

**To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.**

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**Related Clinical Coverage Policies**

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

2A-3, Out-of-State Service  
2B-1, Nursing Facilities  
3A, Home Health Services  
3D, Hospice Services  
3G-2, Private Duty Nursing for Beneficiaries Under 21 Years of Age  
3H-1, Home Infusion Therapy  
5A-1, Physical Rehabilitation Equipment and Supplies  
5A-2, Respiratory Equipment and Supplies  
5A-3, Nursing Equipment and Supplies  
5B, Orthotics and Prosthetics  
8A, Enhanced Mental Health and Substance Abuse Services  
8A-1, Assertive Community Treatment (ACT) Program  
8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers  
8J, Children's Developmental Service Agencies (CDSAs)  
8L, Mental Health/Substance Abuse Targeted Case Management  
8-O, Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders

## **1.0 Description of the Procedure, Product, or Service**

The Community Alternatives Program for Children (CAP/C) is a Medicaid Home and Community-Based Services (HCBS) Waiver authorized under section 1915(c) of the Social Security Act and complies with 42 CFR § 440.180, Home and Community-Based Waiver Services. This waiver program provides a cost-effective alternative to institutionalization for beneficiaries, in a specified target population, who are at risk for institutionalization if specialized waiver services were not available. These services allow these targeted beneficiaries to remain in or return to a home and community-based setting.

HCBS waivers are approved by Centers of Medicare and Medicaid Services (CMS) for a specified time. The waiver establishes the requirements for program administration and funding. Federal regulations for HCBS waivers are found in 42 CFR Part 441 Subpart G, Home and Community-Based Services: Waiver Requirements. NC Medicaid can renew or amend the waiver with the approval of CMS. CMS may exercise its authority to terminate the waiver when it believes the waiver is not operated properly.

This waiver serves a limited number of medically fragile and medically complex children. To enroll and participate in this waiver, the individual shall meet the Medicaid eligibility requirements for long-term care.

NC Medicaid is the administrative authority of the waiver and outlines the policies and procedures governing the waiver. NC Medicaid appoints local case management entities to provide the day-to-day operation of the waiver to ensure the primary six waiver assurances are met. These assurances are:

- a. Level of Care (LOC);
- b. Administrative Authority;
- c. Qualified Providers;
- d. Services Plan;
- e. Health and Welfare; and
- f. Financial Accountability.

The requirements of administration of the CAP/C waiver are lists of target populations, waived Medicaid requirements, services, and the duration of the waiver. The following regulations give the North Carolina Department of Health and Human Services (DHHS) the authority to set the requirements contained in this policy and the CAP/C Waiver:

- a. 42 CFR Part 441 Subpart G, Home and Community-Based Services: Waiver Requirements;
- b. Section 1915 (c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may offer HCBS to state-specified target groups of Medicaid beneficiaries who meet a nursing facility level of care that is provided under the Medicaid State Plan.
- c. Section 1902(a) (10) (B) of the Social Security Act provides that Medicaid services are available to all categorically-eligible individuals on a comparable basis. This HCBS waiver:
  1. targets services only to the specified groups of Medicaid beneficiaries that meet the nursing facility level of care established by this policy; and
  2. offers services that are not otherwise available under the State Plan.

This waiver supplements, rather than replaces, the formal and informal services and supports already available to an approved Medicaid beneficiary. Services are intended for situations where no household member, relative, caregiver, landlord, community agency, volunteer agency, or third-party payer is able or willing to meet the assessed and required medical, psychosocial, and functional needs of the approved CAP/C beneficiary.

The CAP/C Waiver waives certain NC Medicaid requirements (42 CFR 441.300 through 310) in order to furnish an array of home and community based services to a Medicaid beneficiary who is at risk of institutionalization. The CAP/C waiver services are:

- a. Assistive technology;
- b. CAP/C in-home aide;
- c. Care advisor;
- d. Case management;
- e. Community transition service;
- f. Financial management services;
- g. Home accessibility and adaptation;
- h. Vehicle modification;
- i. Participant goods and services;

- j. Pediatric nurse aide services;
- k. Respite care (institutional and non-institutional);
- l. Specialized medical equipment and supplies; and
- m. Training, education and consultative services.

Refer to **Appendix B** for service definitions and **Attachment A, HCPCS Codes**, for services which are billable under the CAP/C Waiver.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  - 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  - 2. the NC Health Choice Program (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. The following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

##### a. Medicaid

The HCBS waiver authority permits a state to offer home and community-based services to an individual who:

- 1. is determined to require a level of institutional care under the State Medicaid Plan;
- 2. is member of a CAP/C waiver target population;
- 3. meets applicable Medicaid eligibility criteria;
- 4. requires one or more CAP/C service(s) that must be coordinated by a CAP/C case manager in order to function in the community;
- 5. is determined to be at risk of institutionalization based on risk indicators identified in a completed comprehensive assessment;

6. Is age 0 through 20 years of age, and meets all of the following medically fragile conditions (**refer to Appendix F**):
  - A. A primary medical (physical rather than psychological, behavioral, cognitive, or developmental) diagnosis(es) to include chronic diseases or conditions including but not limited to 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; and
  - B. A serious, ongoing illness or chronic condition requiring prolonged hospitalization (more than 10 calendar-days, or three (3) hospital admissions) within 12 months, or ongoing medical treatments (refer to **Appendix F** Glossary of CAP terms), nursing interventions, or any combination of these that must be provided by a registered nurse or medical doctor; and
  - C. A need for life-sustaining devices or life-sustaining care to compensate for the loss of bodily function, including but not limited to endotracheal tube, ventilator, suction machines, dialysis machine, Jejunostomy Tube and Gastrostomy Tube, oxygen therapy, cough assist device, and chest PT vest.

Only Medicaid beneficiaries in the following long-term care Medicaid categories listed below are eligible for CAP/C:

1. Medicaid Aid to the Blind (MAB);
2. Medicaid Aid to the Disabled (MAD);

Medicaid beneficiaries in the following Medicaid categories listed below are eligible for CAP/C:

1. Medicaid for Children Receiving Adoption Assistance (I-AS) and
2. Medicaid for Children Receiving Foster Care Assistance (H-SF)

**Note: MAB and MAD** beneficiaries need to be approved for disability by the Social Security Administration.

**Note:** An application for long-term care Medicaid is only approved when all eligibility requirements for CAP/C participation are met, as referenced in **Subsection 2.1.2.**

**b. NCHC**

NCHC beneficiaries are not eligible for CAP/C waiver services.



## 2.2 Special Provisions

### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

#### a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

#### b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing*

*Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide*:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

### **2.2.2 EPSDT does not apply to NCHC beneficiaries**

### **2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.1** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

## **3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

### **3.2 Specific Criteria Covered**

#### **3.2.1 Specific criteria covered by both Medicaid and NCHC**

None Apply

#### **3.2.2 Medicaid Criteria Covered**

- a. Medicaid shall cover medically necessary State Plan services and **CAP/C shall cover** necessary waiver services for an eligible beneficiary who meets the requirements in **Subsection 2.1.2** and **all** of the following criteria:
  1. Requires the approved NC Medicaid HCBS nursing facility LOC. The LOC is a level typically provided in an institution that is directly related to a documented medical diagnosis and functional care need as assessed;
  2. Has a completed comprehensive assessment that finds there is a reasonable indication the beneficiary needs the coordination of CAP/C

services in order to remain in the community due to risk of institutionalization;

**Refer to Appendix F for definition of at-risk of institutionalization;**

3. Requires CAP/C services on a monthly basis, that are not recreational in nature that mitigate institutionalization through coordinated case management and hands on personal assistance;
  4. Requires only an installation of a home or vehicle modification or assistive technology 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) calendar months of approval);
  5. Able to have his or her health, safety, and well-being maintained at their primary private residence or approved location of service for CAP/C with the use of formal and informal supports, refer to **Appendix F** for definition of informal supports;
  6. Has medical needs met within the average cost limitations of the CAP/C Waiver; refer to **Subsection 5.7.3** and **Appendix F**;
  7. Has a primary physician that is connected to a Medical Home.
  8. Able to have an assigned CAP/C slot for waiver entry, contingent to CAP/C allocations;
  9. Has an emergency back-up and disaster recovery plan with reliable formal and informal support to meet the basic needs outlined in the CAP/C assessment and service plan to maintain their health, safety, and well-being; and
  10. Has been determined to be medically fragile, and meet the NC Medicaid HCBS LOC criteria; Refer to **Appendix F and Section 2.1.2** for definition of Medically Fragile.
- b. In addition to the above requirements, a beneficiary electing to direct their own care (**consumer-directed**) shall meet **all** of the following criteria:
1. Understand the rights and responsibilities of directing his or her own care through participation in training, completion of a self-assessment questionnaire, and responses listed within the self-assessment questionnaire;
  2. Be willing and emotionally capable to assume the responsibilities of employer under the consumer-directed care model, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care (**refer to Appendix F for definition of willing and capable**); and
  3. Complete a self-assessment questionnaire that explicitly details the care needs of the beneficiary, how the care interventions will specifically meet the needs of the beneficiary, identifies training needs or opportunities for the employer and employees (if applicable), and how assurances of health, safety, and well-being will be managed in the areas of abuse, neglect, and exploitation, fraud, waste and abuse, and emergency and disaster planning, as listed in **Appendix G**.

- c. In addition to the specific criteria listed in **Subsection 3.2.2(a) and (b)**, the following requirements apply to all CAP/C beneficiaries:
1. Care is maintained at their primary private residence or approved place of service within the average cost limitations of the CAP/C Waiver;
  2. Amount, duration, frequency, and provider taxonomy of CAP/C services and non-CAP/C services are indicated in the beneficiary's service plan and approved by the case management entity;
  3. Services are provided according to all requirements specified in this policy; all applicable federal and state laws, rules, and regulations; the current standards of practice; and provider agency policies and procedures.

**Note:** The case management entity shall ensure that an adequate emergency back-up and disaster recovery plan is in place, because both personal and home maintenance tasks are essential to the well-being of the CAP/C beneficiary. The plan may contain family, friends, neighbors, community volunteers, and licensed home care agencies when possible in the event of an emergency or an unplanned occurrence. An emergency back-up plan is necessary for times when the formally arranged support system is unavailable during regularly scheduled work hours and when the unpaid informal support system is unavailable. The emergency back-up plan must address emergency preparedness.

### 3.2.3 Level of Care Determination Criteria

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.

#### a. Qualifying Conditions

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

1. A service required by physician's judgment that requires:
  - 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 (that is, 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 a licensed nurse:
    - 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(NG) or gastrostomy tube 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. Flushing the tube as recommended.
  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. 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**

When two or more of the following are met, HCBS nursing facility level of care placement may be justified:

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 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.

### **3.2.4 Expedited Criteria (Prioritization) for CAP/C Consideration**

The CAP 1915 (c) HCBS waiver arranges for service consideration on a first-come first-serve basis due to similar acuity needs of individuals applying for participation in the CAP/C Waiver. When a statewide waitlist is implemented, individuals meeting specific criteria shall be expedited for immediate consideration of CAP/C participation, and prioritized for immediate participation, or prioritized to the top of an existing waitlist. Prioritization criteria apply to individuals meeting the following:

- a. Individuals who were receiving personal care-type services through private health insurance plan and the policy holder has determined the need to terminate the policy.
- b. Individuals transitioning from a nursing facility with Money Follows the Person (MFP) designation.
- c. Individuals transitioning from a 90-day hospital or nursing facility stay utilizing service of community transition services.
- d. Eligible CAP/C beneficiaries who are transferring to another county or case management entity.
- e. Previously eligible CAP/C beneficiaries who are transitioning from a short-term rehabilitation placement within 90 calendar-days of the placement.
- f. Individuals identified as 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/C Waiver is able to mitigate risk; or

- g. Medicaid beneficiaries with active Medicaid who are temporarily out of the State due to a military assignment of their primary caregiver.

