiate the process to update the service plan with the waiver beneficiary. This information is documented in the beneficiary service record by the case management entity.

If an unexpected situation occurs, the waiver beneficiary has the autonomy to utilize unauthorized waiver services by notifying the provider agency. The care advisor, the FI and CAP IT system must be notified by provider agency and the waiver beneficiary within 24 hours of the unauthorized service. If the service was a short-term intensive intervention, the service plan would not be updated. The care advisor would give a written approval to the financial manager to reimburse this one-time short-intensive service and the CAP IT system will send a prior approval record to NCTracks for approval of reimbursement. If the service is ongoing, the service plan and service authorizations must be updated

and disseminated to all authorized providers. The care advisor would update the service plan and notify providers. Prior approval of services would be required for short-term intensive interventions with a longer duration and when the waiver beneficiary wanted to provide a pay increase to their direct staff.

All changes that are made to the consumer-directed budget are documented on the service plan that is electronically stored in the CAP IT system. The service plan identifies all waiver and non-waiver services in the amount frequency and duration. The service plan provides a comprehensive overview of the person-centered plans and how services needs will meet the beneficiary care needs.

The FI provides the waiver beneficiary a budget that only identifies the services that are self-directed and the total average budget per month and annually. When changes occurs, the budget is updated and shared with the waiver beneficiary. The case advisor uploads this budget in the supporting documents in the CAP IT systems.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

- v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

Safeguards that are put in place to prevent the premature depletion of the beneficiary's budget include:

- 1) monthly budget analysis reports that are provided directly to the waiver beneficiary and the care advisors; and
- 2) quarterly data reports from the CAP IT system provided to DMA and the case management entity that informs of the average per capita cost of each waiver beneficiary.

The waiver beneficiary is provided a Welcome Letter that informs of the utilization limits of the waiver and an explanation of how cost of care should fall within the average per capital cost of waiver planning. The care advisors meeting monthly with the wavier beneficiary to assess expenditures and other concerns. The case advisor also reviews the expenditure reports submitted by FI and discusses any concerns with expenditures when warranted. Post-approval and post-payment reviews are performed by the case management entity using data from the CAP IT system and FMS.

The service plan and service provision will be continually monitored by the Care Advisor, the FMS and the CAP IT system to ensure needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the Care Advisor will work with the waiver beneficiary to resolve them. If the problem cannot be resolved, the care advisor and case management entity will consult with DMA Program Consultants prior to taking any adverse action towards the waiver beneficiary.

If changes occur that impacts the consumer-directed budget, the waiver beneficiary is provided written information about the impact and the need to address impact with the care advisor or the FI. The care advisor and financial manager provide counsel and guidance to the waiver beneficiary about how to maintain care needs within the average per capita cost while assuring health, safety and well-being.

The financial manager provides monthly aggregate budget reports that clearly identify authorized expenditures and actual expended cost. If the waiver beneficiary has reached or is near to reach the authorized expenditure, the financial manager will notify the waiver beneficiary and the care advisor. The care advisor will assist the waiver beneficiary to realign spending.

Another safeguard is the transmittal to NCTracks of prior approval limits of all waiver services. When an approved service plan is completed, the CAP IT system automatically transmits the approved limits to the Medicaid management system for claim reimbursement. Claims submitted over that amount will not be reimbursed.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

In accordance with Due Process, the State Medicaid Agency ensures the waiver beneficiary, legal representative(s), or both are provided written notice of all adverse decisions. A waiver beneficiary whose SRF is denied, or whose waiver services are denied, suspended, terminated, or reduced, has the right to appeal.

Examples of appealable decisions are:

- a. denial of initial or continued participation in the waiver program;
- b. denial of increase, or reduction, of waiver services included in the service plan; or
- c. Disenrollment from the waiver program.

Only actions initiated by the State Medicaid Agency and appointed case management entities may be appealed. The following decisions may not be appealed:

- a. A provider's refusal to serve a waiver beneficiary;
- b. A physician's level of care recommendation; or
- c. A physician's order.

A waiver beneficiary will not be given the opportunity to a fair hearing by DMA, when basic LOC is not recommended by a physician. The State Medicaid agency's policy, states that a recommendation of a LOC decision must be rendered and fully documented by the treating physician to demonstrate medical necessity. When the physician is not able to document medical necessity to make a level of care recommendation, the individual must dispute that decision directly with the physician. The individual will have the opportunity to present additional information directly to the physician that supports institutional level of care. The physician's decision will impact initial level of care determination as the CAP IT system and Case management entity will not be able to process the assessment without an established LOC recommendation. The individual is provided a referral list of other community resources that are available to meet needs.

Each waiver beneficiary will receive a copy of his or her rights at the time of eligibility screening for home and community based waiver services. In addition, each waiver beneficiary will be provided appeal rights when a CAP service is denial, reduced, or terminated or when the waiver beneficiary is dis-enrolled from waiver participation. The CAP IT system will manage and create adverse notices for the Case management entity to use when an adverse decision is reached.

The adverse notice will contain information on:

- The right to a Fair Hearing;
- The method for obtaining a Fair Hearing;
- The rules that govern representation at Fair Hearings;
- The right to file grievances and appeals;
- The requirements and timeframes for filing a grievance or appeal;
- The availability of assistance in the filing process;
- The toll-free numbers that the individuals may use to file a Grievance, complaint or to request assistance;
- Rights, procedures and timeframes for voicing or filing Grievances and Appeals or recommending changes in policy and services.

The requirements of the appeals process must be consistent with fair hearing established at 42 CFR Part 431, Subpart E.

An approved waiver beneficiary will be granted a fair hearing when dis-enrolled from participation or for any waiver service that is denied, reduced, terminated or suspended. DMA will waive the opportunity for a fair hearing when: 1. The Community Alternatives Program (CAP) special coverage codes/CAP evidence have not been entered or has been removed from eligibility system which indicates the individual has not been approved or is no longer approved for waiver participation; 2. The HCBS Service Request Form is incomplete or has been denied; 3. The waiver beneficiary's Medicaid eligibility is terminated (a hearing will be offered to the participant by the Medicaid eligibility department); 4. The waiver beneficiary is in a Medicaid sanction period. Waiver beneficiaries who misappropriate assets invoke a violation to Medicaid rules which places them in a sanction period. This sanction period temporarily deems the waiver beneficiary ineligible for Medicaid; and 5. The waiver beneficiary's Medicaid coverage is in deductible status. Individuals participating in the waiver are afforded deeming of income which waives resources and assets over the established poverty limit. The calculation of income and assets may impose a monthly spend down, the waiver beneficiary must incur prior to effective date of Medicaid.

Under the provision of the CAP waiver, if an adverse decision is made due to Medicaid eligibility reasons, a waiver beneficiary must grieve to the Medicaid eligibility department to allow the CAP services to continue as authorized. A waiver beneficiary must be fully authorized for Medicaid in the categories of Medicaid for the Blind(MAB) and Medicaid for the Disabled (MAD)-ABD, Medicaid for Children Receiving Adoption Assistance (I-AS), Medicaid for Children Receiving Foster Care Assistance (H-SF).

The State Medicaid Agency and case management entity are primarily responsible to educate the waiver beneficiary about their rights to appeal an adverse decision. When an adverse decision is reached, the case management entity will provide the waiver beneficiary a trackable adverse notice the decision to deny a requested service. This adverse notice will cite the reason(s) for the denial, provide policy citations and provide guidance on how to file an appeal to this adverse decision. The waiver beneficiary is given in instructions on how to file the appeal within the guidelines of DMA's State Plan. When an appeal is filed, the beneficiary is granted an option to mediate as the first attempt to come to an agreement between the requestor of service and DMA. If the adverse decision cannot be resolved in mediation, the waiver beneficiary is entitled to a hearing in front of Administrative Law Judge (ALJ). The waiver beneficiary or the initiator of the adverse decision must adhere to the final decision of the ALJ.

The CAP IT system will manage all adverse decisions to ensure accuracy of notice dates, appropriateness of maintenance of service and compliance to the final decision. The case management entity uploads the adverse notice in the State's data warehouse (Public Consulting Group). The Office of Administrative Hearing will monitor this data bank to initiate and follow through with all appeal requests.

When a referral is made for waiver participation under the consumer-directed option, the waiver beneficiary/responsible party is provided educational information about consumer-direction and their right to request a fair hearing when a choice of provider is denied. The Case management entity and FMS are responsible for explaining to the waiver beneficiary the reason that a selected provider will be denied. The CAP IT system and Case management entity are responsible for providing additional education to the waiver beneficiary/responsible party regarding the procedures once a request for a hearing is made. When the waiver beneficiary has met basic eligibility to participate in the waiver and consumer-direction, the CAP IT system is programmed to request copy of the signed and dated self-assessment questionnaire that describes consumer-direction and the agreed upon terms. Prior to the approval and initiation of waiver services, the CAP IT system validates the file as complete to ensure the self-assessment survey and a freedom of choice are exercised by the waiver beneficiary.

For direct hire staff, the waiver beneficiary will also be informed that if the requested provider met any one of the lifetime bans, employment could not be offered. The lifetime ban includes:

- Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
- Felony health care fraud;
- More than one felony conviction;
- Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
- Felony or misdemeanor patient abuse;
- Felony or misdemeanor involving cruelty or torture;
- Misdemeanor healthcare fraud;
- Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
- Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
- 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.

In addition to the above, the waiver beneficiary/responsible party also receives information about participant's rights that pertains to:

- All providers on the freedom of choice list have met specific DMA criteria for enrollment to provide the particular service;
- How to explore the possibility of a provider not listed, yet desired by the waiver beneficiary/ responsible party, to be enrolled with DMA;
- A statement to inform the waiver beneficiary/ responsible party that a provider, not currently enrolled with DMA would need to meet specific criteria to be enrolled with DMA, before the provider could be authorized to provide service and be reimbursed by Medicaid for services rendered;
- Information on how to contact the DMA consultant if problems are not resolved at the local level or by CAP IT system; and
- How to change agencies or lodge a complaint if unhappy about the care provided or the person rendering the care.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

- a. Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- No. This Appendix does not apply**
 Yes. The State operates an additional dispute resolution process

- b. Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

- a. Operation of Grievance/Complaint System.** *Select one:*

- No. This Appendix does not apply**
 Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver

- b. Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

NCDHHS

- c. Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The case management entity provides the waiver beneficiary training and orientation about the CAP program. This training and orientation provides definitions and explanations about grievances and complaints. The waiver beneficiary is given information about the appeal process. This information is also outlined in the Welcome Letter that is mailed to the waiver beneficiary initially and annually.

Constituents who contact their governmental representatives or any human service professional with complaints concerning this waiver are referred to the NCDHHS. When a complaint is received, Office of Citizen Services (OCS) staff serves as a liaison between the complainant and the DMA program specialist. NCDHHS staff ensure that complaints are thoroughly examined and investigated. Staff determines the most appropriate parties to contact and work with to resolve the situation. Feedback is provided to elected officials regarding constituents concerns. Ensuring that consumers have the proper channel for addressing concerns is key to this program. If a complaint is valid, steps are taken to rectify the situation. If the complaint is not valid, time is spent with the person to educate on the process and help them understand why the situation was handled in a certain manner. There is a three day timeline to address grievances and complaints.

