



**Community Alternatives Program 1915 (c) HCBS
Waiver
February 2017**

**Department of Health and Human Services
CAP/C Waiver Resource Guide**



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What is a Waiver?

- **Specialized Medicaid program for individuals with LTSS needs**
- **Supplements regular Medicaid and other supportive services**
- **Array packet of home and community-based services for community integration and protection of health, safety, and well-being**
- **Specialized financial planning that deems income and assets using LTC Medicaid planning**
- **Person-centered planning**
- **Freedom of choices**



Who is served by the CAP/C Waiver?

- **Medically-complex children under age 21**
- **Children meeting an institutional level of care**
- **Children who are determined to be at risk of institutionalization**
- **Children who require at least 1 waiver service to avoid a hospital stay of 90 days or greater or placement in nursing facility**
- **Children who qualify for Medicaid in the following categories:**
 - **Medicaid for the Blind or Disabled**
 - **Medicaid for children experiencing foster care or who have been adopted.**

How do I access the Waiver?

Through No Wrong Door:

- In-person or by phone at the local Department of Social Services in county of residence
- By mail
- Online
- Representatives may apply on behalf of individuals
- Staff at some hospitals may assist in completing a referral via e-CAP



What are the objectives?

- No Wrong Door
- Innovative ways to meet needs of medically-complex children
- Person-Centered Planning (PCP)
- Community Integration
- Assurances and Health, Safety, and Well-being
- Continuous Quality Improvement
- Cost effective and efficient services
- Real-time interaction with my service providers

What is DMA oversight?

- **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 or her life in the community.
- **Provider Capacity and Capabilities**: There are sufficient HCBS providers, and they possess and demonstrate the capability to effectively serve the CAP beneficiary.
- **Safeguards**: CAP beneficiary is safe and secure in their home and community, taking into account their informed and expressed choices.
- **Rights and Responsibilities**: CAP beneficiary receives support to exercise their rights and accept personal responsibilities.
- **Outcomes and Satisfaction**: CAP beneficiary is satisfied with his or her service(s) and achieved desired outcomes identified in the service plan.
- **Quality Assessment and Quality Improvement**: Continuous Quality Improvement by regular assessments of waiver workflow, satisfaction surveys, grievances, and incident management for efficiency and effectiveness and improved quality.



What is DMA Oversight?

Assurances of:

- Level of Care
- Service Plan
- Qualified Providers
- Administrative Authority
- Financial Accountability
- Health and Welfare



Tools Used to Monitor Oversight

- **Service Request Form (SRF)** – referral and level of care tool – used to determine medical-complexity and Level of care
- **Interdisciplinary comprehensive assessment** addresses 17 core areas to assess risks and service needs
- **Person-Centered Service Plan** to identify strategies to meet risk factors and services needs in the community
- **Emergency-Back-Up Plan** – addresses emergency care needs and disaster recovery plan
- **Beneficiary Rights and Responsibilities Form** provides information about the waiver and your rights and responsibilities while participating in the waiver
- **Annual Participant Experience Survey** to measure satisfaction, outcomes, and areas for improvement
- **Critical Incident Reports and complaints and grievances** use to monitor health, safety and well-being
- **Score cards** to rate the performance rate of case management agencies

Measures Taken to Assure Qualified Providers

- Have a current and signed Provider Administrative Participation Agreement
- Granted a service authorization to render CAP/C services
- Criminal background checks of staff, which must be repeated every two (2) years
- Verification of CPR certification every two (2) years
- DMA specific training and CAP beneficiary specific competencies assessment
- Pediatric experience
- Supervision of CNA every 60 days

How are needs met through the Waiver?

Through Person-Centered Planning:

- Leader of service plan development and discussion team meetings
- Identification of individual and family goals
- Direct and specific services that “meet my family needs when I need them and where I need them.”
- Assumed risk through risk planning

How is my Health, Safety, and Well-being protected?

- **Service Request Form (SFR) to identify complexity and clinical profile**
- **Completion of an assessment to identify risk factors and formal and informal needs to keep me safe in the community**
- **Development of a service plan to address my needs in the amount, frequency, and duration of my risk factors**
- **Resolution of critical incident that puts me at risk**
- **Ability to submit grievances and complaints about the care I am provided**
- **Approved qualified providers**
- **Oversight by DMA**
- **Case management to assess, monitor, refer, link, and follow up with me on a monthly to quarterly basis**

How is my Health, Safety, and Well-being protected?