### 3.2.5 Transfers of Eligible Beneficiaries

When a transfer request is received, the case management entity shall coordinate the transfer of an eligible CAP/C beneficiary to another county or entity within 30 calendar-days.

- a. Case management entities shall coordinate the transfer as soon as possible to prevent gaps in service provisions. The following steps must be completed prior to the transfer:
  - 1. determined anticipated start date of service;
  - 2. coordinated transition plan between provider agencies;
  - 3. discuss and plan for the health, safety, and well-being of the beneficiary;
  - 4. initiate with the Information Technology (IT) contractor the transfer of the electronic health records to the receiving county;
  - 5. arrange 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. coordinate the provision of services to start on the first date of the transfer.
- b. The case management entity shall assist a CAP/C beneficiary three calendar months prior to his or her 18<sup>th</sup> birthday, with coordinating with the local DSS to identify any needed changes to the Medicaid application and to initiate an adult transition plan in anticipation of the 21<sup>st</sup> birthday.

**Note:** An assessment of the remaining number of case management hours must be evaluated by a NC Medicaid or DHHS designated contractor to facilitate the final approval of the transfer.

### 3.2.6 NCHC Additional Criteria Covered

None Apply.

## 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or



- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

#### 4.2 Specific Criteria Not Covered

##### 4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

##### 4.2.2 Medicaid Criteria Not Covered

Medicaid shall not cover CAP/C participation and CAP/C services under any **one** of the following circumstances:

- a. An assessment of medical and functional needs has not been completed by an RN or social worker to determine risk of institutionalization, as defined in **Appendix F**.
- b. The beneficiary 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 despite case management coordination. If services designated in the service plan are not available for more than 30 calendar-days, the case manager must contact NC Medicaid and provide information related to the lack of services to avoid potential disenrollment;
- c. The CAP/C evidence code has not been entered or has been removed from the eligibility information system;
- d. The HCBS Service Request Form (SRF) is incomplete, has been denied, or a request for additional information was not received within the specified timeframe;
- e. The required annual assessment recertification was not approved or completed within 60 calendar-days of the annual assessment date;
- f. The beneficiary is receiving other Medicaid services or other third-party reimbursed services that are adequately meeting assessed needs and CAP/C services would be duplicative;
- g. The beneficiary's currently approved services (Medicaid and non-Medicaid) are meeting assessed care needs and the beneficiary is not determined to be at-risk of institutionalization (refer to Appendix F);
- h. When the only assessed waiver need is a home or vehicle modification or assistive technology, and evidence is provided of the installation and an invoice and a prior approval claims have been submitted to NCTracks;
- i. The beneficiary's 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, listed in **Subsection 7.10**, during the planned and unplanned absences of the paid provider, if applicable;
- j. When services for CAP/C beneficiary, between the ages of 5-21, are listed in an Individualized Education Plan (IEP) under the provisions of Individuals with Disabilities Education Improvement Act of 2004 (IDEA). The funding of such services is the responsibility of state and local education agencies (LEAs);

- k. The CAP beneficiary enters an institution for a short-term rehabilitation or hospital stay or long-term institutional stay (refer to **Subsection 7.11**);
- l. When a legal guardian or primary caregiver of the beneficiary is employed to be the paid caregiver of CAP/C services;
- m. 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 (refer to **Subsection 7.9**);
- n. 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;
- o. The beneficiary's Medicaid eligibility is not active or has been terminated;
- p. The beneficiary is not approved for Medicaid in the specified categories in **Subsection 2.1.2**;
- q. The beneficiary is in a Medicaid sanction period;
- r. The beneficiary does not reside in an approved primary private residence;
- s. The beneficiary or responsible party is not willing or capable to assume the responsibilities of employer under the consumer-directed model of care based on a completed self-assessment questionnaire when electing to participate in consumer-directed care, or does not have an approved representative who is willing and capable to assume the responsibilities to direct the beneficiary's care;
- t. 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; or
- u. 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, refer to **Appendix D**.

**Note:** The CAP/C beneficiary shall be eligible to participate in the CAP/C waiver when in deductible status; however, CAP/C waiver services are not reimbursed by Medicaid until the deductible is incurred.

#### **4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  - 1. No services for long-term care.
  - 2. No nonemergency medical transportation.
  - 3. No EPSDT.

4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

## 5.0 Requirements for and Limitations on Coverage

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 5.1 Prior Approval

Medicaid shall require prior approval for CAP/C Waiver, level of care and waiver services. The provider shall obtain prior approval before rendering CAP/C Waiver services.

### 5.2 Prior Approval Requirements

#### 5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsections 3.2, 5.6.2 and 5.7** of this policy

#### 5.2.2 Specific

The case management entity, or designated entity, shall submit to the DHHS designated contractor the following:

- a. HCBS Service Request Form (SRF) along with the Physician Attestation in **Appendix A**, to determine clinical eligibility for participation in the CAP/C Waiver. The SRF establishes medical fragility and the level of care and is the first indicator of whether a beneficiary is appropriate for CAP/C services. The SRF must be completed within 45 calendar-days from the initiation date. An SRF that is incomplete after 45 calendar-days of initiation will be voided. A slot is not reserved for an SRF pending over 45 calendar-days.
  1. All sections and required fields on SRF must be completed in its entirety to establish eligibility determination for level of care. The sections and fields on the form must contain:
    - A. Service request.
    - B. Beneficiary demographics.
    - C. Beneficiary conditions and related support needs.
    - D. Attestation by physician.
    - E. Date of LOC request and determination.
- b. The interdisciplinary comprehensive assessment identifying assessed needs and functional level of acuity (refer to **Subsection 5.3**); and
- c. A draft of the person-centered service plan that identifies the CAP/C and regular State Plan services in the amount, frequency, duration, and scope based on assessed needs (refer to **Subsection 5.4**).

**Note:** DHHS's designated contractor shall submit an electronic prior approval (PA) transfer to NCTracks of approval or denial of CAP/C participation, when the SRF, interdisciplinary comprehensive assessment, and signed person-centered service plan are finalized.

**Note: Throughout the assessment process and service plan development,** NC Medicaid may revoke administrative oversight and case management appointment if it is determined the case management entity is not in compliance with the CAP/C requirements. In the case of revocation, the person-centered service plan development would temporarily be carried out by NC Medicaid or another case management entity until a new case management entity is appointed.

The person-centered service plan approval authorization process verifies there is a proper match between the beneficiary need and the service provided. This involves identification of over and under-utilized services through careful analysis of the beneficiary's needs, problems, skills, resources, and progress toward the beneficiary's goals.

## 5.3 CAP/C Participation

### 5.3.1 Approval Process

#### **Inquiries and Referrals:**

When inquiry is made about CAP/C services, the case management entity shall provide information about the eligibility for, requirements of, and services of the CAP/C Waiver. This is an opportunity to discuss the benefits and limitations of the CAP/C Waiver. The case management entity, or designated entity, assists with the completion of the SRF. When an SRF is approved, an Introductory Letter is mailed to the prospective CAP/C beneficiary to inform of the first phase of eligibility (medical fragility and LOC) approval.

#### **Assessment Approval:**

When a CAP/C slot is available, the CAP/C beneficiary is placed in assessment-assignment which notifies the case management entity to initiate the assessment. The scheduling of the assessment must be initiated within 10 business days of receipt of the assessment-assignment.

#### **Coordinate with Medicaid Eligibility Staff:**

The case management entity shall alert the county DSS case worker of the in-process CAP/C assessment to begin the long-term care Medicaid application. The case management entity follows up with DSS to ensure that the application is being processed.

#### **Coordinate with Community Care of North Carolina (CCNC)**

The case management entity contacts the local CCNC network to obtain data available in their Provider Portal within five (5) business days of assessment and assignment. This information helps guide the assessment and the Plan of Care Development. The

coordination with CCNC also provides opportunity to confirm enrollment in a health home for the management of preventative and routine health services.

### 5.3.2 Minimum required documents for CAP/C participation approval:

- a. **Initial:** Contact information for the CAP/C beneficiary and primary caregiver; an approved SRF; Signed consent to release information; Signed Participants' Rights and Responsibilities; Signed Freedom of Choice form with selected providers; Service plan that outlines service needs and cost summary; Completed comprehensive interdisciplinary needs assessment that contains the acuity level; Emergency back-up and disaster plan; Job or school verification statement; Physician's order; Individual risk agreement; and self-assessment questionnaire, if applicable.
- b. **Annual:** Contact information for the CAP/C beneficiary and primary caregiver; Signed consent to release information; Signed Participants' Rights and Responsibilities; Signed Freedom of Choice form with selected providers; Service plan that outlines service needs and cost summary; Completed comprehensive interdisciplinary needs assessment that contains the annual LOC assessment and functional acuity level; Emergency back-up and disaster plan; Job or school verification statement; Physician's order; Individual risk agreement; and Self-assessment questionnaire, if applicable.
- c. **Change in Status:** Contact information for the CAP/C beneficiary and primary caregiver; Signed consent to release information; physician's order; Service plan that outlines service needs and cost summary; Completed comprehensive interdisciplinary needs assessment that contains the acuity level; Emergency back-up and disaster plan; Job or school verification statement; signed Freedom of Choice form with selected providers; Individual risk agreement; and Self-assessment questionnaire, if applicable.

## 5.4 CAP/C Comprehensive Interdisciplinary Needs Assessment Requirements

The case management entity's, or designated entity's, approved assessors shall complete an initial and annual interdisciplinary comprehensive needs assessment on each beneficiary to determine medical, physical and psychosocial functioning acuity level to plan for all the beneficiary's assessed needs. The interdisciplinary comprehensive assessment must contain:

- 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;
- o. Housing and finances;
- p. Early Intervention and Education; and
- q. Attestations by the assessors.

The initial interdisciplinary comprehensive assessment is conducted after the approval of the SRF, refer to **Subsection 5.3.1**. Each field in the assessment must be completed prior to the initiation of the service plan. The interdisciplinary comprehensive assessment must be completed within 45 calendar-days of the referral to the case management entity.

Upon completion and NC Medicaid approval of the SRF and the comprehensive assessment, the CAP/C beneficiary or designated representative will agree to select participation in the CAP/C Waiver.

**Note:** Upon the completion and approval of the SRF, or at the time of Assessment Assignment in the case management Information Technology (IT) system, a referral for long-term care Medicaid for CAP/C participation must be made to the local DSS.

## 5.5 CAP/C Person-Centered Service Plan Requirements

The medical, functional, and social information collected through the interdisciplinary comprehensive needs assessment is documented in a service plan in the form of identified service needs, beneficiary's risks, and informal caregiver supports' needs. The service plan is initiated after the completion of the interdisciplinary comprehensive assessment and must be in draft form within five (5) business days of the completed assessment for review and approval by NC Medicaid. The service plan specifies the person-centered goals, objectives, and formal and informal services to address the identified medical and functional care needs of an approved CAP/C beneficiary. The services documented on the service plan effectively meet the needs identified in the assessment. The case management entity uses the service plan to achieve the following:

- a. Summarize the evaluation and assessment information to highlight the beneficiary's strengths and needs;
- b. Outline person-centered goals, objectives, and case management tasks based on the assessment and identified needs;
- c. Identify beneficiary's outcomes to be supported;
- d. Develop a comprehensive list of CAP/C waiver and non-waiver services, medical supplies and durable medical equipment (DME), and document the authorized provider name, amount, frequency and duration of each service;
- e. Summarize plan of care cost totals to ensure the Medicaid and waiver services are within the average established cost limit;
- f. Identify health and welfare monitoring priorities during the service plan period;
- g. Ensure the beneficiary's right to choose among providers as evidenced by a signed provider Freedom of Choice form; and

- h. Develop a service plan annually and update when warranted due to status changes in the CAP/C beneficiary's care needs.