The CAP IT system is also equipped to receive and manage complaints and grievances initiated by the waiver beneficiary or primary caregiver or other service providers. The case management entity has 3 days to address the complaint. The State Medicaid agency reviews the complaint and the resolution by the case management agency for quality assurance and improvement.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

Yes. The State operates a Critical Event or Incident Reporting and Management Process (complete Items b through e)

No. This Appendix does not apply (do not complete Items b through e)

If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

- b. State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Critical events constitute abuse, neglect and exploitation by anyone and any entity, organization or provider. The waiver beneficiary, caregivers, informal support system, hired personal assistant and other providers of waiver beneficiaries or responsible party are instructed on how to report to authorities any incidences of abuse, neglect or exploitation, if suspected. Protective Services are those services provided by the State, federally recognized Tribes, or other government or private organizations or individuals that are necessary to protect the disabled adult or child from abuse, neglect, or exploitation. Details on the State's Children Protective Services (CPS) are provided below.

Article 6, Chapter 108A of the North Carolina General Statutes requires that county departments of social services perform certain activities for disabled individuals alleged to be abused, neglected, or exploited and in need of protective services. In accordance with its authority under N.C.G.S. 143B-153, the North Carolina Social Services Commission has established rules and regulations for the provision of Protective Services for Children. Federally Recognized Tribes will perform protective services for children and adults in accordance with its authority under N.C.G.S. 143B-153. North Carolina General Statutes require that any director receiving a report that a child is in need of protective services shall make a prompt and thorough evaluation to determine whether the child is in need of protective services and what services are needed. The evaluation shall include a visit to the child and consultation with others having knowledge of the facts of the particular situation. A thorough evaluation of a protective service report, shall include identifying indicators of abuse, neglect, or exploitation and the child's strengths and limitations by assessing physical health, mental health, social support, activities of daily living, and instrumental activities of daily living, financial support, and physical environment. (G.S. 108A-103) (10 NCAC 42V .0205, .0206, .0208)

The types of events that warrant notification to State Medicaid agency is reports of abuse, neglect and exploitation that are referred to the local Children Protective Services entities.

There are specific requirements for notifying the District Attorney DMA, and other governmental agencies in the county or catchment area where the adult or child is located, during and upon completion of an evaluation. (G.S. 108A-109) (10 NCAC 42V .0503, .0901)

North Carolina has a mandatory reporting law. County departments of social services and any federally recognized Tribes must accept all reports alleging an abused, neglected, or exploited children who is in need of protective services. This includes anonymous reports.

Any person having reasonable cause to believe that a child is in need of protective services, shall report such information to the director of the county department of social services or federally recognized Tribes, or his representatives, where the disabled child

resides or is present. The report may be made orally or in writing. The report shall include the name and address of the child; the name and address of the child's caretaker; the age of the child; the nature and extent of the child's injury or condition resulting from abuse or neglect; and other pertinent information.

North Carolina conducts a comprehensive functional assessment (evaluation), to determine whether there is a need for protective services in situations where it is alleged that a child has been abused, neglected, or exploited.

To protect the health and welfare of each approved waiver beneficiary, the State Medicaid Agency, on an ongoing basis, identifies addresses and seeks to prevent the occurrence of abuse, neglect and exploitation. In assuring the health, safety and well-being of each waiver beneficiary, the case management entity, shall address remediation efforts that mitigate the waiver beneficiary's health and welfare when a critical incident occurs. A critical incident report shall be completed each time a waiver beneficiary has been involved in a critical incident that jeopardizes his or her health, safety and well-being.

Upon knowledge of the critical incident, a report must be completed within 3 business days. Each case management entity is provided a copy of the critical incident report developed by the State Medicaid agency. The CAP IT system will track receipt of all critical incident reports to ensure timeline is adhered. The CAP IT system will also provide follow-up alerts to the case management entity to ensure the identified waiver beneficiary is receiving the necessary services as identified through the recommendation of the incident report.

The types of critical incidences that must be reported include: death, missing person, use of restraints or seclusions, thefts, injury, abuse, neglect and exploitation, hospital admission, ER visits, concerns of health, safety and wellbeing, and medication error. Incidences of abuse, neglect and exploitation must be carefully followed to ensure services are adequately met to keep the waiver beneficiary safe in the community. Level of reporting is managed by two incident levels: Level I and Level II. Level I incidences must be reported within 3 business days in the CAP IT system. These incidences include, hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered. Level II incidences must be reported within 1 business days to DMA. These incidences include, CPS 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 in injury or hospitalization, wandering away from home, homicide/suicide and media related events.

The critical incident report has fields that identify the waiver beneficiary demographic information, description of the incident, response, action taken/prevention/disposition, notification/reported to other authority, recommendation by the case manager or care advisor of how to mitigate future incidences and the recommendation by the State against the data report and action taken. Each case management entity is provided annual training in critical incident reporting approved by the State Medicaid agency. The case management entity is responsible to education and inform waiver beneficiaries/responsible parties and service providers on types of critical incidences, how to make a report, and the timeframe to make a report. The case management entity must provide training and education initially, quarterly, annually and as needed to all waiver beneficiary. For incidences of abuse, neglect and exploitation, the State has prescribed guideline to react to a report and create an action plan.

To assure the health, safety and well-being of waiver beneficiaries, the goal is to report a critical incident immediately when it happens. However, for incidences that the case management entities are not immediately aware, upon of the knowledge of or discovery of the incident, the case management entity is expected to file a report and follow through to assure the health, safety and well-being of the waiver beneficiary. The report must be submitted through the CAP IT system within 1-3-business day. When the case management entity is notified of an incident, notification or report to other providers or entities must occur within 3 business days of the reported incident.

There is not a requirement for a department of social services or federally recognized Tribes to share specific findings of a Child Protective Service evaluation with an agency operating a waiver. Specific findings of a child protective service evaluation, shall be kept confidential and shall not be released without consent of by a parent of a child or legally appointed guardian or court order. (10 NCAC 42V .0803). Information about a child may be shared with other persons or agencies without the parent's consent to the extent necessary to provide protective services (10NCAC 42V .0803). A memorandum of agreement has been implemented between Division of Aging and Adult Services and Division of Medical Assistance (Waiver Administrator) to share "need to know information:" to ensure the appropriate planning of all waiver beneficiary. Through this memorandum of agreement, the case manager /care advisor and the CPS workers have an agreement to consult with one another about the facts of a particular situation for appropriate care planning and referrals.

Decline in mental or physical health or loss of informal support that would affect the ability of the waiver beneficiary to self-direct are consider a critical events. If this occurs, care advisors will reassess the waiver beneficiary's situation to determine whether the consumer-directed option continues to be appropriate for the individual. Personal Assistants and other direct care workers who are in touch with the waiver beneficiary on a daily or regular basis are instructed to report problems in these areas to the care advisor.

Natural disasters such as hurricanes are considered critical events. Every locality/county must have a disaster plan in place and shelters available that can provide care for individuals and families, including those with special needs, who must evacuate their homes. The waiver beneficiary must have an emergency plan included in his or her record.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or

families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Initially and annually, each waiver beneficiary is provided information about abuse, neglect and exploitation and how to make a report when concerns arise. The service request form generally addresses potential abuse to ensure comprehensive assessment of the waiver beneficiary. The interdisciplinary assessment captures information about informal support systems and their burden of care giving that identifies potential risk factors for abuse, neglect and exploitation. Additional information is provided when requested or when the case manager and care advisor have concerns of abuse, neglect and exploitation.

Prior to waiver approval and after approval, each waiver beneficiary is provided an introductory and Welcome Letter. The contents within the letters address ANE: "As a condition for participating in this waiver, your case manager must plan for your health, safety and well-being. He or she must ensure that the beneficiary is safe at all times and that they are not abused, neglected or exploited. The case manager or care advisor will talk with the waiver beneficiary monthly and make a home visit with them every 90 days to monitor their care needs, to ensure services are provided as planned, and to ensure that their health, safety and well-being are intact. If the beneficiary thinks that he or she is not safe or have any concerns about abuse, neglect or exploitation, he or she may call the local Department of Social Services or federally recognized Tribes for assistance with Child Protective Services. The waiver beneficiary can also call his other case manager or care advisor." The waiver beneficiary is also provided handouts about ANE. Each case manager or care advisor is required to have annual mandatory training that includes abuse, neglect and exploitation and how to complete, assess, report and mitigate critical incidences of waiver beneficiary. The State will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation. In addition, providers are required to provide on-going training to direct service staff in how to recognize abuse, neglect and exploitation, and where to go for help. During the review of beneficiary's rights and responsibilities, the CAP IT system, case manager and care advisors educate and provide information to beneficiary, families and legal representatives. The waiver beneficiary signs a form indicating that they have received information about incident reporting. A criminal background check is performed on all personal care assistants under consumer-direction as an addition safety precaution.

Each waiver beneficiary is required to enroll in PCCM by selecting the PCP of their choice. This enrollment ensures placement in a health home for care management of medical conditions to promote the reduction in hospitalization and utilization cost. Upon enrollment in health home, the Community Care of North Carolina (CCNC) will provide care coordination to individuals who fall in the category of most impactful. These individuals have preventable utilization markers.

- d. Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

A critical event is any incident that puts or have put a waiver beneficiary at risk of harm, which jeopardizes health, safety and well-being. When a waiver beneficiary experiences any one of the following, the case management entity must complete a critical incident report: deaths; thefts; injuries; abuse, neglect or exploitation; admit to a facility; health, safety and well-being; medication errors; Missing person; Restraints or seclusion; other, specified by the incident. Diagnoses, symptoms, family dynamics, psych-economic factors that pose a significant risk to health, safety, and well-being of each waiver beneficiary are identified as part of the intake and assessment process. These items are entered into the CAP IT system's assessment module. The CAP IT system has the capacity to compare identified risk factors with elements of the plan to ensure risks are adequately addressed for all waiver beneficiaries. Each risk identified by the assessment process must be addressed in the individual's service plan or through an individual risk agreement. As a safeguard to ensure the health/well-being of all waiver beneficiaries, a comprehensive needs assessment is conducted initially, annually and when the condition changes. This assessment identifies needs/potential risk factors. Health risk/safety considerations are assessed, and interventions are identified that promote health, independence and safety with the informed involvement of the beneficiary/responsible party. The CME ensures that services/supports are included in the SP to address risk/safety issues identified in the assessment. Case managers monitor specific triggers in the assessment that must have corresponding service plan inclusions. When specific risk triggers are identified during the assessment, both informal/formal services are identified to mitigate risk and promote safety of the waiver beneficiary. If informal/formal services are not able to adequately address the identified risks factors, the waiver beneficiary is given the opportunity to enter into an informed agreement to assume responsibility of risk. This agreement is executed through an individualized risk agreement. When health, safety and well-being issues are identified, a waiver beneficiary/responsible party has the discretion to enter into an Individual Risk Agreement (IRA). This agreement outlines the risks and benefits to the waiver beneficiary of a particular course of action that might involve risk to the waiver beneficiary, the conditions under which the waiver beneficiary/responsible party assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement permits individuals to assume responsibility for their choices personally, through surrogate decision makers, or through planning team consensus.

