Thank you for joining. The CAP Stakeholder Meeting will begin shortly.

Quick tips on attending a Microsoft Teams Live Event

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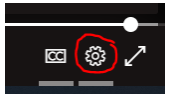

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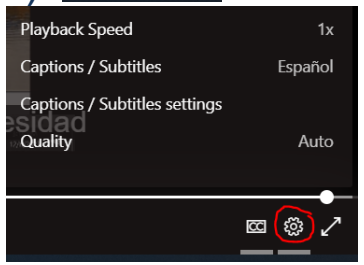

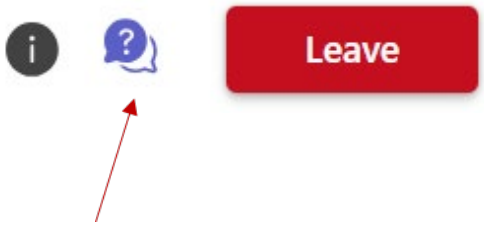

- You can submit questions anytime using the Q&A button at the top right of your screen.
- All questions and comments submitted today will be documented and used to help shape future sessions.
- Webinar materials and an FAQ will be made available to everyone after the session.

Need help during the webinar?

- For technical issues, email: Medicaid.NCEngagement@dhhs.nc.gov

If something isn't working, try refreshing your browser or rejoining the event.

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NC Medicaid
Long Term Services and Supports

Community Alternative Program Stakeholder Meeting

Nov 16, 2026



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AGENDA

- Opening Statement
  - LTSS Deputy Director, Greg Daniels
- Announcements
  - Revised CAP/C Toolkit
  - Updates on Disenrollments from CAP and Due Process
  - Plan of Care/Continued Needs Review Updates
  - Consumer Direction Best Practices
- Questions and Answers

Welcome



Greg Daniels

Deputy Director
Long Term Services and Supports

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Revised CAP/C Toolkit

- **The Toolkit Revision was updated effective Sept 2026**
- **LRP Paid Caregiver Review Tool**
  - **Key revisions include:**
    - Guidance on supporting documentation options has been updated.
    - The supporting documentation has been amended to include a letter from the beneficiary's treating practitioner as an option to support the request.
    - EC Criteria Checklist has been summarized and reformatted but remains aligned with the waiver.
  - Previously denied LRI's or individuals currently under CNR

- **Legally Responsible Individual Toolkit Updated | NC Medicaid**

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Extraordinary Circumstances Reviews are Person Centered

- Extraordinary circumstances for Paid Caregiving are outlined in the waiver.
  - Beneficiary services are approved based on the person-centered Plan of Care needs, which is separate from approving extraordinary circumstances for a paid caregiver.
  - The Case Manager is your first point of contact for all questions about the Plan of Care.
- LRI documentation requirements depend on each individual situation.

There is not a one size fits all, definitive list of documentation.

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Updates on Disenrollments from CAP

- The CAP/DA and CAP/C disenrollments were paused temporarily to update the disenrollment reason options found in e-CAP.
- Both CAP/C and CAP/DA disenrollment drop down reasons are now updated in e-CAP and CME's may begin submitting disenrollments.

- **Key revisions include:**
  - Redefining "**Withdrawals**" as **voluntary** removal from CAP and "**Disenrollments**" as **involuntary** removal from CAP.
  - The only allowable voluntary withdrawal or voluntary disenrollment reason is willful request to be withdrawn/disenrolled from the program because the beneficiary/family is no longer interested in waiver services. This request must be accompanied by an uploaded, signed request by the beneficiary or the legally responsible individual or guardian.
  - All other disenrollment reasons are considered involuntary and will result in the issuance of an involuntary disenrollment notice that includes due process appeal rights.
  - The previously listed reasons have been simplified and rewritten, and many have been moved from voluntary to involuntary to ensure the right to appeal removal from the program.