### 5.5.1 Changes and Revision to the Service Plan

The case management entity along with the CAP/C beneficiary determines whether to revise the person-centered service plan when there is a significant change in the beneficiary's needs. A service plan revision is required when a CAP/C, Medicaid State Plan, or Medicare service is added, reduced, increased, deleted, or when there are changes in type, scope, amount, duration, or frequency of a CAP/C service.

NOTE: Specified plan of care revisions may require a minor change to the approval without the legal guardian or the primary caregiver's signature. The e-CAP system will provide guidance in that area.

Service plan revisions, excluding home and vehicle modifications and assistive technology, may be approved retroactively for up to 30 calendar-days prior to the date the plan is revised when the service, equipment or supply is not procured prior to the first day of the 30 calendar-day retroactive date. The beneficiary or the primary caregiver shall agree to and sign and date the service plan acknowledging changes for CAP/C provision.

**Documenting a change in services:** The case management entity shall revise the service plan as the beneficiary's needs change. Changes to the service plan are submitted in the web-based case management system within 30 calendar-days of identified needs and must be approved within ten (10) calendar-days of the entered revision.

**Documenting a change of provider agency:** A service plan update is required for a change in provider agency, the change is a revision, but external review is not needed. The case management entity obtains a signed agreement from the CAP/C beneficiary or the responsible party consenting to the change in provider(s). The freedom of provider choice form must be uploaded to IT case management system.

### 5.5.2 Person-Centered Service Plan Denial

If the person-centered service plan is not approved, the case management entity or NC Medicaid notifies the CAP/C beneficiary or legal representative through an electronically generated notice that is mailed to the CAP/C beneficiary. The case management entity notifies the DSS's eligibility unit of the notice mailed to the CAP/C beneficiary.

If a person-centered service plan is not submitted with an authorized signature (beneficiary or legal representative) to elect continued participation in the waiver program within ten (10) calendar-days of the expiration of the current year's person-centered service plan, the CAP/C beneficiary becomes ineligible for continuation of participation in the CAP/C Waiver. The DHHS designated contractor or NC Medicaid shall disenroll the CAP/C beneficiary from the CAP/C Waiver. The CAP/C beneficiary is notified in writing of the disenrollment. The DSS is notified of the CAP/C disenrollment and the CAP/C

beneficiaries may be terminated from Medicaid if Medicaid eligibility is contingent upon CAP/C participation.

If the CAP/C beneficiary requests to re-enter the CAP/C Waiver, he or she may re-enter within 90 calendar-days of disenrollment without having to reapply, (completion of the required paperwork identified in **Subsections 5.2.2 - 5.5 is required**) for CAP/C services. CAP/C services are not approved during the period before the reentry process

If the case management entity or, designated entity, does not determine the individual to be at risk of institutionalization based on the comprehensive assessment and the RN exception review validates this decision, the individual or legal representative is notified in writing of the denial of CAP/C participation. The case management entity notifies the DSS of the denial. The individual is not eligible to receive CAP/C services.

## **5.6 Continued Need Review (CNR) Assessment Requirements**

A CNR assessment must be completed at least every 12 consecutive months to determine ongoing need for CAP/C waiver participation and the identification of medical, functional, and psychosocial care needs of the beneficiary for safe community living. The CNR assessment must be completed by week three (3) of the CAP/C effective month. The service plan must not be initiated prior to the completion of the interdisciplinary comprehensive assessment.

The CNR assessment consists of the following:

- a. completed interdisciplinary comprehensive assessment that identifies LOC, the beneficiary's preferences, strengths, needs, and ability to live safely in the community; and
- b. developed and approved person-centered service plan as evidence of completed assessment.

### **5.6.1 Continued Need Review Person-Centered Service Plan Requirements**

The annual service plan is called the CNR service plan. To complete the annual service plan, refer to **Subsections 5.4 and 5.5**. The CNR service plan must be approved by the fifth (5) day of the month following the beneficiary's identified CAP/C effective date. The annual service plan must be completed during the month of the CAP/C effective date. The CNR service plan is effective the first (1) day of the month following the CAP/C effective date and expires one calendar year later. The CNR person-centered service plan achieves the following:

- a. Summarizes the evaluation and assessment information to highlight the beneficiary's strengths, needs, risks, informal caregiver capacity and availability;
- b. Outlines goals and objectives based on the assessment and identified needs; and
- c. Ensures the beneficiary's right to choose from among approved CAP/C services and Medicaid-enrolled providers.



### 5.6.2 CAP/C Effective Date

The effective date for CAP/C participation is the **latest** of the following:

- a. the date of the Medicaid application;
- b. the date the case was approved for an assessment and placed in assessment-assignment in e-CAP;
- c. the date of deinstitutionalization; or
- d. in the event of an appeal, the date the Court issues the order, settlement decision, or other document concluding the appeal.

### 5.6.3 Authorization of Services

If the CAP/C beneficiary or legal representative agrees to the person-centered service plan, by their signature, CAP/C participation is approved. The case management entity shall authorize selected providers according to the approved service plan through service authorizations. The service authorization must detail the approved waiver services authorization period, the specific benefit services, and the tasks to be provided in the amount, duration, frequency, and type. The case management entity shall confirm with the chosen provider the receipt and acceptance of the service authorization within 72 calendar hours of submission of the form. The authorized Medicaid provider shall initiate the rendering of the approved service within five (5) calendar-days of the receipt of the service authorization. The duration of initial approval of CAP/C participation is 13 consecutive months past the initial authorization, unless otherwise notified. For CNR, the authorization period begins on the first (1) day of the month following the beneficiary's CAP/C effective date and expires in 13 consecutive months.

**Note:** The case management entity shall use NC Medicaid-approved forms containing the same information for service authorizations and participation agreements.

Regular Medicaid State Plan providers approved to provide a Medicaid service to a CAP/C beneficiary receive a service authorization or participation notice acknowledging medical necessity has been met to receive the service as outlined in the provider's plan of care. The Medicaid provider will follow the policies and procedures governed by that program.

## 5.7 Waiver Service Requests and Required Documentation

### 5.7.1 Assistive Technology, Equipment, Supplies, Home Accessibility and Adaption, and Vehicle Modifications

For requests for assistive technology equipment and supplies, home modification, and vehicle modification, the following additional information is required:

- a. a plan for how the beneficiary and family is to be trained on the use of the equipment upon installation (the training must be documented by the case manager as completed and signed by the CAP/C beneficiary or responsible party);

- b. evidence of medical need submitted by a physician;
- c. shipping costs, itemized in the request proposal;
- d. a signed agreement consenting to the disenrollment from the CAP/C waiver upon the agreed upon completion of modification or installation of the technology when entering the waiver only for supplies, technology and modifications;
- e. other information as required for the specific equipment or supply requested;
- f. when quotes are required for purchase, adaptation or modification, NC Medicaid determines, based on the request and the geographical region, how many quotes are required to yield a decision of the approved cost for the adaptation or modification; and
- g. NC Medicaid determines the appropriate professional(s) that make written recommendations for services that require those recommendations.

For requests for **assistive technology** equipment and supplies, the following additional information is required:

- a. An assessment or recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the equipment and supplies being requested. The assessment or recommendation must state the cost of an item that a beneficiary requires.
- b. Supplies that continue to be needed at the time of the beneficiary's annual assessment must be recommended by an appropriate professional and contained in the annual assessment package. The assessment or recommendation must be reevaluated if the amount of the item the beneficiary needs changes.

For requests for **adaptive car seats**, the following additional information is required:

- a. CAP/C beneficiary shall have a documented chronic health condition which requires the use of an adaptive car seat for positioning. Car seats are not approved for behavioral restraint.
- b. Case Management agencies, along with the medical professional, shall determine medical need for adaptive car seat by the following:
  - 1. CAP/C beneficiary's weight;
  - 2. CAP/C beneficiary has a seat to crown height that is longer than the back height of the largest child car safety seat if the beneficiary weighs less than the upper weight limit of the current car seat. The measurements must be documented;
  - 3. Reasons why the beneficiary cannot be safely transported in a car seat belt or convertible or booster seat for a CAP/C beneficiary weighing 30 pounds and more; and
  - 4. Certification of necessary care, assessment requirements, and quotes as outlined in **Appendix B**.

For **Home Accessibility and Adaption**, the following additional information is required:

Assessment by a physical therapist, occupational therapist, rehabilitation engineer, or adaptive technology professional that identifies the beneficiary's need(s) with regard to a home modification request.

For **Vehicle Modification**, the following additional information is required:

- a. A vehicle inspection must be conducted for vehicles that are seven (7) – 10 years old, or for vehicles with 80,000 or more miles.
- b. A recommendation by a physical therapist or occupational therapist specializing in vehicle modification, or a rehabilitation engineer.
- c. The recommendation must contain information regarding the rationale for the selected modification, the beneficiary's or primary caregiver's ability to manipulate the modifications, the pre-driving assessment of the beneficiary if the beneficiary will be driving the vehicle, condition of the vehicle to be modified, the insurance on the vehicle to be modified and an evaluation of the safety and life expectancy of the vehicle in relationship to the modification.
- d. If purchasing a vehicle with an existing ramp or lift on it, the price of the used lift on the used vehicle must be assessed and the current value may be approved under this service definition to cover this part of the purchase price. The beneficiary shall not take possession of the vehicle with the existing ramp or lift prior to the approval by NC Medicaid.
- e. The modification must meet applicable standards and safety codes. The case management entity shall conduct a quality assurance inspection on the completed adaptation to ensure a health and safety of the CAP/C beneficiary.
- f. Documentation of car insurance to cover the modification.
- g. If equipment is moved from one vehicle to another, an evaluation of the cost for labor and costs of moving devices or the equipment is required prior to approval.

### 5.7.2 Supportive Services

For requests for supportive services such as community transition, consumer-directed care, caregiver training, education and consultative services, the following additional information is required for:

a. **Community Transition;**

A completed Community Transition Checklist.

b. **Caregiver Training, Education and Consultative Services;**

Short and long-range outcomes directly related to how the requested service or treatment will aid in decreasing the beneficiary's dependence or increase the beneficiary's independence or increase the primary caregiver(s) ability to provide care and to support the CAP/C beneficiary.

- c. **Consumer-Directed election:**
  1. A completed self-assessment questionnaire (refer to **Subsection 3.2.2.b.3** and **Appendix G**);
  2. Representative Needs Assessment and Representative Designation or Agreement, as applicable;
  3. Verification of required training; and
  4. Consumer-directed Agreement packet approved by NC Medicaid.

### 5.7.3 CAP/C Budget Limits

CAP/C service provisions are planned at an average per capita cost per year of \$129,000.

To assure cost neutrality of the waiver, a cost analysis of the total waiver budget and each beneficiary's cost expenditure must be conducted quarterly. When the average per capita cost of waiver services are 75 percent over the average per capita cost of the institutional care, NC Medicaid must do the following:

- a. Develop a cost utilization plan with a timeline of 90 calendar-days to align the waiver expenditure within the CAP/C 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, individual service utilization limits must be implemented until the waiver is within the cost neutrality limits. A beneficiary impacted by cost adjustment plan during this time is carefully case managed to identify other formal and informal resources to absorb a portion of the cost of care.

## 6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### 6.1 Provider Qualifications and Occupational Licensing Entity Regulations

In-home aide services and pediatric services are rendered by a paraprofessional. (Refer to **Appendix B** for service-specific requirements).