The CAP IT system provides the State Medicaid agency and the case management entity, data reports to inform where risk is more inherent and evaluate if these risks are addressed adequately on at least a monthly basis. Assessments are completed at intake, during continued need reviews, or as needed, when the health of the waiver beneficiary changes. Every time the assessment is completed, a plan of care is completed or amended based upon the most current assessment. The CAP IT system generates reports of service plans to address risk factors identified in the assessment. These reports are provided to the case management entity for continuous care planning as well as for the initiation of a revision to the service plan, when needed. The interventions as set forth in the service plan is designed to minimize risk. These interventions are assessed during site reviews to ensure needs are safely met. When an event or issue is observed by or reported to a waiver provider, the provider has the responsibility to notify the local case management entity, and if applicable, other agencies (CPS, the State Medicaid Agency or law enforcement). When an event or issue is identified by or reported to the local case management entity, an incident report is completed. The report is designed to

document: who the report is from; the type of event or issue; the date and time of the event or issue, if applicable; the location of the incident (waiver beneficiary's home, etc.); details of the event; involved parties; the source of the information; individuals who have first-hand knowledge of the event; whether the attending physician was notified; and the name, address and phone number of the physician and any other agencies or individuals that were also notified. The specific nature of an event or issue will determine if notification of others is warranted, e.g., CPS, the State Medicaid Agency, law enforcement, federally recognized Tribes and etc. The waiver participant must be notified of the recommendation of the investigations within 30-days of the incident. Any contact made with other agencies or individuals will be kept confidential. The local case management entity will develop a plan of resolution. All plans developed to resolve identified problems are thoroughly evaluated by case management entity's managers to ensure that they are appropriate, will result in a resolution, which is made available to the waiver beneficiary and/or his or her legal guardian. Reports of neglect, abuse and exploitation are reported to the local DSS or federally recognized Tribes to the Children Protective Services Department. Reports pertaining to inappropriate care by the In-Home Aide Agency, the assigned CNA or personal care aide are reported to the Division of Health Services Regulations to the Home Care compliant section and Health Care Personnel Registry Reports that pertain to skilled nursing care are reported to the Board of Nursing. Reports pertaining to mismanagement of services or misappropriation of Medicaid dollars are reported to Medicaid Program Integrity Section. Child Protective Services within a Department of Social Service/federally recognized Tribes section is responsible for evaluating all cases of abuse, neglect and exploitation. The Child Protective Services unit has a prescribed timeframe of 24, 48 and 72 hours to investigate a case. The waiver beneficiary is provided a disposition of the case within 30-days of the initial home visit. The CPS unit has specific guidelines of evaluating a case to determine if a waiver beneficiary is at risk and needs protection. The assigned Child Protective Service Worker evaluates the waiver beneficiary cognitive skills to determine capacity to make decision and the need for supportive care. If waiver beneficiary is deemed not to be able to make appropriate cognitive decision, CPS will provide an order of protection. The case management entity is responsible for evaluating all other reports, other than law enforcement matters. An evaluation of the report is made against the clinical coverage policy to ensure appropriateness of the waiver performances. The case management entity is at liberty to seek guidance from the State Medicaid agency and the local DSSs when needed.

- e. Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

An incident and death committee meets quarterly to track and trend level II incidences. The committee will review summary of care history, age and gender of the beneficiary, date of enrollment in the program, the significant diagnosis, beneficiary's extent of formal and informal supports, summary of events, contributing factors, beneficiary's enrollment/action surrounding the event, immediate action taken, beneficiary status, identification of risk points and their potential contribution to the event. An analysis of the following will be assessed to trend occurrences for quality improvement:

- Human factor (staffing levels, knowledge, training and competency)
- Prior addressed risk factors
- Equipment-related factors (maintenance)
- Environmental factors (lighting, noise, clutter)
- communication factors (training and adequate tools).

The CAP IT system is designed to evaluate all waiver beneficiaries/provider agencies in the processing/performance of waiver activities. To validate the efficiency/capacity of the CAP IT system, the sampling methodology will be a 100% for waiver year one. Upon approval of a LOC, information is provided about ANE through an Introductory or Annual Letter. This information is also provided during the waiver screening process and the home assessment process. The information included: "As a condition to participate in this waiver, your case manager must plan for your health, safety and well-being. He or she must ensure that you are safe at all times. The CM will talk with you monthly and make a HV with you at least every 90 days to monitor your care needs, to ensure services are provided as planned, and to ensure that your health, safety and well-being are intact. If you think that you are not safe or have any concerns about ANE you can call your local DSS/federally recognized Tribes for assistance with Child Protective Services or you can also call your case manager or care advisor." Parents/responsibility parties of waiver beneficiaries under the age of 18 are informed that per federal regulation, any signs/indication of ANE, the CME is obligated to make a report to the DSS/federally recognized Tribes.

The CAP IT system provides incident and complaint reporting for use by the CME and the State Medicaid Agency. This information can be analyzed through reports on the timeliness of incident reporting. The IT system has the capacity to document responses and follow-up to any complaint or incident entered into the IT system. The State Medicaid Agency has a collaborative working relationship with DAAS. DMA and DAAS will use the quarterly meeting to discuss and implement work plans for tracking of CI reviews/investigations to obtain individual level data on the status/disposition of the CI report.

The CAP IT system will document and classify all incidents that result in CPS referral.

The CAP IT system can document when Critical incidents and CPS referrals were confirmed.

The IT system allows State Medicaid Agency to review a service plan in order to evaluate if the emergency plan is adequate.

The State has an interagency agreement with the Division of Aging and Adults Services-DAAS to provide quarterly data queries of waiver beneficiary reported to be abused, neglected or exploited. The data query provides the date of the report, the alleged perpetrator, and the disposition of the case, confirmed or substantiated. The report is compiled by county, the waiver program, type of report, disposition decision, and the number of reports received on a given waiver beneficiary. The local DSS trains the CPS workers on how to capture and complete the needed information on the report. A planning meeting is scheduled quarterly with the State Medicaid Agency staff and the DAAS staff to review and analyze the data query to identify trends and implement strategies to mitigate future occurrences. The State has trained each case management entity on how to detect and accept critical incident reports (CIR). Upon the knowledge of an incident, each case management entity is required to submit a Critical incident report

(CIR) via the CAP IT system within 1-3 days. The CAP IT system will compile all critical incident reports to ensure accuracy of policy compliance and that the CME did follow-up. Each incident is placed in a data query to track the frequency of each incident to identify trends. The data query generated by the CAP IT system is reviewed by the State Medicaid Agency on a quarterly basis and compared against the data query generated by DAAS. These two reports are used to identify trends and strategies to mitigate future occurrences.

To assure oversight of the incident reporting system, the State Medicaid Agency collaborates with the DAAS. An ANE planning meeting is scheduled quarterly to track and trend all CPS critical incidents. This meeting is two-prong: 1. Review of critical incidents and disposition for all waiver beneficiaries; and 2. Identify statewide strategies to meet the needs of individuals receiving home and community-based services.

The critical incident management system provides the State Medicaid Agency with safeguards to manage the health and welfare of all waiver beneficiaries. The CAP IT system is instrumental to assist the State Medicaid Agency with the following items:

- Document and classify all incidents that result in an APS/CPS referral.
 - Provide incident and compliant reporting for use by the case management entity.
- Real-time data analytic to track immediately all reports entered in the CAP IT system to assure appropriateness of service intervention as well as the State Medicaid Agency to track compliance to policy
- Ability to automatically generate a service plan recommendation to include proposed hours, schedule and skilled level.
 - Identifies and documents all mortalities that result from a critical incident/CPS event.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

- a. Use of Restraints.** *(Select one): (For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

The State does not permit or prohibits the use of restraints

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

Waiver services does not permit the use of unnecessary or unauthorized restraints, including personal restraints and drugs used. This waiver complies with the definition of restraint as stated in the June 22, 2007 memo to State Survey Agency Directors, Ref S&C-07-22, and re: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Refer to: <http://www.cms.gov/surveycertificationgeninfo/downloads/SCletter07-22.pdf> Restraints may be used when determined necessary such as to prevent an infant or small child from inadvertently dislodging a feeding tube, tracheostomy tube during the normal movement throughout the day.

If the case management entity determines that use of the unnecessary or unauthorized restraints are being used on a waiver beneficiary, law enforcement and child protective services will be contacted immediately to report the event. Any known or observed use of restraints is referred to CPS, federally recognized Tribes and DHSR to investigate and report on findings. The State Medicaid Agency is responsible for monitoring investigative reports and findings to ensure the health, safety and well-being of the waiver beneficiary.

Also, if a waiver provider or CAP Program consultant observes or learns that unnecessary or authorized restraints are being used, an incident report must be completed with the date of discovery and submitted to the State Medicaid Agency on same date. The State Medicaid Agency will initiate referrals and investigatory steps within 2-days of notification.

The use of unnecessary/unauthorized restraints or seclusion on the waiver beneficiary indicates a need to reassess or complete a root cause analysis of the incident to allow review of the waiver beneficiary's current medical and functional needs, caregiver's ability and stress level to determine appropriateness of CAP services (safety and well-being, ability to self-direct). The findings of the root cause analysis will inform the need for a plan revision, risk agreement or additional support to the child and family.

The use of restraints is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii.

- i. Safeguards Concerning the Use of Restraints.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one):*

The State does not permit or prohibits the use of restrictive interventions

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

If a waiver provider or CAP Program consultant observes or learns that unnecessary and authorized restrictive interventions are being used, an incident report must be completed within 3 days of discovery.

This waiver program does not permit the use of unnecessary and authorized restrictive interventions that restrict waiver beneficiary movement; waiver beneficiary access to other individuals, locations, or activities; restrict waiver beneficiary rights; or that employ aversive methods to modify behavior, unless provided for a waiver beneficiary for whom it is not used as a restraint, but for safety - such as bed rails, Gerri chair, lift chair, safety straps on wheelchairs.

If the State Medicaid Agency determines unauthorized use of restrictive interventions or the use of the restrictive interventions is out of compliance with the service plan and physician's orders (bed rails, Gerri chairs, lift chairs, or safety straps on wheelchairs as a safety precaution), the appropriate law enforcement and children protective services be will contacted on the day of discovery to report the event. Unauthorized use of restrictive interventions is referred to law enforcement and CPS/federally recognized Tribes for investigation. The State Medicaid Agency is responsible for monitoring investigations and findings to ensure the health, safety and well-being of the waiver beneficiary.

The use of unauthorized restrictive interventions on the beneficiary indicates a need to reassess or complete a root cause analysis of the incident to allow review of the waiver beneficiary's current medical and functional needs, caregiver's ability and stress level to determine appropriateness of CAP services (safety and well-being, ability to self-direct). The findings of the root cause analysis will inform the need for a plan revision, risk agreement or additional support to the child and family. The report will identify the beneficiary's needs, caregiver's ability and stress level to determine appropriateness for CAP services (safety and well-being, ability to self-direct).

When a waiver provider or CAP Program consultant observes or learns restrictive interventions are being used, an incident report must be completed on the date of discovery and submitted to the State Medicaid Agency on the same date. The State Medicaid Agency will initiate referrals and investigatory steps within 2-days of notification.

The use of restrictive interventions is permitted during the course of the delivery of waiver services Complete Items G-2-b-i and G-2-b-ii.