Why is Case Management Important?

- Improve or maintain capacities for self-performance of activities of daily living and instrumental activities of daily living.
- Improve compliance with accepted health and wellness prevention, screening, and monitoring standards.
- Reduce health and safety risks.
- Assist in avoiding unplanned hospitalizations emergency room visits.
- Enhance the availability of socialization to reduce social isolation.
- Reduce risks of caregiver burnout.
- Increase caregiver capacities.
- Enhance awareness and self-management of chronic conditions.
- Engagement.
- Promote a positive personal outlook.
- Improve informal caregiver(s) outlook and confidence in their caregiving role.



Waiver Participation Decisions



Waiver Approval Decision

- Individual in the target population
- Met the criteria for medically-complex
- Met the criteria for institutional level of care
- Have been determined to be at risk of institutionalization and needs at least one (1) waiver service to return to or maintain community placement
- Have been approved for Medicaid in one of the approved categories
- Have an approved service plan with all supporting documents



Waiver Approval Decision

Annual continuation of Waiver Participation

- Annual reassessment of needs
- Signed and approved SP that addresses person-centered goals
- Emergency back-up plan
- Signed Beneficiary Rights and Responsibilities Form



Waiver Entry Denial for Non-Eligibility

- **The Service Request Form (SRF) is incomplete, has been denied or request for additional information was not received within the specified timeframe**
- **An assessment of medical and functional needs has not been completed by an RN or social worker**
- **Does not require and use CAP/C services planned in the service plan that are available to the beneficiary during a 90 calendar day period**
- **The required annual reassessment was not approved or completed within 60 calendar days of the annual assessment date**

Waiver Entry Denial for Non-Eligibility

- **Receiving other Medicaid services or other third-party reimbursed services that are duplicative**
- **Currently approved services (Medicaid and non-Medicaid) are meeting assessed care needs and the beneficiary is not determined to be at-risk of institutionalization**
- **Health and well-being cannot be met through an individualized person-centered service plan or risk agreement when the beneficiary resides in an unsafe home environment placing the eligible beneficiary at risk**
- **Medicaid eligibility is not approved or terminated**

Waiver Entry Denial

- The beneficiary or responsible party refuses to sign or cooperate with the established service plan and any other required documents, placing the eligible beneficiary's health, safety, and well-being at risk
- The case management entity has been unable to establish contact with the beneficiary or his or her responsible party for more than 90 calendar days, for the provision of care, despite more than two (2) verbal and two (2) written attempts
- The beneficiary does not have an emergency back-up or disaster plan with adequate social support to meet the basic needs outlined in the interdisciplinary comprehensive assessment to maintain his or her health, safety, and well-being
- The beneficiary or responsible party demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP/C Waiver as outlined in the Beneficiary Rights and Responsibilities Form signed by the CAP beneficiary

Reasons for Disenrollment

- The beneficiary's Medicaid eligibility is terminated;
- The beneficiary's physician does not recommend nursing facility LOC;
- The SRF is not approved for nursing facility LOC;
- DSS removes the CAP/C evidence;
- The CAP/C case management entity has been unable to establish contact with the beneficiary or the primary caregiver(s) for more than 90 calendar days despite two written and verbal attempts;

Reasons for Disenrollment

- **The beneficiary fails to use CAP/C services as listed in the service plan during a 90 consecutive day time period of CAP/C participation;**
- **The beneficiary's health, safety, and well-being cannot be mitigated through a risk agreement;**
- **The beneficiary or primary caregiver does not participate in development of or sign the service plan;**
- **The beneficiary or primary caregiver(s) fails to comply with all program requirements, such as failure to arrive home at the end of the approved hours of service; or**

Reasons for Disenrollment

- **The beneficiary or primary caregiver demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP/C Waiver as outlined in the Beneficiary Rights and Responsibilities Form signed by the CAP/C beneficiary where there are three (3) such occurrences, and the beneficiary or primary caregiver has been counseled regarding this issue; or after one occurrence, if the beneficiary's health and welfare is at risk and cannot be mitigated.**

CAP/C Waiver Service Package



Personal Care Type Services

- **In-Home Aide** - A service for CAP beneficiaries that, during the hours of service provision, provides hands-on (not merely set-up or cueing) assistance with a minimum of two 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, social environmental and functional condition. Personal Care Aide Services, when medically necessary, shall be provided in the community, home, workplace, or educational settings. The personal care needs must fall within the NA I scope of nursing practice.
- **Pediatric Nurse Aide** - A service for CAP beneficiaries who require extensive hands-on assistance according to **10A NCAC 13J .0901** with:
 - more than three Activities of Daily Living (ADL);
 - at least two nurse aide II tasks; and
 - more than one ADL and have medical or cognitive impairment.
- **Respite** - 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).