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

NC Medicaid requires the following provider qualifications and training be completed before staff is assigned to provide in-home aide services and pediatric nurse aide to the CAP/C beneficiary:

- a. Criminal background checks, which must be repeated every two (2) years, at the time of certification 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 NC Medicaid pediatric training, such as
  1. growth and development;
  2. pediatric beneficiary interactions; and
  3. home care of a pediatric beneficiary.

NC Medicaid requires the following supervision to be performed as listed:

Supervision of the CNA minimally every 60 calendar-days, in the home, by the RN Supervisor.

The following types of staff provide CAP/C waiver services:

- a. Certified Nursing Assistant I, or
- b. Certified Nursing Assistant II

## **6.2 Case Management Entity Qualifications**

Local case management agencies are appointed by NC Medicaid to provide day-to-day oversight of the CAP/C Waiver in the community (refer to **Subsection 6.3**). Competencies of appointed case management entities are evaluated quarterly and documented by a compliance score (refer to **Subsection 7.15**).

The case management entity must be an organization with five (5) or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management entity shall enroll as a Medicaid provider and be appointed through an agreement with Medicaid to provide lead agency CAP/C services. Every five (5) years, the case management entity must recertify as a Medicaid provider.

If a case management entity does not meet the requirement of five (5) years of experience, NC Medicaid will provide technical assistance for a period of one (1) calendar year in order for the agency to build competencies to become approved to provide CAP/C services. NC Medicaid will approve the case management entity once it demonstrates the ability to provide CAP/C services.

### **6.2.1 CAP/C Mandated Requirements to be An Appointed Case Management Entity**

Qualified case management entities shall have:

- a. A resource connection to the service area to provide continuity and appropriateness of care;

- b. Experience in pediatrics, medical-complexities, 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 base experience;
- e. Ability to provide case management by both social worker and nurse;
- f. Physical location;
- g. Computer technology and information technology web-based connectivity to support the requirement of current and future automated programs;
- h. Meet the regulatory criteria under DHHS/DHSR, if applicable;
- i. Staff to participant ratio (appropriate case mix); and
- j. Confirm the rendering of services within five (5) days of submission of the service authorization.
- k. Qualified staff as listed in **Subsection 6.2.1**; and
- l. Signed the 3K-1, *Community Alternatives Program for Children (CAP/C) Waiver*, clinical coverage policy to accept the roles and the responsibility of case management entity, that attest to the adherence of the provision and implementation of the CAP/C Waiver.

**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 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 NC Medicaid-certified training program within 90 calendar-days 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 the health or medical field directly related to homecare, long-term care, or personal care and the completion of a NC Medicaid certified training program within 90 calendar-days of employment;
- 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 the health or medical field directly related to homecare, long-term care, or personal care and the completion of a NC Medicaid certified training program within 90 calendar-days of employment; or
- d. 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 NC Medicaid certified training program within 90 calendar-days of employment.

**Note:** An individual with a Bachelor's degree or who holds a nursing license as described above, without the number of years of experience, may be designated as an apprentice and shall be hired to act in the role of case manager. The supervisor of the case management shall provide direct supervision and approve all waiver workflow documentation and tasks.

### **Case Manager Continuing Education Requirements**

The case manager or care advisor shall complete nine (9) contact hours of 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.

Each case manager shall complete a required training curriculum annually as listed below:

- a. Bloodborne Pathogens and Infection Control;
- b. Health Insurance Portability Accountability Act (HIPAA);
- c. End of life planning;
- d. CAP/C Pediatric Training;
- e. Cultural Diversity, Competency and Awareness; and
- f. Completion of the following NC Medicaid program-specific training modules within one (1) calendar-year of implementation of this clinical coverage policy and within one (1) calendar-year for a newly hired case manager or care advisor:
  1. Introduction to CAP/C;
  2. Case Management 101 for HCBS providers;
  3. Person-Centered planning;
  4. Prior approval Policies and Procedures;
  5. Health, Safety and Well-being and Individual Risk Agreement;
  6. Consumer-directed;
  7. Due Process;
  8. EPSDT;
  9. Money Follows the Person Transition Coordination;
  10. Program Integrity (PI);
  11. Quality Assurance and Performance Outcomes; and
  12. Critical Incident Reporting.

### **6.2.2 Coordination of Care**

CAP/C beneficiaries are eligible to receive all Medicaid services according to Medicaid policies and procedures, except when those policies or procedures restrict participation or duplicate another Medicaid or other insurance service. Case management entities are responsible for the following activities: waiver administrative oversight, care coordination through assessing, care planning, referring or linking and monitoring, and following-up.

Case management and care coordination services are necessary to identify needed medical, social, environmental, financial, and emotional needs. These services are provided to maintain the beneficiary's health, safety, and well-being in the community. It is a required component of the CAP/C Waiver that a case management activity is performed at least monthly (refer to **Subsection 7.6**).

### **6.2.3 Appointed Case Management Entities are Required to Provide Case Management as follows:**

The principle activities of case management are:

#### **a. Assessment**

Case managers shall conduct a comprehensive assessment (refer to **Subsection 5.4**) to:

1. Address all aspects of the beneficiary, including medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational and other areas;
2. Identify conditions and needs for prevention and maintenance;
3. Involve consultation with other informal and paid supports such as family members, medical and behavioral health providers, and community resources to form a complete assessment;
4. Integrate all other current assessments such the comprehensive clinical assessment, medical assessments, and any other appropriate assessments; and
5. Reassess periodically to determine whether a beneficiary's needs or preferences have changed.

#### **Case Manager - Assessment Core Knowledge, Skills, and Abilities**

The case manager or care advisor shall possess the knowledge, skills and abilities:

Knowledge of:

1. Formal and informal assessment practices.
2. The population, disability and culture of the beneficiary being served.

Skills and Abilities to:

1. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, summarizing, and giving options;
2. Develop a trusting relationship to engage beneficiary and natural supports;
3. Engage beneficiaries and families to elicit, gather, evaluate, analyze and integrate pertinent information, and form assessment conclusions;
4. Recognize indicators of risk (health, safety, mental health/substance abuse);
5. Gather and review information through a holistic approach, giving balanced attention to individual, family, community, educational, work, leisure, cultural, contextual factors, and beneficiary preferences;
6. Consult other professionals and formal and natural supports in the assessment process; and
7. Discuss findings and recommendations with the beneficiary in a clear and understandable manner.



**b. Care Planning**

Care planning is the development and periodic revision of a person-centered care plan based on the information collected through the assessment and reassessment process. The care plan identifies all formal services received in the amount, frequency and duration. The care plan also identifies both formal and informal supports to assure the health, safety and well-being of the beneficiary.

Amount, duration, frequency, and provider type of services are indicated in the beneficiary's CAP/C plan of care (POC). Approval for non-CAP/C services remains with the approval authority for the specific service. The local approval authority (LAA) (refer to **Subsection 6.3**) approves CAP/C services and the overall POC (refer to **Subsections 5.4 and 5.5**).

Services are provided according to all requirements specified in this policy: all applicable federal and state laws, rules, and regulations; the current standards of practice; and case management entity policies and procedures.

**Case Manager - Care Planning Core Knowledge, Skills, and Abilities**

The case manager or care advisor shall possess the following knowledge, skills, and abilities:

Knowledge of:

1. The values that underlie a person-centered approach to providing service to improve beneficiary functioning within the context of the beneficiary's culture and community;
2. Models of wellness-management and recovery;
3. Biopsychosocial theories of practice, evidenced-based standards of care, and practice guidelines;
4. Processes used in a variety of models for group meetings to promote beneficiary and family involvement in case planning and decision-making; and
5. Services and interventions appropriate for assessed needs.

Skills and Abilities to:

1. Identity and evaluate a beneficiary's existing and accessible resources and support systems; and
2. Develop an individualized care plan with a beneficiary and his or her supports based on assessment findings that contain measurable goals and outcomes.

**c. Referral and Linkage**

Referral and related activities link a beneficiary with medical, behavioral, social, and other programs, services, and supports to address identified needs and achieve goals specified in the care plan. The case manager or care advisor shall coordinate with other human services agencies as specified in the care plan.

**Referral and Linkage Core Knowledge, Skills, and Abilities**

The case manager or care advisor shall possess the knowledge skills, and abilities:

Knowledge of:

1. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, recreation, and housing resources; and
2. Current laws, regulations, and policies surrounding medical and behavioral healthcare.

Skills and Abilities to:

1. Research, develop, maintain, and share information on community and other resources relevant to the needs of the beneficiary.;
2. Maintain consistent, collaborative contact with other health care providers and community resources;
3. Initiate services in the care plan in order to achieve the outcomes derived for the beneficiary's goals; and
4. Assist the beneficiary in accessing a variety of community resources.

**d. Monitoring and Follow-up**

Case managers or care advisors may make announced and unannounced visits with the beneficiary, responsible party, and service providers to ensure that the service plan is effectively implemented and adequately addresses the needs of the beneficiary.

**Case Manager - Monitoring and Follow-up Knowledge, Skills, and Abilities**

The case manager or care advisor shall possess the following knowledge, skills and abilities:

Knowledge of:

1. Outcome monitoring and quality management;
2. Wellness-management, recovery, and self-management; and
3. Community beneficiary-advocacy and peer support groups.

Skills and Abilities to:

1. Collect, compile and evaluate data from multiple sources;
2. Modify care plans as needed with the input of the beneficiary, professionals, and natural supports;
3. Discuss quality-of-care and treatment concerns with the beneficiary, professionals, formal and natural supports;
4. Assess the motivation and engagement of the beneficiary and his or her supports; and
5. Encourage and assist a beneficiary to be a self-advocate for quality care.

### 6.3 General Case Management Responsibilities

NC Medicaid is the administrative authority of the CAP/C waiver. The case management entity shall comply with the following NC Medicaid guidelines:

- a. CAP/C application, rules, policy and procedures;
- b. Provider enrollment;
- c. Authorization of qualified providers for the provision of program services in the community;
- d. Program rates and limits;
- e. CAP/C enrollment;
- f. Level of care evaluation;
- g. Beneficiary service plans;
- h. Prior authorization of services;
- i. Utilization management;
- j. Quality assurance and quality improvement strategy (QIS Framework);
- k. Continuous quality improvement;
- l. Performance measures and benchmarks for the case management entity; and
- m. Audits and reports.

### 6.4 Specific Case Management Entity Responsibilities

The Case Management Entity is the local entry point for CAP/C Waiver entry and management. The case management entity shall:

- a. Develop referral procedures according to NC Medicaid standards and local policy and share these procedures with the appropriate providers and organizations;
- b. Educate the caregiver of children, about CAP/C Waiver;
- c. Process referrals;
- d. Provide assistance in obtaining documentation from medical staff to determine level of care;
- e. Provide assistance in verifying with DHHS Fiscal Contactor whether medical documentation supports nursing facility level of care;
- f. Assess beneficiary's appropriateness for CAP/C services;
- g. Provide case management or care advisement to the CAP/C beneficiary;
- h. Ensure the average per capita cost planning methodology, service limits, beneficiary monitoring details, quality assurance reporting and beneficiary risk mitigation; and
- i. Complete critical incident reports within 72-hours of the incident.

### 6.5 Medicaid Provider Requirement to Provide CAP Waiver Services

Medicaid providers seeking to provide CAP/C services shall be approved by NC Medicaid through a managed change request (refer to **Appendix B**). Each selected Medicaid provider of CAP/C services shall undergo a CAP/C overview and orientation training prior to rendering authorized services, and annually thereafter.

The CAP/C provider shall provide a copy of their policies and procedures that identifies the assurance of nonuse of restraints and seclusions.