- i. Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one): (This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

The State does not permit or prohibits the use of seclusion

Specify the State agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State of North Carolina does not permit the use of seclusions including personal restraints and drugs for any waiver beneficiary. All waiver services and regular State Plan services must be provided in accordance with all requirements specified in this waiver and the State's governing clinical coverage policy; all applicable federal and state laws, rules, and regulations; the current standards of practice; and provider agency policies and procedures. Each case management entity must have a policy on seclusion that complies with the definition of seclusion as stated in the June 22, 2007 memo to State Survey Agency Directors, Ref S&C-07-22, and re: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Refer to: <http://www.cms.gov/surveycertificationgeninfo/downloads/SCletter07-22.pdf>

When evidence is received that unauthorized use of seclusion is out of compliance with the service plan, a critical incident report must be completed by the case management entity on the date of discovery. The case management entity must notify the appropriate law enforcement and child protective services to report the occurrence. The State Medicaid Agency will follow-up within 2-days of notification to ensure incident is correctly mitigated.

- The use of seclusion is permitted during the course of the delivery of waiver services.** Complete Items G-2-c-i and G-2-c-ii.

- i. Safeguards Concerning the Use of Seclusion.** Specify the safeguards that the State has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- ii. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

- a. Applicability.** Select one:

- No. This Appendix is not applicable** (do not complete the remaining items)
 Yes. This Appendix applies (complete the remaining items)

- b. Medication Management and Follow-Up**

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

- c. Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

- i. Provider Administration of Medications.** Select one:

- Not applicable.** *(do not complete the remaining items)*
- Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

- iii. Medication Error Reporting.** *Select one of the following:*

- Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
Complete the following three items:

(a) Specify State agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record*:

(c) Specify the types of medication errors that providers must *report* to the State:

- Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

Specify the types of medication errors that providers are required to record:

- iv. State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the State's quality improvement strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.
(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")

i. Sub-Assurances:

- a. Sub-assurance:** *The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death. (Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number/percent of waiver beneficiaries who were screened for ANE where an appropriate action plan was implemented to address risk factors within 45 days of the report. Numerator: number of waiver beneficiaries who were screened for ANE where an appropriate action plan was implemented to address risk factors within 45 days **Denominator:** number of waiver beneficiaries screened for ANE

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and APS and CPS data reports.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor and APS and CPS data reports	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver beneficiaries who received an introductory/annual letter that provided information and education on abuse, neglect and exploitation, and how to report a concern of ANE. Numerator: number of waiver beneficiaries who received an introductory/annual letter that provided information and education about ANE Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management and case management entities' case files.

Responsible Party for data collection/generation <i>(check each that applies):</i>	Frequency of data collection/generation <i>(check each that applies):</i>	Sampling Approach <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor and case management entities' case files	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="text"/>	
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of death incident reports for unexplained deaths that had a root-cause analysis narrative summation. Numerator: number of death incident reports for unexplained deaths that had a root-cause analysis narrative Denominator: number of waiver beneficiaries with a death report

Data Source (Select one):

Mortality reviews

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management, case management entities' case files and DMA's MMIS.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor, case management entities' case files and DMA's MMIS	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

b. **Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of Level II Critical Incident Reports that had a follow-up resolution approved by the State Medicaid agency within 15 days of the initial incident date. Numerator: number of Level II critical incident reports that had a follow-up resolution approved within 15 days of the incident date Denominator: number of Level II critical incident reports

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system, case management entities' file and APS and CPS data.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor, case management entities' file and APS and CPS data	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other	

	Specify:	
	<input style="width: 100%;" type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>

Performance Measure:

Number and percent of Level I and II Critical Incident Reports submitted by the specified timeframe. Numerator: number of case management entities that submitted Level I and II critical incident reports by the specified timeframe Denominator: number of Level I and II Critical Incident Reports

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system, case management entities' file and APS and CPS data.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input style="width: 100%;" type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor, case management entities' file and APS and CPS data	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input style="width: 100%;" type="text"/>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of Level I and II Critical Incident Reports that had a follow-up safety action plan, when indicated, within 15 days of the initial incident. Numerator: number of Level I and II critical incident reports that had a follow-up safety action plan, when indicated, within specified timeframe Denominator: number of Level I and II critical incident reports

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system, case management entities' file and APS and CPS data.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor, case management entities' file and APS and CPS data	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify:	

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Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input style="width: 100%; height: 20px;" type="text"/>

- c. *Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number/percent of providers with an approved policy by DMA prohibiting unnecessary/unauthorized restrictive interventions (restraints, seclusions) for waiver beneficiaries. Numerator: number of providers with an approved policy by the DMA prohibiting unnecessary/unauthorized restrictive interventions (restraints, seclusions) for waiver beneficiaries. Denominator: number of providers

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and case management entities' file.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: IT contractor and case management entities' file	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

Performance Measure:

Number/percent of beneficiaries with a Level III CIS for unnecessary/unauthorized restraints/restrictions that were mitigated in the required timeframe. N:# of beneficiaries with a Level II CIS for unnecessary/unauthorized restraints/restrictions that were mitigated in the required timeframe. D: #of waiver beneficiaries with a Level II CIS for unnecessary/unauthorized restraints/ restrictions

Data Source (Select one):

Critical events and incident reports

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system, case management entities' file and APS and CPS data.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: IT Contractor, case management entities' file and APS and CPS data	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: [Dropdown]
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: [Dropdown]
	<input type="checkbox"/> Other Specify: [Dropdown]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: [Dropdown]	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: [Dropdown]

- d. *Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver beneficiaries who completed recommended annual preventative/wellness appointments. Numerator: number of waiver beneficiaries who completed recommended annual preventative/wellness appointments Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system, case management entities' file and Provider Portal network data system

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor, case management entities' file and Provider Portal network data system	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver beneficiaries who were assigned and connected to a medical health home(PCP). Numerator: number of waiver beneficiaries who were assigned and connected to a medical health home(PCP) Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and DMA's MMIS.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor and DMA's MMIS	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver beneficiaries who had a scheduled visit with their primary care provider on at least an annual basis. Numerator: number of waiver beneficiaries who had a scheduled visit with their primary care provider on at least an annual basis Denominator: number of waiver beneficiaries

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system, case management entities' file and provider portal informatics.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor, case management entities' file and provider portal informatics	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver beneficiaries who report overall health and well-being was adequately assessed and planned for in their person-centered service plan. Numerator: number of waiver beneficiaries who report overall health and well-being was adequately assessed and planned for in their person-centered service plan. Denominator: number of waiver beneficiaries responding to the survey

Data Source (Select one):

Reports to State Medicaid Agency on delegated

If 'Other' is selected, specify:

The source of these reports are from the CAP IT case management system and DMA's file and experience survey respondents.

Responsible Party for data collection/generation(<i>check each that applies</i>):	Frequency of data collection/generation(<i>check each that applies</i>):	Sampling Approach(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor and DMA's file and experience survey respondents	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (<i>check each that applies</i>):	Frequency of data aggregation and analysis(<i>check each that applies</i>):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The CAP IT system is designed to collect data and generate reports all waiver beneficiaries and provider agencies in the processing and performance of waiver activities. To validate the efficiency and capacity of the CAP IT system, the sampling methodology will be a 100% for waiver year one. As a safeguard to ensure the health and well-being of all waiver beneficiaries, a comprehensive needs assessment is conducted initially, annually and when the condition changes. This assessment identifies needs and potential risk factors. Health risk and safety considerations are assessed, and interventions

are identified that promote health, independence and safety with the informed involvement of the beneficiary/responsible party. The CME ensures that services and supports are included in the service plan to address risk and safety issues identified in the assessment. Case managers monitor specific triggers in the assessment that must have corresponding service plan inclusions. When specific risk triggers are identified during the assessment, both informal and formal services are identified to mitigate risk and promote safety of the waiver beneficiary.

Initially and annually, the waiver beneficiary is provided information about ANE through an Introductory or Annual Letter. This information is also provided during the waiver screening process and the home assessment process. The information includes a statement of: "As a condition to participate in this waiver, your case manager must plan for your health, safety and well-being. He or she must ensure that you are safe at all times. The CM will talk with you on a monthly basis and make a HV with you at least every 90 days to monitor your care needs, to ensure services are provided as planned, and to ensure that your health, safety and well-being are intact. If you think that you are not safe or have any concerns about ANE you can call your local DSS/federally recognized Tribes for assistance with Adult/Child Protective Services or you can also call your case manager or care advisor." Parents/responsible parties of waiver beneficiaries under the age of 18 are informed that per federal regulation, any signs/indication of ANE, the CME is obligated to make a report to the DSS/federally recognized Tribes.

The case management entity must maintain monthly contact by phone or in person with the waiver beneficiary, and also required to conduct a face-to-face visit with the waiver beneficiary on a quarterly basis or more frequently based on the risk factors identified in the assessment. The case management entity must hold a multidisciplinary team meeting to address all needs to ensure health, safety and well-being.

The case management entity is provided a monthly risk indicator summary to review and discuss with the waiver beneficiary and other providers.

On a routine basis, the case management entity must review and evaluate service provision through the review of paid claims and time and record documentation as well as observe a formal service being provided to the waiver beneficiary in the setting the service is approved.

The CAP IT system allows State Medicaid Agency to review a service plan in order to evaluate if the emergency plan is adequate based on risk factors as a result changes in needs and risk factor due to incidences. This review is completed on a quarterly basis.

b. Methods for Remediation/Fixing Individual Problems

- i.** Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

The system design allows for quick remediation when noncompliant areas are discovered. Real-time data reports of programmed performance measures and the ability to run ad-hoc reports external to programmed performance measures allows the State Medicaid Agency to evaluate the effectiveness of its system and promote continuous quality improvement measures. Data analysis from the CAP IT system assists with the monitoring of health and welfare of all waiver beneficiaries. This analysis allows the case manager to ensure that the service plan is kept current and updated on a continuous basis with the waiver beneficiary's changing needs. When the case manager discovers a waiver beneficiary is at risk, the potential risk must be addressed immediately or within 72 hours. This may include calling a team meeting to address the issue, getting medical advice for the waiver beneficiary, or seeing that the waiver beneficiary is removed from imminent danger, risk or an unsafe environment. If the case manager or care advisor discovers that the waiver beneficiary has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must staff this with the team to implement a comprehensive safety plan. If it is found that the critical incident was not reported to CPS, the case manager or care advisor must immediately submit a report to CPS. If it is found that the critical incident was not reported timely, technical assistance will be provided by the State Medicaid Agency; the Case management entity must submit a corrective action plan to reduce future occurrences of untimely critical incident reports to CPS.

Upon discovery of non-compliance of ensuring the health and well-being of a waiver beneficiary through regular monitoring and planning, the State Medicaid Agency notifies the responsible Case management entity and assist in structuring a monitoring schedule and areas to monitor. The Case management entity must develop a corrective action plan within 3 days of notification to submit to the State Medicaid Agency. The Medicaid Agency reviews the corrective action plan, makes a final decision and issues directives for the Case management entity to follow. The corrective action plan is monitored and progress or concerns are tracked and discussed with the case management entity monthly. Repeated findings of non-compliance by a Case management entity will result in termination of new enrollment until successful completion of the corrective action plan. The State Medicaid Agency will provide staff training and technical guidance to ensure success. If corrective action plan is not remediated within 90 days, a recommendation may be made to terminate provider enrollment status as case management entity.

If the case manager or care advisor discovers the waiver beneficiary has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must address this with the team to implement a root cause analysis of multiple incidents.