Supportive Services

- **Care Management** - 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 for continual community integration.
- **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.
- **Community Transition** - A service for prospective CAP beneficiaries for transitioning from an institutional setting to a community setting. The funds are used to pay the necessary and documented expenses for a CAP beneficiary to establish a basic living arrangement.

Supportive Services

- **Participants Goods and Services** - A service for CAP beneficiaries that provides equipment, or supplies not otherwise provided through this CAP or through the Medicaid State Plan. This service helps assure health, safety, and well-being when the CAP beneficiary or responsible party does not have funds to purchase the medically necessary item or service.

- **Training, Education, and Consulting Services** - 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 or the individual (such as family members, neighbors, friends, personal care assistant, or companions) who provide care.

Modification Type Services

- **Assistive Technology** - Assistive technology for CAP beneficiaries includes items, product systems, supplies, and equipment that are not covered by State Plan Home Health or Durable Medical Equipment and Supplies, 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.
- **Home Accessibility and Adaptation** - Equipment and physical adaptations or minor renovations, 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.

Modification Type Services

- **Specialized Medical Equipment and Supplies** - Specialized medical equipment and supplies are:
 - **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 documented by an assessment of need.
 - **Vehicular transport vest:** A durable medical equipment for safe transport

- **Vehicle Modification** - 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 unmodified motor vehicle such as an automobile or van that is the CAP beneficiary's primary means of transportation.

Future CAP/C Training

- June 2017- Consumer-Direction

Support and Assistance

- **Assigned Case Management Agency; for local offices in your community contact, 1(888) 705-0970**
- **Department of Social Services; for local office in your county contact, 919-527-6335**
- **Division of Medical Assistance– 919-855-4340**

CAP/C Waiver Service Description- abbreviated revision of what you need to know



Case Management

A service that directs and manages the special health care, social, environmental, financial and emotional needs of a CAP beneficiary to assist in navigating community systems and gaining access to Medicaid services for the health, safety and well-being of the CAP participant.

The case manager performs the following:

- A. Assessing;
- B. Care Planning;
- C. Referral and Linkage; and
- D. Monitoring and Follow-up

There are two types of case managers under case management and four principles of case management (listed below):

Case Manager provides services for a CAP beneficiary participating in provider-led services.

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 needs 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.

Respite

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, family emergencies, planned special circumstances such as vacations, hospitalizations, or business trips; relief from daily responsibility and stress of caring; or the provision of time for the caregiver(s) to complete essential personal tasks. Respite care may be provided either in the beneficiary's residence or in a licensed facility.

Institutional Respite: Provision takes place in a Medicaid-certified nursing facility or hospital with swing beds.

Non-Institutional Respite: Provision takes place in the CAP beneficiary's home.

Three respite services: In-home Aide respite; Pediatric Aide respite; and Nursing respite

720 hours per fiscal year (July-June)

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

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 management entity, provider agency, and family to track the respite hours used to ensure the beneficiary remains within the approved limits.

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

Pediatric Nurse Aide

A service for CAP beneficiaries who require extensive hands-on assistance according to 10A NCAC 13J .0901 with:

- A. more than three Activities of Daily Living (ADL);
- B. at least two nurse aide II tasks; and
- C. more than one ADL and have medical or cognitive impairment.

The CAP beneficiary is 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 I or II or certification in pediatric care, or a recommendation by an RN that competencies are met in the area of need.

This services is not for normal age-appropriate functioning.

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.

14 days per year of recreational leave, when planned for in the initial and annual person-centered service plan.

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

CAP In-Home Aide Service

A service for CAP beneficiaries that, during the hours of service provision, provides hands-on (not merely set-up or cueing) assistance with a minimum of two extensive ADLs.

The personal care needs must fall within the NA I scope of nursing practice.

The CAP beneficiary is unable to perform these activities independently due to a medical condition or diagnosis identified and documented on an assessment.