### **6.5.1 Providers for Community Transition Funding**

Medicaid providers who have the capacity as verified by the case management entity (refer to **Appendix B**) to provide items and services of sufficient quality to meet the need for which they are intended shall provide transition services. Items and services (with 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.

### **6.5.2 Providers for Home Accessibility and Adaptation Modifications**

Home accessibility equipment and supplies procured through Medicaid must be provided by an enrolled Medicaid Durable Medical Equipment and Supplies (DME) provider. The case management entity, through a service authorization, authorizes providers who have demonstrated the ability to perform home modifications and installation of equipment.

### **6.5.3 Providers for Institutional Respite Services**

Institutional respite services must be provided in a Medicaid certified nursing facility or a hospital with swing beds under 10A NCAC 13D rules for the licensing of nursing homes.

### **6.5.4 Providers for Non-Institutional Respite Services**

Non-institutional respite services must be provided by a homecare agency licensed by the State of North Carolina in accordance with 10A NCAC 13J.1107, In-Home Aide Services. If the beneficiary's service plan requires the personal care aide, who provides extensive assistance and substantial hands-on care to a CAP/C beneficiary who is only able to perform part of the activity, the personal care aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-256. This applies to provider-led non-institutional respite.

### **6.5.5 Providers for Specialized Medical Equipment and Supplies**

The case management entity, through a service authorization, authorizes providers who have demonstrated the ability to supply requested equipment and supplies.

### **6.5.6 Providers for In-Home Care Aide**

Personal care aides, along with pediatric and in-home aides are provided by home care agencies licensed by the state of North Carolina who comply with NC General Statutes 131E-135 through 142 and 21 NCAC 36.0403 (a) and 21 NCAC 36.0403 (b). Workers providing level III – personal care tasks shall be listed as a Nurse Aide I. A spouse, parent, child or sibling of the CAP/C beneficiary may be employed to provide this service **only** if the person meets all of the following:

- a. CAP/C beneficiary and provider are 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 to provide the personal care task at that level as defined in 10A NCAC 13J.1110; and
- c. Any employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the CAP/C beneficiary. This restriction also applies to other relatives and hired personnel.

### 6.5.7 Provider for Financial Management

The provider for financial management shall:

- a. be approved by Medicaid as a fiscal intermediary and have the capacity to provide financial management services through both the Budget Authority or Employer Authority model, refer to Appendix F;
- b. be authorized to transact business in the State of North Carolina; and
- c. have three years of financial management experience.

### 6.6 Licensure and Certification

The following rules apply to below listed agencies within the Division of Health Service Regulation (DHSR), and must be complied with:

**Home Care Agency:** 10A NCAC Chapter 13 Subchapter J

**Health Care Personnel Registry:** 10A NCAC Chapter 13 Subchapter O

#### Nurse Aides

N.C. Home Care Licensure Rules (10A NCAC 13J)

GS Chapter 90, Article C – The Nurse Aide Registry Act

NC Board of Nursing, Nurse Aide I Tasks

NC Board of Nursing, Nurse Aide II Tasks

Refer to NCBON, <http://www.ncbon.com/>, regarding the applicable nurse aide tasks and competencies.

## 7.0 Additional Requirements

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### 7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

## 7.2 Service Record

A service record must be maintained on each CAP/C beneficiary by the case management entity and approved CAP/C provider(s). A service record is a collection of either electronic or printed material that provides a documentary history of the CAP/C beneficiary's HCBS participation and service interventions. The documentation in the service record must comply with all applicable federal and state laws, rules, and regulations.

## 7.3 General Documentation Requirements for Reimbursement of CAP/C Service

The minimum service documentation requirements of the CAP/C Waiver are listed below. All Medicaid providers shall document services prior to seeking Medicaid reimbursement. The case management entity shall perform follow-up documentation to verify the provision of the service, or to reflect attempts to ascertain why a CAP/C beneficiary is not participating in an approved service according to the established service plan or schedule.

**For Specialized medical equipment and supplies**, bill cost for the item, including delivery charges and taxes. The cost is what is invoiced by the supplier. The charge to Medicaid must not exceed the maximum reimbursement rates for the equipment or supply. Documentation must comply with the requirements in **Subsection 5.7**.

**For Home accessibility and adaptation**, bill cost for the item, including applicable installation and delivery charges, taxes, and permit fees. The cost is what is invoiced by the supplier/installer. Documentation must comply with the requirements in **Subsection 5.7.1**.

**For Institutional Respite Care-**, bill the Medicaid Nursing Facility rate for the CAP/C beneficiary's catchment area for the calendar-day(s) of respite provided to the CAP/C beneficiary. Documentation must comply with the requirements in **Subsection 5.7**.

**For In-Home aide, and pediatric and non-institutional Respite**, bill the customary charge for the units provided to the CAP/C beneficiary for each date of service. Documentation must comply with the requirements in **Subsections 6.5.4 and 6.5.6**.

**For Financial Management**, bill Medicaid rate for units provided to the CAP/C beneficiary for each month fiscal intermediary services are provided. Documentation must comply with the requirements in **Subsection 6.5.7 and Appendix B-Financial Management**.

**For Community Transition, participant goods and services, and training, education and consultative services**, bill the cost for the item, including applicable delivery charges, and taxes. The cost is what is invoiced by the supplier. Documentation must comply with the requirements in **Subsection 5.7.2**.

#### 7.4 Service Note

The documentation for CAP/C waiver services must fully detail the purpose of the intervention along with the date and duration of time taken to complete the approved service or task. The documentation must be completed within 72 hours of the intervention and signed and dated by the personnel performing the service or task. The case management entity's case management activities must comply with **Subsections 6.2.2 and 6.2.3**.

The service note must contain, at a minimum, all of the following:

- a. the purpose of the visit;
- b. the beneficiary's name;
- c. date and duration of the contact;
- d. the goals reflected in the current service plan;
- e. progress towards person-centered goals;
- f. recommendation for continuation, revision or termination of CAP/C service(s); and
- g. the signature and date the service note was written.

If the 72-hour mandatory documentation time is not adhered to, it is considered a "late entry." Documentation must be noted in the service record as a "late entry" and record:

- a. date the documentation was made;
- b. reason for missing timely entry; and
- c. date of the actual due-date that was missed.

**Note:** A late entry must be documented within 365 calendar-days of the actual service date when other supporting documentation is available to confirm the service intervention.

#### 7.5 Signatures

All entries in the electronic record must be signed with a full signature. A full signature consists of the credentials, degree or license for professional staff or the position of the individual who provided the service for paraprofessional staff. For the electronic records, signatures, and facsimile signatures may be used if the provider's process is consistent with all applicable laws, rules and regulations such as the N.C. Boards of Medicine and Nursing and the N.C. rules governing licensure of home care agencies, and case management entity's internal policy.

#### 7.6 Frequency of Monitoring of beneficiary and services

The case management entity and CAP/C providers shall conduct:

- a. a monthly contact by telephone or in person with the CAP/C beneficiary to monitor and assess CAP/C services;
- b. a monthly or quarterly (*based on identified risk indicators in the completed comprehensive assessment*) multidisciplinary treatment team meeting with all providers identified in the service plan to:
  1. monitor health and well-being, and
  2. review the provision of and continued appropriateness of these services;

- c. a monthly or quarterly (*based on risk indicators*) contact visit, with the CAP/C beneficiary or responsible party, to monitor health and well-being and assess CAP/C services; and
- d. monthly review ensuring that respite service is rendered as authorized; and
- e. quarterly review monitoring total use of respite services over the previous 90-day period.

### 7.7 Corrections in the service record

Changes or modification in the original documentation for the purpose of making a correction can be made at any time, when in compliance to **Subsection 7.3**, licensure or certification rules governing the CAP/C waiver service. Whenever corrections are necessary in the beneficiary's record, case management entity shall seek technical assistance from the DHHS designated contractor (IT contractor) to make the changes to the electronic record and CAP/C providers shall follow their internal policies and procedures.

### 7.8 Waiver Service Specific Documentation

The case management entity shall obtain the below required documentation prior to the approval and implementation of the following CAP/C services:

- a. Assistive Technology;
- b. Home Accessibility and Adaptation Services;
- c. Specialized Medical Equipment and Supplies;
- d. Training, Education and consultative Services;
- e. Vehicle Modification; and
- f. Participant Goods and Services.

The required documents for the above services are:

- a. Comprehensive Interdisciplinary Needs Assessment completed by the case manager identifying equipment, supply, adaptation, or modification needs;
- b. copy of the physician's attestation, order, or signature certifying necessary care along with the request for equipment, supply, adaptation, or modification needs. The recommendation must be less than one-calendar year from the date the request is received;
- c. recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the equipment, supply, adaptation, or modification being requested;
- d. the estimated life of the equipment as well as the length of time the beneficiary is expected to benefit from the equipment, must be indicated in the request;
- e. an invoice from the supplier that shows the date the equipment, supply, adaptation, or modification were provided to the beneficiary and the cost, with related charges and maintained in the e-CAP system;
- f. long-range outcomes related to training needs associated with the beneficiary's utilization and procurement of the requested equipment, supply, adaptation or modification are reported in the Service Plan, as appropriate; and



- g. documentation for specific equipment, supplies, adaptation, and modification as outlined in the definition. Refer to **Appendix B** for these requirements.

The consumer-directed beneficiary, primary caregiver or responsible party shall maintain timesheets and workflow sheets of their hired assistance that are consistent with the record and retention policy, refer to **Section 7.9**.

If the consumer-directed beneficiary transfers back to the traditional planning of the CAP/C Waiver, the case management entity shall take possession of those files and maintain those files consistent with the record and retention policy.

### **Respite Service**

The case management entity and the Medicaid provider shall document respite service as requested based on the category of respite, institutional or non-institutional and the required documentation must contain the following components:

- a. Name of the CAP/C beneficiary;
- b. Medicaid identification;
- c. Type of respite service provided;
- d. Date of the service;
- e. Location the service was provided;
- f. Duration of the service;
- g. Task performed; and
- h. Completed and signed service note, refer to **Subsection 7.3**.

**Note:** It is the primary responsibility of the case management entity to monitor the respite hours so not to exceed maximum limits.

## **7.9 General Records Administration and Availability of Records**

CAP/C providers shall make service documentation available to NC Medicaid and case management entities to review the documentation to support a claim for CAP/C services rendered, when requested. The service record must have:

- a. Service authorization submitted by the case management entity; and
- b. Service documentation, refer to **Subsection 7.3** required for service billed.

The case management entity shall retain the following documentation in the service record:

- a. the referral;
- b. all assessments;
- c. service plans;
- d. case management notes;
- e. service authorizations;
- f. monthly contacts;
- g. quarterly beneficiary visits;
- h. quarterly multidisciplinary team meeting documents;

- i. reported incidents;
- j. reported complaints;
- k. copies of claims generated by the case management entity;
- l. required documents generated by other providers and approved by the case management entity; and
- m. related correspondence complying with all applicable federal and state laws, rules and regulations, and agency policy for the date of services.

### 7.10 Health, Safety and Well-being

The primary consideration underlying the provision of CAP/C services and assistance for a CAP/C beneficiary is his or her desire to reside in a community setting. Enrollment and continuous participation in CAP/C services may be denied based upon the inability of the program to ensure the health, safety, and well-being of the beneficiary.