Upon discovery of non-compliance of the CAP IT contractor, a corrective action plan is developed to remediate the noncompliance with a completion date within 3 business days. Repeated findings of non-compliance by a CAP IT contractor results in fines and penalties. If the errors cannot be remediated, the contract will be terminated.

- ii. Remediation Data Aggregation**

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Health and Welfare that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Health and Welfare, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver’s critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state’s waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State Medicaid Agency has developed a quality management plan that integrates, analyzes and responds to information from multiple sources across functions within the State's system. The plan also involves partners and stakeholders including waiver beneficiary/primary caregiver, case management entities and provider agencies, as well as representatives from various State agencies. The overall purpose of the Quality Improvement Strategy (QIS) for this waiver is to design, develop, implement, and manage a Quality Assessment and Quality Improvement Program that ensures that the State Medicaid Agency meets the Centers for Medicare and Medicaid Services' six (6) waiver assurances. This waiver quality framework is supported by a Web-based software application referred to as e-CAP. This CAP IT system supports the operation of the CAP program. The CAP IT system provides the means by which the waiver can be organized, tracked and made more effective.

The State Medicaid Agency reviews the data that is entered in the waiver IT system daily through case analysis and approval decisions. Each uploaded document is reviewed to assure accuracy and completeness. The information in the assessment is validated against other IT systems such as NCTracks and the Provider Portal system. Real-time data analytic is used to track immediately all reports entered in the CAP IT system to ensure appropriateness of service intervention as well as the State Medicaid Agency to track compliance to policy. Quarterly data queries are collected to review trends in incidences, timelines and utilization. From those reports, the State Medicaid agency identifies a quality improvement focus for the quarter. The case management entities are informed of the quality improvement focus and are provide training, technical guidance throughout the focus period. A pre and post review of the case management compliance rate is performed to measure progress and effectiveness. The case management entities access a score based on their performance in all areas of quality framework.

The overall purpose of the Quality Improvement Strategy (QIS) for this HCBS waiver is to assure the health, safety and well-being of waiver beneficiaries through a well-designed system that allows for ease of discovery and quick remediation to full compliance. The State Medicaid Agency's QIS is designed to produce monthly, quarterly, annual and ad-hoc reports to provide assurances for the following items:

1. The six (6) waiver assurances and it associated performance measure are adhered on a daily basis.
2. The discovery of non-compliance areas are quickly remediated and the results yield improvement in the system design and future waiver services and performance measures.
3. Participant-centered outcomes related to:
 - a. Waiver beneficiary access;
 - b. Participant-centered services planning and delivery;
 - c. Provider capacities and capabilities;
 - d. Waiver beneficiary safeguards;
 - e. Waiver beneficiary rights and responsibilities;
 - f. Waiver beneficiary outcomes and satisfaction; and
 - g. System performance.

Program design sets the stage for achieving the desired outcomes for waiver beneficiaries. Design features include:

- a. Identifying indicators and standards against which performance is measured;
- b. Developing an approach to collect, synthesize, and share performance information; and
- c. Developing a cohesive work plan that directs time, effort, and resources into the process.

The quality improvement system captures and assesses data in three areas to ensure each individual waiver beneficiary

receives quality health care that is delivered cost effectively and in the appropriate setting:

1. Level of Care: Are enrollees categorized properly, and can this be compared across case management entities?
2. Cost: Are we staying within the cost limits, both at the individual level and at the county and state levels?
3. Quality: Are there opportunities for systems improvement? Are there variations between counties that can help us identify ways to more effectively provide services? Are there individuals who need immediate attention? Are the six waiver assurances being adequately monitored and met?

The CAP IT system refines waiver processes in order to consistently and accurately assess waiver beneficiary’s needs, determine waiver beneficiary’s eligibility, authorize service provision, make provider referrals, ensure waiver beneficiary’s due process and support HCBS level of care prior approval for waiver participation.

The CAP IT system refines the provider-based services planning process to ensure: 1) HCBS waiver assessments are the basis for services planning; 2) service plans can be reviewed by the waiver administrative authority entity quickly and effectively; 3) service plans are reflective of CMS guidelines for family/person-centered planning and the waiver beneficiary’s assessment; and 4) service plan data can be used for DMA utilization management reviews.

The CAP IT system refines the quality assurance reporting process to ensure all core quality measures are consistent and time-bound to DMA's IT system implements a continuous quality improvement process that encompasses direct service providers, case managers and DMA in concert with the beneficiaries and their informal caregivers or representatives.

The CAP IT system improves waiver beneficiary monitoring functionality to include outcomes definition and tracking.

The CAP IT system retools the day-to-day waiver administration and oversight as one integrated process to include: participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved limits; level of care evaluation; review of waiver beneficiary service plans; prior authorization of waiver services; utilization management; and quality assurance and quality improvement activities.

Discovery Sources and Data Sources

Waiver data and direct waiver beneficiary’s experiences are collected to assess the ongoing implementation of the program and identify strengths and opportunities for improvement. Discovery methods must ensure that staff, processes, data systems, and reporting mechanisms are working as intended to meet minimum standards and desired outcomes. Waiver draws from several data sources to monitor performance, including:

1. The web-based case management and business process tool
2. On-site audits and reviews;
3. Desktop audits and reviews
4. The Medicaid Fiscal Contractor
5. NC Division of Health Services Regulation for licensure/certification records; and
6. DMA Program Integrity Unit for audits, reviews, and investigations.
7. Experience Surveys
8. Stakeholder's input

Remediation

Remediation is the actions taken to remedy specific problems or concerns that arise. As a first step, identified areas of weak performance are brought up to minimum standards through an understanding of the problem. Subsequently, correction or remedial action should be taken to correct the root causes of the problem to improve performance in the weak area to prevent similar problems in the future.

The CAP IT system is designed to evaluate all waiver beneficiaries, provider agencies, contracted vendors in the processes and performance of waiver activities. To validate the efficiency and capacity of the each of entities that collaborate with this waiver program, the CAP IT system performs a 100% quality assurance of all waiver processes. Algorithms are programmed in the CAP IT system to provide tracking and monitoring of the six waiver assurances and its associated performance measures to identify trends and non-complaint areas which allows for system improvement. Routine reports are generated through the CAP IT system for quarterly monitoring and tracking by the State Medicaid office. Because the CAP IT system is real-time, ad-hoc may be generated at any time to evaluate any areas within the quality improvement system to determine compliance or utilization.

Continuous Improvement

The Waiver Quality Management Strategy determines how improvements in skill levels, processes, and systems can be established to initiate and sustain higher levels of performance. The changes should, at a minimum, improve system design flaws that allowed for weak performance, but more importantly map out how both existing and improved data and quality information can lead to continuous improvement in the waiver program.

Quarterly stakeholder meetings are held to address trends and to provide training and technical guidance.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
<input type="checkbox"/> Other	<input type="checkbox"/> Other

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
Specify: <input type="text"/>	Specify: <input type="text"/>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

A quarterly assessment of the functionality of the CAP IT system is conducted to monitor the performance and waiver specification per the approved contract scope of work. A State Medicaid representative review reports and conduct testing to assess the effective of the waiver functionality and it reliability of design. The CAP IT system designed to review and process all waiver processes at 100%. The system reports reviewed on a quarterly basis must reflect a 100% accuracy rate in all waiver processes executed through the CAP IT system. A less than 100% accuracy rate or when trends of incorrect execution of a particular waiver process is identified, a meeting is held with vendor to address concerns, identify causes and assist with the implementation of a corrective action plan. If the system is functioning as designed, but the waiver functionality is incongruent with processes, a contract amended is initiated to address the issue(s). The vendor must submit specification for approval to the State Medicaid agency that addresses the new functionality. After the approval of the specification, a user acceptance test is performed to ensure the updated functionality is working as designed. Upon the completion of this process, the State Medicaid agency ensure the system is functioning as designed through observation and review.

If the system is not functioning as designed, the vendor will have 5 business days to correct the area(s) of concern.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

A safeguard implemented by the State Medicaid Agency to evaluate the Quality Improvement Strategy for this waiver is data analytic. The State Medicaid Agency is able to run queries on a daily, monthly, quarterly and annual basis to evaluate its system's performance to identify improvement strategies. The system, both the CAP IT system and MMIS is programmed to automatically generate reports pertaining to the six waiver assurances and its associated performance measures. Ad-hoc reports can be generated to query any area such as assessments, service plans, critical incident reports, survey results and claims. The CAP IT system will conduct reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, or different LOC and appeals on a monthly basis to assure accurate and 100% compliance of the waiver QIS. The Division of Medical Assistance will review this information quarterly to assure compliance of waiver assurances.

Another safeguard implemented by the State Medicaid Agency is recommendations from the Home and Community Care Quality Management committee. Each year the QM Committee will conduct an annual evaluation of the QM Program and Develop an Annual QM Work Plan. This committee meets quarterly to evaluate the strategies identified during the annual planning meeting. System improvements are implemented when areas of weaknesses are identified or when the system warrants.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Financial Integrity and Accountability of the waiver is the primary responsibility of the State Medicaid Agency. In conjunction with the State Medicaid Agency Waiver and Program Integrity Unit, the IT system and the MMIS will provide oversight in financial integrity and accountability.

The State does not require an independent audit of provider agencies specific to this 1915 (c) HCBS waiver. The program integrity process the State uses is described below:

DMA Office of Compliance and Program Integrity (OCPI) and/or its agents conduct post-payment reviews of providers that deliver Medicaid Waiver services. The DMA's IT System receives prior authorizations from utilization review and authorizations are communicated, documented, and archived in system's portal known as NCTracks. DMA's MMIS has edits and audits programmed to allow claims to process appropriately before provider is paid. DMA Office of Compliance and Program Integrity uses robust data analytic tools to include the Fraud and Abuse Management System (FAMS), Java-Surveillance and Utilization Review System (JSURS), and Advantage Suite to identify and detect overutilization and underutilization of services, and improper or aberrant billing

practices by providers. FAMS and JSURS have the capacity to identify providers billing practices or behaviors outside the norm of its peers. Advantage Suite has the capacity to identify overutilization and underutilization of services. When providers are identified through data analytics, a Data Analytics Report is created and assigned to an investigator to conduct further research and make a recommendation to refer a provider for post-payment review or prepayment review. Post-payment reviews are conducted by DMA Office of Compliance and Program Integrity (OCPI) and/or its authorized agents to determine if the provider delivered services in accordance with the policies, rules, and regulations for the claim billed. Post-Payment reviews may include a review of service request forms, assessments, family/person centered service plan, prior authorizations, staff qualifications, and claims paid.

Whenever provider paid claims spike for various reasons, or failed to substantially comply with previous requirements in an audit, provider may be considered for prepayment claims review. Prepayment claims review may include review of service request forms, service orders, assessments, staff qualifications, family/person centered service plan, and claims prior to payment. A provider placed on prepayment claims review has to obtain a 70% accuracy rate for three consecutive months to successfully complete the program. Providers may stay on prepayment claims review up to twelve months. Should a provider not meet the 70% accuracy rate, DMA may terminate the provider from the Medicaid program.