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Examples for Revised Drop-Down Options

Program	Current Termination Type	Original Language	Revised Termination Type	Revised Language
CAP/C	Withdrawal Reasons	**Beneficiary enrolled in another program**	Involuntary Disenrollment with appeal rights	**Beneficiary moving from CAP waiver services to other Medicaid services example, managed care, innovations etc.**
CAP/C	Disenrollment Reasons (both voluntary and involuntary)	**Beneficiary is receiving other services**	Involuntary Disenrollment with appeal rights	**Beneficiary moving from CAP waiver services to other Medicaid services example, managed care, innovations etc.**
CAP/C	Disenrollment Reasons (both voluntary and involuntary)	**Managed care disenrollment**	Involuntary Disenrollment with appeal rights	**Beneficiary moving from CAP waiver services to other Medicaid services example, managed care, innovations etc.**
CAP/DA	Withdrawal Reasons	**Beneficiary enrolled in another program**	Involuntary Disenrollment with appeal rights	**Beneficiary moving from CAP waiver services to other Medicaid services example, managed care, innovations etc.**
CAP/DA	Voluntary disenrollment reasons	**Managed care disenrollment**	Involuntary Disenrollment with appeal rights	**Beneficiary moving from CAP waiver services to other Medicaid services example, managed care, innovations etc.**
CAP/C	Disenrollment Reasons (both voluntary and involuntary)	**Transferred to a residential facility**	Involuntary Disenrollment with appeal rights	**Beneficiary not eligible for CAP services as beneficiary no longer resides in a private residence**
CAP/C	Disenrollment Reasons (both voluntary and involuntary)	**Transferred to hospital**	Involuntary Disenrollment with appeal rights	**Beneficiary not eligible for CAP services as beneficiary no longer resides in a private residence**
CAP/C	Disenrollment Reasons (both voluntary and involuntary)	**Transferred to skilled care**	Involuntary Disenrollment with appeal rights	**Beneficiary not eligible for CAP services as beneficiary no longer resides in a private residence**
CAP/DA	N/A	**N/A**	Involuntary Disenrollment with appeal rights	**ADD TO CAP/DA - Beneficiary not eligible for CAP services as beneficiary no longer resides in a private residence**

Disenrollments from CAP

- Reminder that all reductions, denials, suspensions, or terminations must receive an adverse notification with appeal rights.
- The notifications are generated though the e-CAP system which formats the letter and includes the appeal right notification.
- The appropriate disenrollment notice (voluntary or involuntary) is generated by based on reason selected and input from the CME.
  - CMEs are reminded to include specific, appropriate narrative for each disenrollment in addition to the selected reason. The narrative is needed by mediators and legal representation if the decision is appealed.
- Previously submitted Withdrawal requests from the old drop down list may be denied and will need to be resubmitted to align with the updated workflow.

Disenrollments from CAP

- Note: It is not appropriate to stop services after submission of a disenrollment request. DHB must review and approve or deny the disenrollment request and beneficiaries must receive due process rights and maintenance of service when appropriate. It is a violation of due process to stop services prematurely.
- CMEs should **not** manually create and submit a DHB 2193 form to DSS **until** the disenrollment request is:
- Reviewed by DHB, **and**
- Approved, by DHB **and**
- The 30-calendar day appeal period has passed.
  - After the formal system disenrollment is completed, beneficiaries have 30 calendar days from the date of the letter to appeal, and premature submission of the DHB 2193 form could disenroll the beneficiary before they exercise their rights.

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Plan of Care/Continued Needs Review Updates

- **The timeliness for CAP/C CNR completion has improved! The number of CNRs pending review has been significantly reduced month over month.**
- The focus remains on maintaining quality and ensuring appropriate care for all beneficiaries.
- Hands-on care authorizations are automatically extended to support continuity of care while the plan of care remains under review.
  - For questions about ongoing services during a review, contact your case manager and/or your financial manager agency.
  - After review of NCTracks, NC Medicaid can assist if authorizations are not located.