This services is not for normal age-appropriate functioning.

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.

14 days per year of recreational leave, when planned for in the initial and annual person-centered service plan.

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

Financial Management Services

Financial management services are provided for CAP beneficiaries who are directing their own care through consumer-direction to ensure that consumer-directed funds outlined in the service plan are managed and distributed as intended.

Monthly management fees are included in the plan of care.

1 hour of management fees is approved per month to manage monthly responsibilities.

Responsibilities of the financial manager:

- 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

Employee under consumer-direction hiring exclusions

Individuals with the following criminal records are excluded from hire:

- 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.

Assistive Technology

Includes items, product systems, supplies, and equipment, that are not covered by Medicaid State Plan Home Health or Durable Medical Equipment and Supplies.

The cost of assistive technology is included in a combined home and vehicle modification budget of \$28,000 per beneficiary per the cycle of the CAP, which is renewed every five years.

The purpose of this service is to provide medically-necessary health care to:

- improve the accessibility and use of the beneficiary's environment; or
- address 24/7 beneficiary coverage issues.

Assistive technology may include:

- 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.

Community Transition Services

Community transition services are available to cover one-time expenses for prospective individual who make the transition from an institution to their own primary private residence in the community.

Community transition services are available to cover one-time, initial set-up expenses, not to exceed \$2,500.

Service must be utilized with 90 calendar-days from the date of beneficiary's discharge from an institution.

Community Transition Services may cover the following:

Equipment, essential furnishings, and household products; moving expenses; security deposits; set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating); environmental health and safety assurances, such as pest eradication, allergen control, one-time cleaning prior to occupancy; personal hygiene supplies; first week supply of groceries; up to a one month supply of medication in instances when the beneficiary is not provided with medication upon discharge from the nursing facility; and service does not include ongoing payments for rent.

Home Accessibility and Adaptation

Home accessibility and adaptation provides equipment and physical adaptations or minor renovations, 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.

The cost of home modification is included in a combined assistive technology and vehicle modification budget of \$28,000 per beneficiary per the cycle of the CAP, which is renewed every five years.

The CAP does not cover items that are available through Medicaid State Plan.

Home modifications can be provided only in the following settings:

- A primary private residence where the CAP beneficiary resides that is owned by the individual or the family;
- A rented residences when the modifications are portable

The case management entity authorizes the services and verifies training, technical assistance, permits, inspections, safety and ability to meet beneficiary's needs.

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.

Participants Goods and Services

Participants goods and services is a service for CAP beneficiaries that provides equipment, or supplies not otherwise provided through this CAP or through the Medicaid State Plan. This service helps assure health, safety and well-being when the CAP beneficiary or responsible party does not have funds to purchase the medically necessary item or service.

\$800.00 per fiscal year (July –June)

Specialized Medical Equipment and Supplies

- **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 documented by an assessment of need.
- **Vehicular transport vest:** A durable medical equipment for safe transport, documented by an assessment of need.
- **Adaptive car seat:** A durable medical equipment for safe transport, documented by an assessment

Adaptive tricycles for a CAP beneficiary: - \$ 3,000 over cycle of the five (5) year waiver.

Vehicular transport vest for individuals 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 beneficiary weighs less than the upper weight limit of the current car seat as documented in the service record. As priced per medical documentation.

Adaptive car seat as priced per medical documentation.

Vehicle Modification

Vehicle modification is a service for a CAP beneficiary that enables increased independence and physical safety through safe transport. This service often plays a key role in preventing institutionalization.

The cost of vehicle modification is included in a combined home and assistive technology budget of \$28,000 per beneficiary per the cycle of the CAP, which is renewed every five years.

The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the modification in the event of an accident.

The case management entity authorizes the services and verifies training, technical assistance, permits, inspections, safety and ability to meet beneficiary's needs.

Medicaid assumes no liability related to use or maintenance of the modification.

A vehicle inspection must be completed on vehicles that are 7 – 10 years old, or for vehicles with 80,000 – 150,000 or more miles.