DMA-OCPI post-payment vendors include Public Consulting Group (PCG) and Health Management Systems (HMS). The prepayment review vendor is the Carolinas Center for Medical Excellence (CCME). DMA-OCPI provides oversight and monitoring of the vendors' performance on a routine basis to ensure contract compliance and quality performance which may include case referrals, special initiatives, provider performance reports, quality assurance reports, and recommendations. All vendors are invited and encouraged to participate in joint training sponsored by DMA-OCPI and The Medicaid Fraud Control Unit on an annual basis. Training often covers case studies, recent provider trends, investigative techniques, policy, rules, and regulation updates, and data analytics used to target reviews and investigations.

The CAP IT system contains algorithms with logic that is able to interpret information from the Service Request Form (SRF) and the assessment that results in the development of a service plan. The assessment tool has key indicators to identify risk factors in the areas of sensory and communication, mental and behavioral health, informal supports, housing and finance, safety and well-being, and medical and diagnostic functioning. Upon the completion of the assessment, the CAP IT system, analyzes the data gathered and provides the case manager a report that contains risk indicators and suggestions on the types of services the waiver beneficiary would need to maintain health, safety and well-being in the community. The case manager reviews those risk indicators along with the waiver beneficiary in order to develop the service plan. The CAP IT system also monitors services as listed on the service plan through monthly and quarterly documentation the case manager is required to complete in the CAP IT system. The case manager gathers information about waiver participation and health and welfare during contact with the waiver beneficiary and providers as well as from the review of paid claims. Key responses entered from the case manager populate to the service plan, the beneficiary profile and a risk indicator section to aid in assessing if the waiver beneficiary's needs are adequately addressed and met. The case manager is required to respond to probing questions in the monthly and quarterly monitoring assessment that analyze if services are provided as planned and if these services are meeting needs in the amount, frequency and duration. The CAP IT system provides a summary of beneficiary which is referred to as "beneficiary at a glance". This summary provides an overview of all care needs, services approved, risk indicators, ADLs composite score and caregiver involvement and availability. If the analysis by the CAP IT system reveals that needs do not appear to be met or there are concerns of risk, the case manager is prompted to complete a change in status assessment, a plan of care revision or a risk agreement. The DMA consultant reviews this information and provides guidance to the case manager.

Level of care determination is generated by the CAP IT system. When the assessment is approved which determines the beneficiary to be at-risk of institutionalization and appropriate to participate in the CAP waiver, the CAP IT system automatically transmits the prior approval (PA) to DMA's MMIS. When the service plan is completed by the case manager that identifies the service types in the amount, duration and frequency, the CAP IT systems automatically transmits the service types in the amount, frequency and duration to DMA's MMIS for the purpose of adjudication of claims. DMA's MMIS will adjudicate claims up to the amount transmitted by the CAP IT system. DMA's contract administrator is responsible to ensure the CAP IT system is transmitting level of care PAs and service limit PAs to DMA's MMIS system timely and correctly. The contractor administrator will review all PAs transmitted to DMA's MMIS and will run data queries each week to assure claims adjudicated per the PA. The State will review PA transaction in waiver year one at a 100% sampling methodology. An assessment at the end of waiver year one will be made to determine the sampling methodology for waiver year two.

The CAP IT system reviews 100% cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from consistent failure to comply with service plan.

Post-payment reviews of all Medicaid providers conducted by the State Medicaid Agency look at the complete audit trail including the approval of the service plan, the case manager's authorization to the provider that rendered approved services, service provision, service documentation and the case manager's authorization for claims submission and actual claims data.

Results of monthly monitoring are reviewed by the IT system and the State Medicaid Agency. The findings are shared with the case management entities. The findings enable the agencies to improve the manner in which financial integrity and accountability are operated. The QA review process is not a negative process, but one that leads to the continuous quality improvement of the waiver. Additionally, QA/QI places prior approval limits on services to assure claims data is billed as planned in the amount, frequency and duration. This process ensures compliance of monthly budget monitoring.

Post-payment review is a function of DMA's Program Integrity (PI) Unit. The waiver unit reviews claim data monthly to identify out

layers and unusual occurrences. Out layers and unusual occurrences are investigated to assure financial soundness and integrity. Concerns are referred to DMA’s PI unit for an official investigation and follow-up. In addition to this process at the state level, the CME reviews paid claims routinely to ensure accuracy of service provision and reports concerns to DMA for follow-up.

The efforts of the Program Integrity Section promote program fiscal efficiency of Medicaid money spent and the services rendered by all Medicaid providers. Program Integrity Section is tasked with multiple responsibilities. These responsibilities include:

- coordinating provider fraud, abuse and administrative over-payments;
- determining the accuracy of Medicaid eligibility determinations;
- performing reviews of claims filed to identify problem areas;
- assisting in claim payment audits;
- conducts periodic reviews with providers who bill for payments; and
- referring cases of possible fraud to the Attorney General’s Medicaid Investigations unit.

For this waiver, submitting PAs to DMA’s MMIS is a new process of the financial accountability assurance. Because of this new process, for waiver year one, DMA will review all PAs submitted to its MMIS and all claims data generated

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the State’s quality improvement strategy, provide information in the following fields to detail the State’s methods for discovery and remediation.

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. (For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")

i. Sub-Assurances:

- a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. (Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of waiver claims denied or suspended for incorrect billing codes and service rates. Numerator: number of waiver claims denied or suspended for incorrect billing codes and service rates Denominator: number of waiver claims

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

The source of these reports are from CAP IT system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>

<input checked="" type="checkbox"/> Other Specify: IT Contractor and DMA's MMIS managed by CSRA	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of direct support staff reimbursed at their negotiated pay rate.
Numerator: number of direct support staff reimbursed at their negotiated pay rate
Denominator: number of direct support staff

Data Source (Select one):

Financial records (including expenditures)

If 'Other' is selected, specify:

The source of these reports are from CAP IT system, FMS records and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

IT Contractor, FMS records and DMA's MMIS managed by CSRA		
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver claims that prior approval limits were submitted in the correct amount, duration and frequency. Numerator: number of waiver claims that prior approval limits were submitted in the correct amount, duration and frequency Denominator: number of waiver claims

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

The source of these reports are from CAP IT system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation (check each that applies):	Frequency of data collection/generation (check each that applies):	Sampling Approach (check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group:

IT Contractor and DMA's MMIS managed by CSRA		
	<input checked="" type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify:
	<input type="checkbox"/> Other Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify:	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify:

- b. **Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.**

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:

Number and percent of case management entities that report overall claim reimbursement paid waiver claims in authorized amount, frequency and duration. Numerator: number of case management entities that report overall claim reimbursement paid waiver claims in authorized amount, frequency and duration Denominator: number of case management entities

Data Source (Select one):

On-site observations, interviews, monitoring

If 'Other' is selected, specify:

The source of these reports are from CAP IT system and respondent surveys.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):

<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor and respondent surveys	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of waiver claims successfully paid based on edits and audits for the waiver
 Numerator: number of waiver claims successfully paid based on edits and audits for the waiver
 Denominator: number of waiver claims

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

The source of these reports are from CAP IT system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review

<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval = <input type="text"/>
<input checked="" type="checkbox"/> Other Specify: IT Contractor and DMA's MMIS managed by CSRA	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: <input type="text"/>
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: <input type="text"/>
	<input type="checkbox"/> Other Specify: <input type="text"/>	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input checked="" type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

Performance Measure:

Number and percent of claims reimbursed according to the rates approved in the waiver application
 Numerator: Number of claims reimbursed according to the rates approved in the waiver application
 Denominator: Total number of claims reviewed

Data Source (Select one):

Financial audits

If 'Other' is selected, specify:

The source of these reports are from CAP IT system and DMA's MMIS managed by CSRA.

Responsible Party for data collection/generation(check each that applies):	Frequency of data collection/generation(check each that applies):	Sampling Approach(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> 100% Review
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Less than 100% Review
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Representative Sample Confidence Interval =

<input checked="" type="checkbox"/> Other Specify: CAP IT system and DMA's MMIS managed by CSRA	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified Describe Group: [Dropdown]
	<input type="checkbox"/> Continuously and Ongoing	<input type="checkbox"/> Other Specify: [Dropdown]
	<input type="checkbox"/> Other Specify: [Dropdown]	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis (check each that applies):	Frequency of data aggregation and analysis(check each that applies):
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: [Dropdown]	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: [Dropdown]

- ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible. The CAP IT system for this waiver is designed to evaluate all waiver beneficiaries and provider agencies in the processing and performance of waiver activities. To validate the efficiency and capacity of the CAP IT system programmed to support DMA’s administrative operation on this waiver, the sampling methodology will be a 100% sampling for waiver year one. As a safeguard for financial accountability assurance, the State Medicaid Agency has programmed in its IT system functionality to place prior approval limits on all waiver services. These limits are electronically transmitted to the State’s MMIS to inform claim reimbursement. These prior approval limits will prevent over payments of Medicaid claims processing. The prior approval limits will also prevent providers from submitting Medicaid claims prior to the effective date of service implementation. The Medicaid Fiscal Agent, CSRA is responsible for ensuring that waiver claims are paid correctly. All services are appropriately coded and audits and edits are placed within the system to ensure claims are paid correctly. Audits have been tested to ensure claims for the waiver services will process as per Medicaid guidelines. The case management entities in conjunction with IT system monitor service authorization against paid claims to ensure that they are coded and paid correctly and that these paid claims correspond with the approved services in each waiver beneficiary’s service plan. The IT system in conjunction with the Medicaid waiver services unit monitors expenditures to ensure that monthly benefit limits are not exceeded and the program stays within its approved budget. DMA Office of Compliance and Program Integrity (OCPI) and/or its agents conduct post-payment reviews of providers that deliver Medicaid Waiver services. The DMA’s IT System receives prior authorizations from utilization review and authorizations are communicated, documented, and archived in system’s portal known as NCTracks. DMA’s MMIS has edits and audits programmed to allow claims to process appropriately before the provider is paid. DMA Office of Compliance and Program Integrity uses robust data analytic tools that include the Fraud and Abuse Management System (FAMS), Java-Surveillance and Utilization Review System (JSURS), and Advantage Suite to identify and detect over-

utilization, and underutilization of services, as well as improper or aberrant billing practices by providers. FAMS and JSURS have the capacity to identify providers billing practices or behaviors outside the norm of its peers. Advantage Suite has the capacity to identify overutilization and underutilization of services. When providers are identified through data analytics, a Data Analytics Report is created and assigned to an investigator to conduct further research and make a recommendation to refer a provider for post-payment review or prepayment review. Post-payment reviews are conducted by DMA Office of Compliance and Program Integrity (OCPI) and/or its authorized agents to determine if the provider delivered services in accordance with the policies, rules, and regulations for the claim billed. Post-Payment reviews may include a review of service request forms, assessments, family/person centered service plan, prior authorizations, staff qualifications, and claims paid.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.

Upon discovery of non-compliance, a root-cause analysis is completed to identify the source of the systems error. If a CSRA/NCTracks (MMIS) issue is discovered, a Medicaid Policy Memo (Change Service Requests) is generated to identify and resolve the issue.

Upon discovery of non-compliance, the State Medicaid Agency contacts the provider to alert of the paid claim error and requests proposal on repayment, which can include recoupment of payment and/or adjustment to future provider payments; if trends or patterns are revealed of continued non-compliance, an audit is conducted, which may result in further sanctions or disbarment as a Medicaid-enrolled provider.