- a. Assessment of the beneficiary's medical, mental, psychosocial and physical condition and functional capabilities, may indicate inability to participate in the CAP/C Waiver when **one** of the following conditions cannot be mitigated for the CAP/C beneficiary:
  1. The beneficiary is considered to be at risk of health, safety and well-being when his or her responsible party cannot cognitively and physically devise and execute a plan to safety;
  2. The beneficiary lacks the emotional, physical and protective support of a willing and capable caregiver who shall provide adequate care to oversee 24-hour hands-on support or supervision to ensure the health, safety, and well-being of the beneficiary with debilitating medical and functional needs;
  3. The beneficiary's needs cannot be met and maintained by the system of services that is currently available to ensure the health, safety, and well-being;
  4. The beneficiary's primary private residence is not reasonably considered safe due to:
    - A. a heating and cooling system that exacerbates medical condition which results in multiple hospital admissions or emergency room visits;
    - B. lack of refrigeration for the storage of food and required medication or supplements;
    - C. a plumbing, water supply and garbage disposal (garbage and infection material) that exacerbates medical condition which results in multiple hospital admissions and emergency room visit;
    - D. electrical wiring is a fire hazard; or
    - E. lack of any type of heating and cooking appliance, to maintain the recommended nutritional balance based on medical diagnosis.
  5. The beneficiary's primary private residence presents a physical or health threat due to:
    - A. the proven evidence of unlawful activity conducted;
    - B. threatening or physically or verbally abusive behavior by the beneficiary, family member or other persons who live in the home exhibited on more than two (2) incidents; or

- C. presence of a health hazard due to pest infestation, hoarding of animals or animal excretion.  
These conditions would reasonably be expected to endanger the health and safety of the beneficiary, paid providers or the case manager or care advisor;
  - 6. The beneficiary's continuous intrusive behavior impedes the safety of self and others by attempts of suicide, injury to self or others, verbal abuse, destruction of physical environment, or repeated noncompliance with service plan and written or verbal directives;
  - 7. The beneficiary's primary caregiver or responsible party continuously impedes the health, safety and well-being of the beneficiary by:
    - A. refusal to comply with the terms of the service plan;
    - B. refusal to sign a plan and other required documents;
    - C. refusal to keep the case management entity informed of changes in the status of the beneficiary; or
    - D. refusal to remove or lessen the risk or hazard that create an unsafe environment; or
  - 8. The 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 a Child Protective Services (CPS) assessment or care plan.
- b. CAP/C provider or beneficiary's caregiver shall not use unauthorized or unnecessary interventions that:
    - 1. restrict CAP/C beneficiary's movement;
    - 2. restrict CAP/C beneficiary access to other individuals, locations, or activities;
    - 3. restrict participant rights; or
    - 4. employ aversive methods to modify behavior, (unless provided for a CAP/C beneficiary for whom it is not used as a restraint, but for safety-such as bed rails, safety straps on wheelchairs, standers, adaptive car seats, and specialize crib beds).
  - c. CAP/C provider or beneficiary's caregiver shall not use the following unauthorized or unnecessary restraints:
    - 1. personal; or
    - 2. mechanical.
  - d. CAP/C provider or beneficiary's caregivers shall not use the following:
    - 1. Drugs used as restraints; or
    - 2. Seclusion.

## 7.11 Individual Risk Agreement

An Individual Risk Agreement (IRA) outlines the risks and benefits to the beneficiary of a particular course of action that might involve risk to the beneficiary, the conditions under which the beneficiary is responsible for the agreed upon course of action, and the accountability trail for the decisions that are made. An individual risk agreement permits a beneficiary to accept responsibility for his or her choices personally, through surrogate decision makers, or through planning team consensus. The IRA tool is found in **Appendix E**.

## 7.12 Absence from CAP/C Participation

### Hospital Stays of 30 Calendar-days or Less

When a CAP/C beneficiary is temporarily absent from CAP/C participation, the case management entity shall take the following course of action:

- a. Determine the reason for the admission, the prognosis, and anticipated length of the absence from the primary private residence;
- b. Suspend all CAP/C services except for case management;
- c. Notify the discharge planner that the beneficiary is a CAP/C beneficiary;
- d. Notify the county DSS that the beneficiary has been hospitalized;
- e. Monitor the beneficiary's progress through contact with the discharge planner and other appropriate parties;
- f. Monitor any changes that can extend the hospitalization beyond 30 calendar-days or result in a transfer to a nursing facility or rehabilitation center;
- g. Determine, as necessary, the medical and related home care needs with the physician, discharge planner, and other appropriate parties when the beneficiary is released;
- h. Alert CAP/C providers when to resume care;
- i. Inform the DSS Medicaid staff that the beneficiary continues on the CAP/C services; and
- j. Revise the service plan, if applicable, and sends notices of change to service providers and sends to NC Medicaid nurse consultant for approval, if needed.

### Hospital Stays Longer than 30 Calendar-days

Hospital stays of more than 30 calendar-days affect Medicaid eligibility and CAP/C participation. If the beneficiary is hospitalized for more than 30 calendar-days, the CAP/C case management entity shall contact the local DSS staff to learn when the beneficiary's Medicaid status changes to long-term-care budgeting. The case management entity shall coordinate with the DSS worker the effective date of disenrollment from the CAP/C Waiver based on the date of the change in Medicaid eligibility for the beneficiary. The case management entity initiates the disenrollment based on the notice of change letter from the local DSS.

### Nursing Facility Admissions

Because the beneficiary has already been disenrolled from CAP/C participation due to the nursing facility admission, the case manager or care advisor shall suspend all CAP/C services for 30 calendar-days from the admission date. Service providers are notified of the nursing facility placement. For short-term rehabilitation stays that do not exceed 30

calendar-days, the beneficiary can resume the CAP/C services upon discharge. For nursing facility stays greater than 31 days but less than or equal to 90 calendar-days, the beneficiary can be expedited back on the CAP/C Waiver with a change in status assessment and service plan.

### **Temporary Out of Primary Private Residence**

If a beneficiary temporarily (for 30 calendar-days or less) leaves his or her primary private residence without knowledge of or prearrangement by the case manager, the case management entity shall suspend the delivery of CAP/C services by contacting the provider agencies until contact has been made with the beneficiary. No CAP/C services can be provided during this absence. The local DSS Medicaid eligibility staff is notified when an extended absence has been approved to occur. The CAP/C slot remains available to the beneficiary. The case management entity shall track the absence, since an extended absence can affect Medicaid eligibility and continued CAP/C participation. Unless prior approved by the case management entity, CAP/C participation is terminated after 90 calendar-days of absence from the primary private residence when CAP/C services are not being provided.

### **7.13 Voluntary Withdrawals**

A CAP/C beneficiary can make a decision to voluntarily withdraw from CAP/C participation at any time. The CAP/C beneficiary shall submit a written notice containing the date of withdrawal from CAP/C and the beneficiary's, or his or her responsible party's, signature to the case management entity. The case management entity coordinates the CAP/C disenrollment activity. The planning process for disenrolling the CAP/C beneficiary must coincide with the date the beneficiary makes in the request to withdraw.

The beneficiary is allowed to rescind the voluntary withdrawal request prior to the effective date of the change in services, or within 90 calendar-days of the effective date.

### **7.14 Disenrollment**

The case management entity shall disenroll the beneficiary when CAP/C is no longer appropriate, in accordance with CAP/C policies and procedures implemented by NC Medicaid as listed in **Subsections 4.2.1** and **4.2.2**. When a CAP/C beneficiary's participation is terminated, the beneficiary's responsible party is notified in writing. Refer to <https://medicaid.ncdhhs.gov/>, for information on due process.

The proposed effective date depends on the reason for the disenrollment. Any of the following are reasons for disenrollment:

- a. The beneficiary's Medicaid eligibility is terminated from CAP/C coverage eligibility;
- b. The beneficiary's physician does not recommend the beneficiary's needs are at a nursing facility level;
- c. The annual assessment reflects care needs that are not approved for nursing facility LOC;
- d. DSS removes the CAP/C evidence and cannot reenter the evidence;
- e. 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;

- f. 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;
- g. The beneficiary's health, safety, and well-being cannot be mitigated through a risk agreement;
- h. The beneficiary or primary caregiver does not participate in development of or sign the service plan;
- i. The beneficiary or primary caregiver(s) fails to comply with all program requirements consistently, such as failure to arrive home at the end of the approved hours of service, or manipulation of the coverage schedule without contacting the case manager for approval; or
- j. 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.

**Note:** Disenrollment from CAP/C, under items "e." through "j" above, may ensue if:

- a. there are three (3) such occurrences, and the beneficiary or primary caregivers have been counseled regarding this issue; or
- b. after one occurrence, if the beneficiary's health and welfare is at risk and cannot be mitigated.

### 7.15 Quality Assurance

NC Medicaid is expected to have, at the minimum, systems in place to measure and improve its performance in meeting the CAP/C assurances that are set forth in 42 CFR 441.302. These assurances address important dimensions of quality, assuring that service plans are designed to meet the needs of a CAP/C beneficiary and that there are effective systems in place to monitor CAP/C beneficiary health and welfare as described below:

- a. The quality, appropriateness, and outcomes of services provided to a CAP/C beneficiary; and
- b. The cost efficiency of the CAP/C beneficiary's care.

Appointed case management entities are designated to assure the quality and performance of the waiver. Each case management entity shall maintain a compliance score of 90% (an aggregated total of established benchmarks, refer to **Mandated Waiver Assurances**) on a quarterly basis for continuation as an appointed case management entity. A compliance score under 90% each month results in a corrective action plan and prohibition of enrollment of new CAP/C beneficiaries. A compliance score of less than 90% for three (3) consecutive months can result in disenrollment as an appointed case management entity.

## Objectives

Quality improvement activities are a joint responsibility of NC Medicaid and its 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:

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

The following are quality assessment and quality improvement activities of the CAP/C Waiver:

- a. Review of initial applications and continued need reviews for appropriateness, accuracy and outcomes;
- b. Review of effectiveness of and compliance to authorized CAP/C services on a quarterly basis;
- c. Annual Participant experience survey sent by NC Medicaid to a representative sample of CAP/C beneficiaries;
- d. Critical incident reporting; Complaints and grievances; and
- e. Site or desk-top audits of case management entities and CAP/C provider agencies.

The purpose of case management, which must be tracked, is to:

- a. Improve or maintain beneficiary capacities for self-performance of activities of daily living and instrumental activities of daily living;
- b. Improve beneficiary compliance with accepted health and wellness prevention, screening and monitoring standards;
- c. Reduce beneficiary health and safety risks;
- d. Implement strategies to avoid unplanned hospitalizations;
- e. Avoid emergency room visits as a means for receiving primary care;
- f. Enhance beneficiary socialization and reduce social isolation;

- g. Reduce risks of caregiver burnout;
- h. Increase caregiver capacities;
- i. Enhance beneficiary awareness self-management of chronic conditions;
- j. Foster a more engaged beneficiary;
- k. Promote a positive beneficiary personal outlook; and
- l. Improve informal caregiver(s) outlook and confidence in their caregiving role.

#### **Mandated Waiver Assurances**

Quality assurance activities are conducted to monitor the following six (6) mandated waiver assurances:

- a. Level of Care
  - 1. CAP/C applicants for whom there is reasonable indication that services may be needed in the future are provided an individual LOC evaluation;
  - 2. The LOC of an enrolled CAP/C beneficiary is reevaluated at least annually or as specified in the approved waiver; and
  - 3. The processes and instruments described in the approved waiver are applied to LOC determination.
- b. Service Plan
  - 1. Service plans address all a CAP/C beneficiary's assessed needs, as found in **Subsection 7.10** and person-centered goals, either by the provision of CAP/C services or through other means;
  - 2. The state monitors services plan development in accordance with its policies and procedures;
  - 3. Service plans are updated or revised in the same month as the CAP/C effective date or when warranted by changes in a CAP/C beneficiary;
  - 4. Services are delivered in accordance with the service plan, which lists the type, scope, amount, duration and frequency of the services; and
  - 5. A CAP/C beneficiary is afforded choice between CAP/C services and institutional care and between and among CAP/C services and providers.
- c. Qualified Providers
  - 1. The state verifies that providers initially and continually meet required licensure and certification standards and adhere to other standards prior to their furnishing CAP/C services;
  - 2. The state monitors non-licensed and noncertified providers to assure adherence to CAP/C requirements; and
  - 3. The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.
- d. Administrative Authority



NC Medicaid retains administrative authority and responsibility for the operation of the CAP/C Waiver by exercising oversight of the performance of CAP/C Waiver function by other state and local and regional non-State agencies and contracted entities.

e. Financial Accountability

State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

f. Health and Welfare

On an ongoing basis, the state identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.