Exclusions:

- Vehicles over ten (10) years old; or
- Vehicles with 200,000 or more miles

Explanation of terms



Explanation of Terms

- **Fiscal year – the financial planning period for DMA; financial planning period is from July 1st – June 30th**
- **Waiver life cycle – the planning period for the execution and administration of an approved Home and Community-Based Services waiver such as CAP/C; waiver approval period is for 5 years- CAP/C waiver is approved from 2017-2022**
- **CAP effective date – The approval entry date of waiver participation.**

Explanation of Terms

- **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).**
- **Unplanned waiver service occurrence requests are used to request an adjustment beyond the approved waiver service for a particular day(s) due to an unexpected event (for example a sick or snow day).**

Frequently Asked Questions



FAQs

Q: Is there a PowerPoint presentation available?

A: The CAP/C presentation materials can be found on the DMA website here:

<https://dma.ncdhhs.gov/providers/programs-services/long-term-care/community-alternatives-program-for-children>

Q: In future presentations, can acronyms be spelled out when first used.

A: DMA trainings will clarify commonly used acronyms in future trainings. A list of commonly used acronyms can also be found on slide 54.

Q: Will there be a pro-rated budget for the portion of the waiver which begins 3/1/17 and extends to 6/30/17? Will a beneficiary have access to the full budget for that fiscal year or will services to be billed per fiscal year not be available until 7/1/17?

A: Budget limits are immediately available on the effective date of the approved amended waiver.

FAQs

Q: When is the new CAP/C waiver effective?

A: The new waiver is effective March 1, 2017 to February 28, 2022.

Q: Is it required to have Medicaid approved prior to applying for CAP/C?

A: No

Q: Is there a waitlist for the CAP/C program? If so what is the estimated wait time?

A: No

FAQs

Q: With regards to the policy stating a beneficiary can be dis-enrolled from CAP/C if they fail to use services listed in the service plan during a 90-day consecutive period; Is it possible for a caregiver to request a temporary suspension of services if the family has plans to be out of town? If so, will a temporary suspension of services place the beneficiary at risk of CAP/C dis-enrollment?

A: No; if planned and approved by the case manager

Q: In addition to the service definitions listed on the PowerPoint presentation, can additional information regarding the service limits/budget amounts be provided?

A: Detailed information about CAP/C services can be found on the DMA website, refer to slide 48.

FAQs

Q: A beneficiary who previously received CAP/C services relocated to a different state for an extended period of time. The beneficiary has returned to North Carolina and would like to receive CAP/C services again. Can the beneficiary be reinstated to CAP/C or do they have to start the application process from the beginning?

A: The waiver allows priority consideration for specific reasons. The priority considerations include:

- Deinstitutionalizing (90 or more day in a hospital) from a hospital or nursing facility
- Relocating back to North Carolina from a military reassignment
- Private insurance terminating

FAQs

Q: When can consumer-direction start? Can an in-home caregiver be financially compensated for services provided?

A: The plan is to implement consumer-direction statewide by July 2017.

Q: What types of “risks” are not covered by CAP/C that caregivers may assume?

A: The comprehensive assessment will inform of risk factors and the case manager should address those risks factors with the caregiver.

FAQs

Q: Are Palliative Care services covered by CAP/C?

A: Palliative Care services are no longer included in the waiver. These services are now provided through Medicaid State Plan.

Q: Is ABA therapy available to help children with self-injurious behavior cope with being in the community?

A: Therapy services are covered through Medicaid State Plan.

Q: Are incontinent supplies no longer provided by the waiver? Will incontinent supplies be provided under Goods and Services or Specialized Medical Equipment?

A: Incontinence supplies are no longer included in the waiver. These supplies are provided Medicaid State Plan.

FAQs

Q: Will separate training be provided to explain the change of CAP/C nursing services moving to Private Duty Nursing?

A: Yes

Q: Nursing services previously received under CAP/C are now administered by Private Duty Nursing; have qualifications for Private Duty Nursing changed?

A: The Private Duty Nursing policy has been revised.

Q: With regards to nursing services for an emergency back-up plan, how can this be provided if there is a shortage of nurses? Can several companies be used on the plan?

A: Emergency back-up is the family's plan when formal supports are not available.

FAQs

Q: Is respite care calculated by units or hours?

A: Respite care is billed by units.

Q: Are units the standard measurement of time for all cases or does it vary case by case?

A: Units are the standard measurement for services billed by units (1 unit = 15 minutes).

Q: What is the budget limit for home and vehicle modifications?

A: The budget limit for home and vehicle modifications is \$28,000 per beneficiary per the cycle of the CAP, which is renewed every 5 years.