Whenever provider paid claims spike for various reasons, or failed to substantially comply with previous requirements in an audit, provider may be considered for prepayment claims review. Prepayment claims review may include review of service request forms, service orders, assessments, staff qualifications, family/person centered service plan, and claims prior to payment. A provider placed on prepayment claims review has to obtain a 70% accuracy rate for three consecutive months to successfully complete the program. Providers may stay on prepayment claims review up to twelve months. Should a provider not meet the 70% accuracy rate, DMA may terminate the provider from the Medicaid program.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party <i>(check each that applies):</i>	Frequency of data aggregation and analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Other Specify: <input type="text"/>	<input type="checkbox"/> Annually
	<input type="checkbox"/> Continuously and Ongoing
	<input type="checkbox"/> Other Specify: <input type="text"/>

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- No
- Yes

Please provide a detailed strategy for assuring Financial Accountability, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in

the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

2012 is the last time the fee schedule was changed for waiver services. The current rates are based on the July 1, 2012 Medicaid CAP Children and Disabled Adults fee schedules. Generally, the State determines rates through a fee-for-service fee schedule methodology. For fee schedule rates, the State has historically solicited data from providers to inform the rate development process. The following components are typical considerations in the State fee development:

- Staffing Assumptions and staff wages
- Employee-related expense (e.g., benefits, employer taxes)
- Non-direct program expenses (e.g., supplies, training and supervision)
- Provider administrative overhead
- Direct staffing hours – this considers the training and other non-billable activities that practitioners are involved in.

The State does not have a defined timeframe for rebasing of rates. From a review perspective, the State does interact and solicit feedback from the stakeholder community on an ongoing basis including the feasibility of the current fees in place. A formal review/rebase of waiver rates will be reviewed in SFY 2017-2018.

Rates are set to reimburse reasonable cost as defined in section 1861(v) of the Social Security Act. Service rates are developed using various methodologies; Medicaid historical fee schedules, Medicare, historical cost to providers, cost modeling and Medicare established fee schedules; and, in some cases, providers are invited to participate in forums related to rate setting.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service. The waiver participant is provided information about the waiver and payments when a referral is made and during the initial assessment process and annually thereafter.

North Carolina establishes reimbursement rates applicable to services provided by providers and facilities. The rates are based on the costs incurred and reported by the providers with certain limits. Rates are generally set for the rate period based on the historical costs of the facility for a prior year (adjusted for inflation), rather than on the actual costs of providing the services for which the rate is claimed.

Reimbursement for all providers for the following services is capped:

- Home accessibility and adaptation -- \$28,000 for the life of the waiver
- Participant Goods and Services - \$800 per fiscal year
- Assistive Technology- \$28,000.00 per life of the waiver
- Community Transition Services- \$2,500.00 per Waiver beneficiary over the lifetime of the waiver
- Training and Education Services- \$500.00 per state fiscal year

Case management – 72 hours or 288 units per calendar year for ongoing case management and 8 hours or 32 units per year for assessments

Vehicle Modification- \$28,000max. over the lifetime of the waiver

Maximum reimbursement for all providers for the following services is the same per unit rate (one unit = 15 minutes) and is determined at least annually by DMA:

- Personal Care Assistant Services
- Personal Care Services to include In-home Respite services and Nursing services
- Respite Care (Non-Institutional)
- Financial Management
- Care Advisor
- Case Management

North Carolina establishes per diem rates for the following services

- Respite Care (Institutional)

Other:

- Waiver Supplies - units vary by item and are consistent with State Plan services
- Personal emergency response services - paid per month

DMA is in constant communication with providers and their associations through frequent meetings. Consumers may submit complaints by phone, or in writing. DMA complaints are investigated by Program Integrity who is available to receive complaints from patients, their families, other providers, former employees of a provider, and through federal and state referrals. Program Integrity staff investigates the complaint.

- b. Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The billing flow for waivers services is directly from the providers to the State's claims payment system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)**c. Certifying Public Expenditures (select one):**

- No. State or local government agencies do not certify expenditures for waiver services.**
- Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

Select at least one:

- Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-a.)*

- Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability**I-2: Rates, Billing and Claims (3 of 3)**

- d. Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

CSRA is the fiscal agent (FA) for Medicaid claim processing and payment. It is the FA's responsibility to process valid Medicaid claims from enrolled providers in accordance with NCDMA policies, edits, audits, guidelines, and reimbursement methodologies. Payments are made through MMIS and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers.

A prior approval of a LOC determination and a special waiver coverage code must be in the MMIS system before performing and billing any service to Medicaid.

The provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid because Medicaid is the payer of last resort.

Once the provider determines that the invoice is a Medicaid claim, the provider then bills NCTracks for payment.

Validation that services have been provided as billed is a function of quality assurance conducted by the IT system and the case management entities. Audits include verification that the services were provided as billed. Additional validation is through desk and onsite audits and Program Integrity reviews.

Annually the DMA's Accountability Team conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of enrolled providers. This review includes monitoring of requirements that addresses staff qualifications, service authorizations, family/person centered plans, service documentation, and billing protocol. For the waiver, a validation of the following is reviewed:

1. Have the required signatures on or before services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and
7. Include a 24-hour schedule of coverage, if warranted.

During and prior to waiver participation the State Medicaid Agency validates:

- The IT system reviews 100% of its cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided.
- The reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, different LOC and appeals

on a monthly basis to assure accuracy and 100% compliance of authorized services.

- The IT system conducts quality assurance reviews that include a review of the family/person centered plan and service documentation for each waiver beneficiary. The reviewer reviews the current service request form, the assessment and the approved family/person centered, service documentation, and paid claims to insure that services were billed appropriately as according to the service plan.

- The IT system places prior approval limits on all service plans to identify deviations from the providers and review provision of services monthly. If there are consistent deviations and the service is authorized on the service plan, the case manager must review these with the waiver beneficiary for further validation.

The State Medicaid Agency/IT system will provide each case management entities with QI reports to validate all authorized services. The case management entities will contact the IT system/State Medicaid Agency when program integrity concerns are present. The State Medicaid Agency will arrange for a program integrity review of the concerns.

In addition to the activities described above, the State Medicaid Agency utilizes desktop reviews and on-site reviews (audits), reports, and special reviews to ensure program accountability for service plan development and implementation. These desktop reviews and on-site reviews occur annually and as needed.

Submitted claims are systematically reviewed by the fiscal agent to ensure that all required information is present. Completed claims processed through MMIS are run against system edits to verify:

- Services are prior authorized (i.e., level of care);
- Individual is a Medicaid beneficiary and is enrolled in the waiver (i.e. CAP indicator);
- Provider is an enrolled waiver provider;
- Claim is not a duplicate;
- Claim is paid per the published rates; and the participant was not institutionalized during the time covered.

Payments are made through CSRA/NCTracks and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers.

Validation that services have been provided as billed is a function of quality assurance conducted by the IT system and the case management entity. Additional validation that services were provided as billed is performed during case management entity and provider on-site compliance monitoring reviews, conducted by the State Medicaid Agency's Program Integrity Unit. Validation will also be achieved through participant's surveys by mail or by telephone; education about fraud and abuse and how to report concerns of payment integrity and quality of care. During enrollment and annually thereafter, each waiver participant will be provided education and information regarding financial accountability. In addition, post payment reviews, review of provider records and claims will also be used for validation.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

- a. **Method of payments -- MMIS** (*select one*):

- Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- Payments for some, but not all, waiver services are made through an approved MMIS.**

Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are not made through an approved MMIS.**

Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system (s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

- b. Direct payment.** In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
- The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
- The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

- Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

- c. Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one*:

- No. The State does not make supplemental or enhanced payments for waiver services.
- Yes. The State makes supplemental or enhanced payments for waiver services.

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

- d. Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- No. State or local government providers do not receive payment for waiver services. Do not complete Item I-3-e.
- Yes. State or local government providers receive payment for waiver services. Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish:

Case management entities are not providers of waiver services such as specialized medical equipment and supplies, home accessibility and adaptation, participant goods and services and assistive technology. They are used as a pass through. When a

waiver service of such is identified as a need, the case management entity assists the waiver beneficiary in identifying a waiver provider based on freedom of choice. When a provider is selected by the waiver beneficiary, a service authorization is forwarded to the selected provider by the CME to initiate the provision of that waiver service.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**
- The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

- The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- The State contracts with a Managed Care Organization(s) (MCO) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**
- This waiver is a part of a concurrent 1115/1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

- a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one:*

- Appropriation of State Tax Revenues to the State Medicaid agency**
- Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

- Other State Level Source(s) of Funds.**

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

- b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One:*

Not Applicable. There are no local government level sources of funds utilized as the non-federal share.

Applicable

Check each that applies:

Appropriation of Local Government Revenues.

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Other Local Government Level Source(s) of Funds.

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one:*

None of the specified sources of funds contribute to the non-federal share of computable waiver costs

The following source(s) are used

Check each that applies:

Health care-related taxes or fees

Provider-related donations

Federal funds

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

- a. Services Furnished in Residential Settings.** *Select one:*

No services under this waiver are furnished in residential settings other than the private residence of the individual.

As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.

- b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.
- Yes.** Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- No.** The State does not impose a co-payment or similar charge upon participants for waiver services.
- Yes.** The State imposes a co-payment or similar charge upon participants for one or more waiver services.

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services (if any are checked, complete Items I-7-a-ii through I-7-a-iv):

- Nominal deductible**
- Coinsurance**
- Co-Payment**
- Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. **Co-Payment Requirements.**

ii. **Participants Subject to Co-pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)**a. Co-Payment Requirements.****iii. Amount of Co-Pay Charges for Waiver Services.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)****a. Co-Payment Requirements.****iv. Cumulative Maximum Charges.**

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability**I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)****b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one:*

- No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration**J-1: Composite Overview and Demonstration of Cost-Neutrality Formula**

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.

Level(s) of Care: **Hospital, Nursing Facility**

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	18223.87	66329.29	84553.16	99797.96	28683.21	128481.17	43928.01
2	18858.03	68319.17	87177.20	102791.90	29543.70	132335.60	45158.40
3	19511.93	70368.74	89880.67	105875.65	30430.01	136305.66	46424.99
4	20199.65	72479.80	92679.45	109051.92	31342.91	140394.83	47715.38
5	20859.39	74654.20	95513.59	112323.48	32283.20	144606.68	49093.09

Appendix J: Cost Neutrality Demonstration**J-2: Derivation of Estimates (1 of 9)****a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		Hospital	Nursing Facility
Year 1	4000	26	3974
Year 2	4000	26	3974
Year 3	4000	26	3974
Year 4	4000	26	3974
Year 5	4000	26	3974

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay for the waiver is 309.8 days. This figure is actual average length of stay for waiver participants from July 1, 2014 through June 30, 2015 (SFY 2015). Note that the overall length of stay for the CAP waiver is comparable the average length of stay across the previous 2010 CAP/C waiver submission.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

SFY 2015 Medicaid expenditure data for all waiver services for the CAP-C waiver recipients serve as the base data for this estimate of Factor D. Historic Medicaid experience was leveraged in the development of the utilization projections. Historic unit cost experience along with the State fee schedules were leveraged for the initial waiver projection year; for waiver years 2 through 5, the costs were trended using 3% inflation consistent with recent trends for the waiver program. User projections developed for each service are based on the total number of approved waiver slots and the proportion of total clients expected to utilize each waiver service based on Medicaid experience along with past waiver expectations. Historical waiver expenditures for Nursing were removed from the Factor D calculation as these services will be moving to the State Plan.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SFY 2015 Medicaid expenditure data for all State Plan services for the CAPC waiver beneficiaries serve as the base data for this estimate of Factor D'. Expenditures were trended using 3% inflation. Historical waiver expenditures for nursing were shifted to the Factor D' calculation as these services will be moving to State Plan; based on estimates provided by Moody's economy.com (refer to the medical care services section under the 'Source' link). The CPI (Consumer Price Index) is the inflation metric that was used.