    Email Medicaid.providerombudsman@dhhs.nc.gov if Prior Authorizations are missing from NCTracks.
- If the review results in either a denial or reduction, due process applies and maintenance of service is put in place to ensure there is no gap or changes in service until a final determination is made.

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Consumer Direction Best Practices

- NC Medicaid is working with their vendors and systems to improve service authorization documentation for exceptional circumstances (such as CNR processing delays) so FMAs can authorize clock-ins and pay claims timely.
- New Consumer Direction services should not begin prior to completing all required steps and the generation of prior authorizations
- OPR Requirement – CMS requires identification of Ordering / Prescribing / Referring Medical Provider NPIs for each instance of services. It is crucial CMEs provide this information to the FMAs for timely claim adjudication
- New Respite Providers – When a beneficiary changes respite providers, the CMEs must provider respite hours remaining upon respite provider transition. The receiving Respite provide may reach out to the CME for this information if not initially provided.
- The Employer of Record, the beneficiary and the family should all be part of regular check-in's and MDT meetings.

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Questions and Answers

- Reminder:
  - For complaints, concerns, or issues related to CAP services, or program operations, please contact the NC Medicaid Ombudsman Program:
    - Email: Medicaid.ProviderOmbudsman@dhhs.nc.gov or
    - Phone: 877-201-3750.
- For case-specific questions, documentation needs, or service coordination, please contact your case management agency.

- Stakeholder FAQ webpage is available: Stakeholder FAQs

- CAP Stakeholder Workgroup webpage: Stakeholder Webpage

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Next CAP Stakeholder Meetings

These sessions are quarterly on the third Monday at 1 p.m.

The next session is scheduled for:

- Feb. 15, 2027

Registration details and meeting information will be shared ahead of each session.

- **Appendix: Due Process and Reference Information**

  - General Principles
  - Filing an Appeal
  - Office of Administrative Hearings (OAH)

Due Process Appeal Rights - General Principles

a. Federal law requires due process appeal rights for all adverse decisions made by NC Medicaid or its contractors regarding Medicaid services.
   - An Adverse Decision is required any time a requested service is denied, terminated, suspended, or reduced.
   - This means the Medicaid beneficiary must have appropriate notice of the adverse decision and must have an appropriate opportunity to challenge the decision.

b. The decision written is called the Notice of the Adverse Decision
   - Appropriate notice includes a written decision that is clear and easy to understand with all the reasons for the decision thoroughly explained.
     - Denial letter must include what is denied, why it was denied and how they can appeal the decision, as well as the timeframe for filing an appeal.
   - All adverse decisions must be uploaded to the Due Process/Appeals Clearinghouse

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Due Process Appeal Rights – Filing an Appeal

a. Beneficiaries or an authorized representative may file via mail, phone (oral), or fax.
   - Beneficiaries must file appeals directly to Office of Administrative Hearings (OAH).

b. The appeal process, includes mediation and possibly a hearing at the Office of Administrative Hearings (OAH), and is the opportunity to challenge the decision.
   - A state fair hearing may be requested within 30 days from the date of the notice.
   - Maintenance of service may be available for cases that involve previously authorized services that were denied or reduced.
   - Pursuant to 42 C.F.R. § 431.224, “a recipient may request that an appeal be expedited if the time otherwise permitted for a hearing could jeopardize the recipient's life, health, or ability to attain, maintain, or regain maximum function.”

Due Process Appeal Rights – OAH

Questions about the appeal or any additional information or evidence the family wishes to be considered should be directed to the Office of Administrative Hearings.

Until a final determination is made, any previously approved services continue under maintenance of service and previously approved services should not lapse during this process.

Office of Administrative Hearings (OAH)

- Attention: Clerk of Court
- 1711 New Hope Church Road
  Raleigh, NC 27609
- Telephone: 984-236-1850
- Facsimile: 984-236-1871

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