FAQs

Q: Is a sex offender background check included in the background check or separately?

A: Background check

Q: How can the parents/guardians of beneficiaries be assured that providers are completing the criminal background checks?

A: A financial management agency is mandated to complete the background checks.

Q: Does this training count towards caregiver training?

A: No, this training will not count towards the Caregiver Training and Education service.

FAQs

Q: What are the 17 core functional areas that were mentioned in this training?

A: 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; Early Intervention and Education

Q: Are special needs car seats allowed for Specialized Medical Equipment/Supplies or Vehicle Modifications?

A: Specialized Medical Equipment/Supplies

Q: Under PDN, will participants be grandfathered at the same for 1 year, then changes will be implemented?

A: An annual reassessment is conducted on all waiver beneficiaries to inform of ongoing needs and service limits.

Q&A

Q: What is the difference between respite, short term intensive, and unplanned waiver events?

A:

- Respite is used to provide relief to the caregiver.
- STI is used to address an acuity need lasting 3 weeks or less.
- Unplanned waiver event is used to cover an extra hour during of service due to an expected event

Q: Will STI or respite be used for summer breaks?

A: No; a plan of care revision should be created to meet summer break care needs

Q: Who determines the number of respite hours approved for a beneficiary?

A: Up to 720 hours per fiscal year can be used.

Q&A

Q: What are the changes to those being moved to PDN?

A: A private duty nursing certification period was entered for all children previously receiving CAP nursing. The hours of nursing will continue in the amount, frequency and duration through the next annual assessment.

Q: Will PDN allow choice of which nursing agency accompanies the child to public school?

A: The PDN department will be able to address this question.



Q&A

Q: Are respite hours distributed per family or per beneficiary? Can respite be used for multiple CAP/C children?

A: Respite hours are distributed per family. Up to 720 hours per fiscal year can be used.

Q: Will respite reflect dates for the fiscal year or CNR year?

A: Respite hours are planned per fiscal year for claim reimbursement. The CAP plan of care will show the respite time per CAP waiver year.



Q&A

Q: If a previously modified vehicle is totaled can a new vehicle be modified?

A: The beneficiary should have insurance coverage. A request may be made for consideration.

Q: Will CAP/C cover the cost for repairs of modified vehicles?

A: A request may be made for consideration and a decision will be made per policy guidelines.

Q: Are adaptive car seats covered under vehicle modifications services? What is the dollar amount?

A: Adaptive car seats are covered under specialized medical equipment. Requests require a certification of medical necessity, assignment requirements, and quotes.

Q: If the beneficiary has been approved for a vehicle modification in the previous waiver, will the new waiver allow them to request additional items for a different vehicle?

A: A request may be made for consideration and a decision will be made per policy guidelines.



Q&A

Q: Is the \$28,000 budget per recipient or family.

A: The \$28,000 budget is per family per the CAP cycle of 5 years.

Q: Is there coverage for alternative residence options (e.g. divorced parents and there are two homes)?

A: CAP/C provides equipment and physical modifications to the beneficiaries primary private residence. However modifications may be approved for a separate residence when custody is shared per a court order.

Q: What kinds of home modifications are considered portable?

A: Some examples of portable items covered under home modifications services include portable wheelchair ramps, back-up generators for a ventilator, air filtration system and filters.

Q&A

Q: Can caregiver training/education be used by consumer direct PAs to obtain their nursing aide certificate?

A: CAP/C training and education services are intended to train consumer-directed staff and caregivers on how to care for the beneficiary when the training is not a requirement of another service, entity or program.

Q: Will CNA or CPR trainings and certificates be covered under the waiver?

A: No

CAP/C Abbreviations and Acronyms

ADL	activities of daily living
CAP/C	Community Alternatives Program for Children
CAP/DA	Community Alternatives Program for Disabled Adults
CAN	Certified Nursing Assistant
CPR	cardiopulmonary resuscitation
CPS	Child Protective Services
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance
DME	durable medical equipment
DSS	Division of Social Services (State or County)
eCAP	IT system to manage CAP workflow and business processes
FI	financial intermediary
HCBS	Home and Community-Based Services
LOC	level of care
LTC	long-term care
LTSS	Long-Term Services and Supports
MID	Medicaid identification number
NA	Nurse Aide
PCP	Person-Centered Planning
RN	Registered Nurse
SRF	Service Request Form