Part D prescribed drugs are automatically removed from the cost associated with Factor D'. The Medicaid Management System has logic to identify individuals with Part D coverage to deny claims submitted to Medicaid. Data generated for D' do not include costs of prescribed drugs for dual eligibles under Part D

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SFY 2015 Medicaid expenditure data from nursing facilities and hospitals were used for the estimate of Factor G. Specific to hospital expenditures, the Medicaid claims experience was adjusted to reflect the total payments to hospitals inclusive of Medicaid supplemental payments. Institutional users comparable to the population eligible for the waiver were identified based on DRG and NPI/taxonomy code criteria. Specific to hospital expenditures, the Medicaid claims experience was adjusted to reflect the total payments to hospitals inclusive of Medicaid supplemental payments. For the waiver projection years, the Factor G estimates were derived by trending the expenditures using 3% inflation. The State uses is a 4% inflation rate which is based on estimates provided by Moody's economy.com (refer to the medical care services section under the 'Source' link). The CPI (Consumer Price Index) is the inflation metric that was used.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

SFY 2015 State Plan expenditure data for the institutional population of children that was identified for the estimate Factor G was used for the estimate of Factor G'. In subsequent years the expenditures are trended using 3% inflation. The State uses is a 4% inflation rate which is based on estimates provided by Moody's economy.com (refer to the medical care services section under the 'Source' link). The CPI (Consumer Price Index) is the inflation metric that was used.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select “*manage components*” to add these components.

Waiver Services	
In-Home Care Aide Service	
Financial Management	
Assistive Technology	
Case Management	
Community Transition	
Home Accessibility and Adaptation	
Institutional and Non-Institutional Respite	
Participant Goods and Services	
Pediatric Nurse Aide Services	
Specialized Medical Equipment and Supplies	
Training, Education and Consultative Services	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Care Aide Service Total:						23920734.60
In-Home Care Aide Service	15	1303	3948.00	4.65	23920734.60	
Financial Management Total:						1674.00
Financial Management	15 min	4	18.00	23.25	1674.00	
Assistive Technology Total:						325080.00
Assistive Technology	instance	108	35.00	86.00	325080.00	
Case Management Total:						10066025.62
Case Management	15 min	3977	179.00	14.14	10066025.62	
Community Transition Total:						24000.00
Community Transition	instance	2	1.00	12000.00	24000.00	
Home Accessibility and Adaptation Total:						2197938.20
Home Accessibility and Adaptation	event				2197938.20	
GRAND TOTAL:						72895468.07
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						18223.87
Average Length of Stay on the Waiver:						310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		508	1.00	4326.65		
Institutional and Non-Institutional Respite Total:						12137377.00
Institutional Respite	per diem	2	1.00	206.00	412.00	
Non-Institutional Respite	15 min	3035	775.00	5.16	12136965.00	
Participant Goods and Services Total:						1543118.85
Participant Goods and Services	event	1855	13.00	63.99	1543118.85	
Pediatric Nurse Aide Services Total:						18421431.90
Pediatric Nurse Aide Services	15 min	1707	3110.00	3.47	18421431.90	
Specialized Medical Equipment and Supplies Total:						2067107.86
Specialized Medical Equipment and Supplies	instance	1369	4441.00	0.34	2067107.86	
Training, Education and Consultative Services Total:						23320.00
Training, Education and Consultative Services	instance	53	40.00	11.00	23320.00	
Vehicle Modifications Total:						2167660.04
Vehicle Modifications	instance	482	1.00	4497.22	2167660.04	
GRAND TOTAL:						72895468.07
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						18223.87
Average Length of Stay on the Waiver:						310

Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Care Aide Service Total:						24640928.76
In-Home Care Aide Service	15	1303	3948.00	4.79	24640928.76	
Financial Management Total:						1724.40
Financial Management	per month	4	18.00	23.95	1724.40	
Assistive Technology Total:						481089.00
Assistive Technology					481089.00	
GRAND TOTAL:						75432108.89
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						18858.03
Average Length of Stay on the Waiver:						310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	avg cost per year	155	35.00	88.68		
Case Management Total:						10365016.48
Case Management	15 min	3977	179.00	14.56	10365016.48	
Community Transition Total:						24720.00
Community Transition	avg cost per year	2	1.00	12360.00	24720.00	
Home Accessibility and Adaptation Total:						2263876.60
Home Accessibility and Adaptation	avg cost per year	508	1.00	4456.45	2263876.60	
Institutional and Non-Institutional Respite Total:						12490210.13
Institutional Respite	per diem	2	1.00	213.19	426.38	
Non-Institutional Respite	15 min	3035	775.00	5.31	12489783.75	
Participant Goods and Services Total:						1827618.39
Participant Goods and Services	event	2133	13.00	65.91	1827618.39	
Pediatric Nurse Aide Services Total:						18952308.90
Pediatric Nurse Aide Services	15 min	1707	3110.00	3.57	18952308.90	
Specialized Medical Equipment and Supplies Total:						2127905.15
Specialized Medical Equipment and Supplies	instance	1369	4441.00	0.35	2127905.15	
Training, Education and Consultative Services Total:						24019.60
Training, Education and Consultative Services	instance	53	40.00	11.33	24019.60	
Vehicle Modifications Total:						2232691.48
Vehicle Modifications	avg cost per year	482	1.00	4632.14	2232691.48	
GRAND TOTAL:						75432108.89
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						18858.03
Average Length of Stay on the Waiver:						310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Care Aide Service Total:						25361122.92
In-Home Care Aide Service	15	1303	3948.00	4.93	25361122.92	
Financial Management Total:						1776.24
Financial Management	per month	4	18.00	24.67	1776.24	
Assistive Technology Total:						568425.20
Assistive Technology	instance	178	35.00	91.24	568425.20	
Case Management Total:						10678245.00
Case Management	15 min	3977	179.00	15.00	10678245.00	
Community Transition Total:						25461.60
Community Transition	instance	2	1.00	12730.80	25461.60	
Home Accessibility and Adaptation Total:						2331791.12
Home Accessibility and Adaptation	event	508	1.00	4590.14	2331791.12	
Institutional and Non-Institutional Respite Total:						12866562.93
Institutional Respite	per diem	2	1.00	219.59	439.18	
Non-Institutional Respite	15 min	3035	775.00	5.47	12866123.75	
Participant Goods and Services Total:						2164944.21
Participant Goods and Services	event	2453	13.00	67.89	2164944.21	
Pediatric Nurse Aide Services Total:						19536273.60
Pediatric Nurse Aide Services	15 min	1707	3110.00	3.68	19536273.60	
Specialized Medical Equipment and Supplies Total:						2188702.44
Specialized Medical Equipment and Supplies	instance	1369	4441.00	0.36	2188702.44	
Training, Education and Consultative Services Total:						24740.40
Training, Education and Consultative Services	instance	53	40.00	11.67	24740.40	
Vehicle Modifications Total:						2299670.20
Vehicle Modifications	instance	482	1.00	4771.10	2299670.20	
GRAND TOTAL:						78047715.86
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						19511.93
Average Length of Stay on the Waiver:						310

Appendix J: Cost Neutrality Demonstration
J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Care Aide Service Total:						26132759.52
In-Home Care Aide Service	15	1303	3948.00	5.08	26132759.52	
Financial Management Total:						1829.52
Financial Management	per diem	4	18.00	25.41	1829.52	
Assistive Technology Total:						674306.50
Assistive Technology	instance	205	35.00	93.98	674306.50	
Case Management Total:						10998592.35
Case Management	15 min	3977	179.00	15.45	10998592.35	
Community Transition Total:						26225.44
Community Transition	instance	2	1.00	13112.72	26225.44	
Home Accessibility and Adaptation Total:						2401742.72
Home Accessibility and Adaptation	event	508	1.00	4727.84	2401742.72	
Institutional and Non-Institutional Respite Total:						13242916.11
Institutional Respite	per diem	2	1.00	226.18	452.36	
Non-Institutional Respite	15 min	3035	775.00	5.63	13242463.75	
Participant Goods and Services Total:						2556361.08
Participant Goods and Services	event	2812	13.00	69.93	2556361.08	
Pediatric Nurse Aide Services Total:						20120238.30
Pediatric Nurse Aide Services	15 min	1707	3110.00	3.79	20120238.30	
Specialized Medical Equipment and Supplies Total:						2249499.73
Specialized Medical Equipment and Supplies	instance	1369	4441.00	0.37	2249499.73	
Training, Education and Consultative Services Total:						25482.40
Training, Education and Consultative Services	instance	53	40.00	12.02	25482.40	
Vehicle Modifications Total:						2368658.86
Vehicle Modifications	instance	482	1.00	4914.23	2368658.86	
GRAND TOTAL:						80798612.53
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						20199.65
Average Length of Stay on the Waiver:						310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
In-Home Care Aide Service Total:						26904396.12
In-Home Care Aide Service	15	1303	3948.00	5.23	26904396.12	
Financial Management Total:						1884.24
Financial Management	per diem	4	18.00	26.17	1884.24	
Assistive Technology Total:						741972.00
Assistive Technology	instance	219	35.00	96.80	741972.00	
Case Management Total:						11326058.53
Case Management	15 min	3977	179.00	15.91	11326058.53	
Community Transition Total:						27012.20
Community Transition	instance	2	1.00	13506.10	27012.20	
Home Accessibility and Adaptation Total:						2473797.44
Home Accessibility and Adaptation	event	508	1.00	4869.68	2473797.44	
Institutional and Non-Institutional Respite Total:						13642790.94
Institutional Respite	per diem	2	1.00	232.97	465.94	
Non-Institutional Respite	15 min	3035	775.00	5.80	13642325.00	
Participant Goods and Services Total:						2839200.00
Participant Goods and Services	event	3000	13.00	72.80	2839200.00	
Pediatric Nurse Aide Services Total:						20704203.00
Pediatric Nurse Aide Services	15 min	1707	3110.00	3.90	20704203.00	
Specialized Medical Equipment and Supplies Total:						2310297.02
Specialized Medical Equipment and Supplies	instance	1369	4441.00	0.38	2310297.02	
Training, Education and Consultative Services Total:						26245.60
Training, Education and Consultative Services					26245.60	
GRAND TOTAL:						83437577.21
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						20859.39
Average Length of Stay on the Waiver:						310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	instance	53	40.00	12.38		
Vehicle Modifications Total:						2439720.12
Vehicle Modifications	instance	482	1.00	5061.66	2439720.12	
GRAND TOTAL:						83437577.21
Total Estimated Unduplicated Participants:						4000
Factor D (Divide total by number of participants):						20859.39
Average Length of Stay on the Waiver:						310