**Home and Community Characteristics**

CAP/C service providers shall adhere to the home and community characteristics in all service settings by assuring:

- a. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community;
- b. Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources;
- c. Individuals receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
- d. Individuals select the setting from among available options, including non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources);
- e. Each individual's rights of privacy, dignity, respect and freedom from coercion and restraint are protected;
- f. Settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices; and
- g. The direct provider facilitates individual choice regarding services and supports, and who provides these.

**The following additional HCBS Characteristics must be met in Provider Owned or Controlled**

**Residential Settings:**

- a. Provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the state, county, city or other designated entity;
- b. Provide privacy in sleeping or living unit;
- c. Provide freedom and support to control individual schedules and activities, and to have access to food at any time;
- d. Allow visitors of choosing at any time; and
- e. Are physically accessible.

Any modification of these conditions under 42 CFR 441.301(c)(4)(VI)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan. Refer to North Carolina DHHS's HCBS Transition Plan for additional information.

#### **Monitoring for Home and Community Character:**

Foster Care Homes must follow the Home and Community Based Services Final Rule as outlined in North Carolina's DHHS State Transition Plan.

### **7.16 Program Integrity (PI)**

CAP/C Medicaid providers that arrange for services that are not documented on the service plan and authorized by NC Medicaid and are not medically necessary are referred to Medicaid's Program Integrity unit for evaluation and potential recoupment of reimbursement.

Home care agencies that provide nursing or services that are not medically necessary or not performed according to the Service Authorization are referred to Medicaid's Program Integrity unit for evaluation and possible recoupment of reimbursement.

Licensed nurses and nurse aides who falsify medical records in an effort to qualify a beneficiary for CAP/C are referred to the N.C. Board of Nursing or the appropriate North Carolina Health Care Personnel Registry (DHSR, the N.C. Board of Nursing, or both).

NC Medicaid shall randomly select a representative sample of CAP/C providers to ensure compliance with this policy and the CAP/C waiver federal requirements and assurances.

NC Medicaid shall randomly select a representative sample of case management entities and CAP/C providers to ensure compliance with the six (6) federal waiver assurances governed by the 1915(c) HCBS Waiver, and state assurances found in 42 CFR 441.302.

### **7.17 Use of Telephony and Other Automated Systems**

Providers may utilize telephony and other automated systems to document the provision of CAP/C services.

### **7.18 Beneficiaries with Deductibles**

A CAP/C beneficiary who has a deductible is able to participate in the CAP/C traditional or the consumer-directed option; however, the CAP/C beneficiary as well as the provider agency or the personal assistant shall understand and agree to the conditions of incurring and paying a deductible monthly. When a CAP/C beneficiary is self-directing care, the beneficiary shall understand that they are responsible to pay their deductible in order for the hired employee(s) to be paid. The hired employee(s) shall understand and accept that if the beneficiary does not pay their deductible, he or she shall not be paid for services rendered during the deductible period until the deductible is met or paid.

### **7.19 Marketing Prohibition**

Agencies providing CAP/C services are prohibited from offering gifts or service related inducements of any kind to entice a beneficiary to choose it as their CAP/C provider, or to entice a beneficiary to change from their current provider.

Case management entities shall comply with the waiver mandate of conflict-free case management as found in 42 CFR Part 441 Subpart G, Home and Community-Based Services: Waiver Requirements and HCBS Final Rule.

## 8.0 Policy Implementation/Revision Update Information

**Original Effective Date:** November 1, 1992

### Revision Information:

Date	Section Revised	Change
7/1/2010	Sections detailed below	CMS approval of July 2010 waiver renewal
7/1/2010	2.3	Ages eligible for participation changed from birth through 18 years to birth through 20 years
7/1/2010	3.2	Criteria for participation changed to: During each quarter of CAP/C participation, recipient must require case management and at least one other waiver service (excluding respite).
7/1/2010	3.3	Cost Neutrality mechanism changed from individual recipient monthly budget limits to aggregate model with limits on individual services
7/1/2010	3.4	Levels of care changed from Intermediate, Skilled, and Hospital to Nursing Facility and Hospital
10/1/2010	Sections detailed below	Initial promulgation of existing coverage with revisions based on the CMS approval of July 2010 waiver renewal
10/1/2010	5.1.2	Wait list policy changed to prioritize beneficiaries becoming de-institutionalized or transferring from another county or another Medicaid program
10/1/2010	5.2	Addition of congregate nursing care
10/1/2010	5.3	Addition of new service: Pediatric Nurse Aide
10/1/2010	5.4	Change in CAP/C Personal Care services staff level and qualifications
10/1/2010	5.5	Waiver supplies changed to delete items now offered by state plan and add adaptive tricycles
10/1/2010	5.6	Expanded allowable home modifications and budget limit for home modifications
10/1/2010	5.8.11	Addition of mid-year review for high-cost recipients
10/1/2010	5.9	Addition of new service: Motor Vehicle Modifications
10/1/2010	5.10	Addition of new service: Community Transition Funding

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
10/1/2010	5.11	Addition of new service: Attendant Care
10/1/2010	5.12	Addition of new service: Caregiver Training and Education
10/1/2010	5.13	Addition of new service: Palliative care
10/1/2010	6.1.1	Provider qualifications for case managers changed
10/1/2010	6.2.1	Provider qualifications for direct care nursing staff changed
10/1/2010	6.2.2	Provider qualifications for direct care nurse aides changed
11/1/2010	Attachment A: Claims-Related Information	Addition of TD and TE modifiers for T1000, T1005 and addition of Congregate Nursing Code, G1054 TD and G0154 TE
1/1/2012	Section 1.1, 5.2, 5.3, 5.4, 5.7, 5.11	Attendant care service deleted
1/1/2012	Section 3.2.c	Clarification that level of care is determined by both HP and the DMA Nurse Consultant
1/1/2012	Section 3.2.e, 4.2 c	Wording added to clarify that “quarter” is defined as a rolling 90 calendar-days
1/1/2012	Section 4.2 j	Clarification of use of restraints.
1/1/2012	Section 5.1.2 g	Changed “social worker” to “non-RN” to more accurately reflect case manager qualifications
1/1/2012	Section 5.2, 5.3, 5.4. 5.5, 5.13	Clarification that the service will be discontinued if not required and used for one quarter.
1/1/2012	Section 5.2.f	Clarification of criteria for approval of CAP/C nursing services when private insurance is paying for nursing services
1/1/2012	Section 5.2.k	Wording changed to include adult (18-20 year old) recipients
1/1/2012	Section 5.3	Annual limit on service raised due to higher rate
1/1/2012	Section 5.5	Clarification that service authorization for waiver supplies is given only for waiver incontinence products
1/1/2012	Section 5.6	Criteria for approval of generator changed
1/1/2012	Section 5.6.h.2	Clarification of criteria for approval of home modifications to rental property
1/1/2012	Section 5.6.m	Deleted requirement for contractor to be licensed

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
1/1/2012	Section 5.6.n	Clarification of what must be submitted with a request for home modifications
1/1/2012	Section 5.7	Clarification that respite hours are based on total formal support hours
1/1/2012	Section 5.8.5	Information added regarding data sharing with CCNC.
1/1/2012	Section 5.8.11	Criteria for submission of mid year reviews changed
1/1/2012	Section 6.1.1	Added qualifications for Case Manager supervisors
1/1/2012	Section 7.7.e	Period of time for record retention increased
1/1/2012	Appendix A	Clarified that “calendar” days are used.
1/1/2012	Appendix B	Clarified method for obtaining employment verification
1/1/2012	Attachment A(C)	Added code T1004 for Pediatric Nurse Aide Respite; deleted codes and references to T2027 Attendant Care Services and G0154 TD and TE Congregate Care.
1/1/2012	Attachment B	Updated Letter of Understanding
1/1/2012	3.2 e, 4.2.e	States that waiver incontinence supplies may not be the only waiver service besides case management.
1/1/2012	5.1.2 e	Criteria for monitoring of wait list recipients added
1/1/2012	5.1.2.r	Responsibilities of Case Manager Supervisor added
1/1/2012	5.2, Attachment A	Congregate nursing services added back in.
1/1/2012	5.2.g	Criteria added that nursing services will be denied if private insurance covering nursing services was voluntarily dropped within preceding year.
1/1/2012	5.3, Attachment A	Congregate services added.
1/1/2012	5.6	Clarification of assessor requirements for home modifications
1/1/2012	5.8.9, 5.8.10	Modified to include new procedure of CCME doing claims reviews.
1/1/2012	5.10	Clarification of limits on Community Transition Funding

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
1/1/2012	6.1.2	Criteria added for case manager supervisor to co-sign work before billing case management activities provided before training completed.
1/1/2012	6.8	Provider qualifications for palliative care services changed
3/1/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
03/01/2017	Sections detailed below	CMS approval of waiver renewal
03/01/2017	Section 1.0	This section was revised to identify non-waiver services that are available to a CAP/C beneficiary. The comprehensive definition and description of 1915(c) HCBS waiver and the assurances of the waiver were added to this section.
03/01/2017	Section 2.0	Clarity was provided to this section to describe the eligibility requirements for participation in the CAP/C waiver.
03/01/2017	Section 3.0	This section was updated to provide clarity to the eligibility criteria of when CAP/C is covered to include level of care and the qualifying conditions and the identification of priority individuals.
03/01/2017	Section 4.0	This section was updated to clarify when CAP/C services are not approvable.
03/01/2017	Section 5.0	This section was updated to describe CAP/C approval processes and the minimum requirements of completing a referral, assessment and service plan and all limitation imposed. This section was updated to describe the required documentation for waiver service requests.
03/01/2017	Section 6.0	This section was updated to provide clarity of each waiver service and the provider's eligibility and required credential/licensure to render these CAP/C services. This section was updated to include the care coordination responsibilities and competency level of the CAP/C case management entities and staff.

Date	Section Revised	Change
03/01/2017	Section 7.0	This section was updated to provide clarity in the areas of waiver compliance. A description of the general documentation requirements, frequency of monitoring. A description of when corrections are needed to the service record was added to this section.
03/01/2017	Attachment A	This section was updated to identify new processes for claim-related information.
03/01/2017	Appendix A	Form was added to reflect the new referral process for CAP/C participation
03/01/2017	Appendix B	Appendix added to describe waiver services and elaboration on requirements.
03/01/2017	Appendix C	Appendix updated to reflect new processes for determining service hours for a waiver beneficiary.
03/01/2017	Appendix D	Appendix D updated to identify the updated Beneficiary Rights and Responsibilities requirements to participate in CAP/C program.
03/01/2017	Appendix E	Appendix added to comply with HCBS Final Rule in Person-Centered Planning and risk.
03/01/2017	Appendix F	Appendix added to define CAP/C terms.
03/01/2017	Appendix G	Self-Assessment Questionnaire for Consumer-Direction was added to comply with the service package.
03/01/2018	All Sections and Attachments	Technical changes to correct typographical errors, misspellings, punctuation and omissions. Changes to clarify waiver terms, guidelines, and services and update appendices.
03/06/2018	All Sections and Attachments	Policy posted with an Amended Date of March 1, 2018
03/08/2018	Appendix F	Under definition for Medically Fragile, the following statement was removed to allow additional stakeholder engagement to define the conditions for Medically Fragile criteria, letter c:  <b>“Note: Assistance with ADLs does not constitute care to compensate for the loss of bodily function.”</b>  Policy posted on this date with no change to amended date.



Date	Section Revised	Change
05/09/2018	Sections Indicated Below	Corrected errors in the March 1, 2018 version of the policy, as noted below. No change to Amended Date.
05/09/2018	Section 4.2.2	A time frame was added to letter (d) that was not previously included in the policy. Time frame was removed from policy.
05/09/2018	Appendix B	Under the description of unplanned occurrences, an example of time was provided. Example was removed as it was not in the previous policy.
05/09/2018	Appendix B	Adaptive car seat was inadvertently added to assistive technology, and a utilization limit was added in error. Adaptive car seat is a specialized medical equipment and supply and is correctly added to the right waiver service. The reference error, for the adaptive car seat made in the assistive technology section, was removed from policy.
05/09/2018	Appendix D	Letter (a) corrected to state individuals under the age of 21 must met the medical fragility criteria if applying for CAP/C waiver services.  Letter (q) corrected with the right calendar days as listed in the Subsection 4.2.2 of the policy
09/21/2018	Page 78	Under the heading "HOME ACCESSIBILITY AND ADAPTATION" in item (l.) the word "portal" was changed to "portable" so the statement is, "Portable back-up generator for a ventilator ..."
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.

### Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NC Tracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

**A. Claim Type**

Professional (CMS-1500/837P transaction) billed through NCTracks

**B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

**C. Code(s)**

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)			
S5125	T1004	T1016	S9122TG
S5165	T1005TD	T2041	S9122TF
H0045	T105TE	T2025	T2040
S5150	T1019		T2027
	T2038		T2039
	S5111		S9122TF
	T2029		E0700

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Refer to the CAP/C, fee schedules for current rate and billing units: <https://medicaid.ncdhhs.gov/>

**F. Place of Service**

Case management services are provided in the case manager's office, a beneficiary's primary private residence, the community, acute inpatient hospital, or nursing facility. Acceptable places for all other CAP/C services to be provided are dependent on service type.

**G. Co-payments**

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

**H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

**Date of Service:** Date of service billed must be the date the service is provided or rendered.

**CAP/C Claim Reimbursement**

The case management entity shall bill for case management services, home accessibility and adaptation, vehicle modifications, adaptive tricycles, adaptive car seats, training and education services, community transition services, participant goods and services, according to this policy, their own agency policy, and *NCTracks Provider Claims and Billing Assistance Guide*:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

Approved CAP/C providers shall bill for, financial management, in-home aide, pediatric nurse aide, home accessibility and adaptation, assistive technology, and medical equipment and supplies according to **Subsections 6.4, 6.5, and 7.3**, their own agency policy and *NCTracks Provider Claims and Billing Assistance Guide*:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

CAP/C services are provided in an amount, duration, and scope, consistent with the beneficiary's medical needs and must be provided according to the service authorization. The amount of service provided cannot exceed what is contained in the approved CAP/C service plan. A provider shall not

bill for a service if the procedure is not valid for the CAP/C benefit program, or if the policies and procedures relevant to that service were not adhered to. CAP/C providers shall not file a claim for a beneficiary who is ineligible for CAP/C services.

The following case management activities or tasks, performed for a specific beneficiary, are billable:

- a. Assessing the individual for CAP/C participation. This documents the time for both members of the assessment team (if applicable) to arrange, coordinate, and complete assessment activities;
- b. Planning CAP/C services, along with completing the service plan and revising the plan as needed;
- c. Locating service providers for approved CAP/C services and ordering the services from those providers. Locating and arranging informal support to meet the beneficiary's needs;
- d. Coordinating the provision of other Medicaid home care services, such as Private Duty Nursing, Home Health and DME;
- e. Monitoring CAP/C services, along with the delivery of services and reviewing claims and related documentation;
- f. Monitoring the beneficiary's situation, documenting the continuing need for CAP/C participation, the level of care and the appropriate services, as well as taking appropriate action on findings;
- g. Working with the CAP/C beneficiary, family, and others involved in the beneficiary's care to assure the health, safety, and well-being. This provides emergency planning and backup planning activities;
- h. Coordinating Medicaid eligibility issues with DSS, along with those related to helping the beneficiary get information to DSS;
- i. Arranging and coordinating activities related to the disenrollment of CAP/C that occurs prior to the disenrollment date;
- j. Time spent talking with those involved in the beneficiary's care;
- k. Time coordinating the service authorizations; and
- l. Time spent completing other correspondence directly related to the beneficiary's care.

A request for payment for linking an individual to Medicaid services through the completion of a SRF for an individual who does or does not become a participant of the CAP/C program can be made when a final decision of approval or denial is rendered on the SRF.

**Note:** The maximum hours of reimbursement for this activity is two (2).

A request for payment for an assessment of an individual who does not become a CAP/C beneficiary can be made if **all** of the following conditions are met; this type of claim is called an "assessment only" claim:

- a. The individual has a properly approved SRF;
- b. The assessment was completed according to CAP/C policies and procedures;

- c. The assessment is documented and certified by both assessors on the CAP/C assessment form; and
- d. The individual is authorized for Medicaid in a Medicaid category eligible for CAP/C coverage on the date of service.

**Note:** The maximum hours of reimbursement for this activity is six (6).

Both claim types described above are paid directly by NC Medicaid instead of through NCTracks. To submit a request for reimbursement for these claim types:

- a. Prepare a paper claim for the identified service
- b. Prepare a cover letter that reports:
  - 1. The Individual's name and Medicaid ID number; and
  - 2. The number of hours used to perform tasks.

For assessment only requests, list the reason the individual will not be participating in CAP/C.

The following case management activities are considered administrative costs and are not allowed to be billed separately:

- a. outreach;
- b. travel time;
- c. activities after the beneficiary's discharge; termination, or death;
- d. attending training;
- e. completing time sheets;
- f. recruiting, training, scheduling, and supervising staff;
- g. billing Medicaid;
- h. documenting case management activities; and
- i. gathering information to respond to quality assurance requests that are not covered activities for case managers and care advisors.

## Appendix A: CAP/C Service Request Form

Service Request For CAP Services	
<p><b>* = Required</b> <span style="float: right;"><a href="#">Print</a></span></p> <p>Request Date * <input type="text" value="01/09/2018"/> Service Requested * <input type="text" value="CAP Children"/> Service Request ID <input type="text" value="0"/></p>	
Beneficiary Demographics	
<a href="#">MMIS Lookup</a>	
Beneficiary's First Name	<input type="text"/>
Last Name *	<input type="text"/>
Beneficiary has Medicaid? *	-- select --
Medicaid MID	<input type="text"/>
Social Security Number *	<input type="text"/>
Medicare ID	<input type="text"/>
Date of Birth *	<input type="text"/> Age <input type="text"/>
Gender *	-- select --
Marital Status *	-- select --
County *	-- select --
Primary language	-- select --
Beneficiary Address	
Address 1	<input type="text"/>
Address 2	<input type="text"/>
City	<input type="text"/>
State	<input type="text" value="NC"/> Zip <input type="text"/>
Phone	<input type="text"/>
Receiving Protective Services? *	Yes <input type="text"/>
Legal guardian in place? *	Yes <input type="text"/>
Private Insurance? *	Yes <input type="text"/>
Legal Guardian Details	
Guardian Last Name	<input type="text"/>
First Name	<input type="text"/>
Phone	<input type="text"/>
Address 1	<input type="text"/>
Address 2	<input type="text"/>
City	<input type="text"/>
State	<input type="text" value="NC"/> Zip <input type="text"/>
Private Insurance Details	
If private insurance is currently being used, is the private insurance about to expire?	-- select --
If private insurance in place, does private insurance cover in-home aide or nursing services?	-- select --
If in-home aide or nursing coverage, enter coverage amount	<input type="text"/>
Insurer's Name	<input type="text"/>
Policy ID #	<input type="text"/>
Phone	<input type="text"/>
Other Services Beneficiary Is Receiving	
Home Health	<input type="checkbox"/>
PCS	<input type="checkbox"/>
Hospice	<input type="checkbox"/>
CAP/C or CAP/DA	<input type="checkbox"/>
Independent Living Services	<input type="checkbox"/>
Block grant services	<input type="checkbox"/>
Is beneficiary receiving another Medicaid program about to end? *	-- select -- Specify <input type="text"/>
Beneficiary has been informed regarding their choice of providers.	-- select --
Is beneficiary interested in the CAP Choice Option?	-- select --
Beneficiary (legal guardian) has agreed to this request? *	-- select --
Has this individual previously been on a CAP/C case management agency wait list but received a notice to reapply? *	-- select --

Is beneficiary currently in an institution (hospital or nursing facility)? *	Yes
Institution/Hospital Name	
Anticipated discharge date	
Name of Discharge Planner	
Discharge Planner Telephone	
Comments	
If institutional transition, is this beneficiary expected to use Money Follows the Person (MFP) resources?	-- select --
If institutional transition, is this beneficiary expected to use the community transition service?	-- select --
<b>Beneficiary Conditions and Related Support Needs</b>	
<b>Diagnosis Information</b>	
<b>Diagnosis</b>	<b>ICD Code</b>
<b>ICD Version</b>	
<b>Primary Dx</b>	
<a href="#">Diagnosis Entry</a>	
Is there an active AIDS diagnosis? *	-- select --
If AIDS dx present, current CD4 (T) count?	-- select --
Is there a MH diagnosis?	-- select --
Is there a IDD diagnosis?	-- select --
Medically Stable? *	-- select --
Prognosis	
<b>Hospitalizations (Include current stay if applicable)</b>	
Total number of hospital stays in the last year? *	
# of hospital readmissions in the last year (for the same admitting diagnosis)? *	
# of unplanned hospitalizations in the last year (regardless of diagnosis)? *	
If hospitalized in the last six months, were any of the stays greater than 10 days?	-- select --
<b>Medications</b>	
<b>Medication Name</b>	<b>PRN</b>
<b>Strength</b>	<b>If PRN, freq &gt; every 4 hrs?</b>
<a href="#">Meds Entry</a>	
# of Prescription Meds	
# of Meds Requiring Nurse to Administer	
# of Psychiatric/Psychotropic Meds Used for MH Dx	
Requires RN Monitored injections and/or IVs	-- select --
Considering all current medications, does beneficiary require medications assistance?	-- select --
<b>Sensory/Communication Limitations</b>	
Speech ability/making self-understood (Rarely/never) *	-- select --
Hearing (Severe difficulty or none) *	-- select --
Vision (Severe difficulty or blind) *	-- select --
<b>Orientation and Cognitive Status</b>	
Is Beneficiary Oriented	
- To Time *	-- select --
- To Person *	-- select --
- To Place *	-- select --
Beneficiary has Cognitive Skills for Daily Decision-making *	-- select --

Mood			
Unrealistic fears	<input type="checkbox"/>	Crying/tearfulness	<input type="checkbox"/>
Sad, pained, worried facial expressions	<input type="checkbox"/>	Negative statements	<input type="checkbox"/>
Persistent anger	<input type="checkbox"/>	Anxious non-health concerns	<input type="checkbox"/>
Elevated mood, euphoric	<input type="checkbox"/>	Expansive	<input type="checkbox"/>
Unpleasant mood in morning	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>
Excessive irritability	<input type="checkbox"/>		
Behavior			
Wandering	<input type="checkbox"/>	Verbal expressions of distress	<input type="checkbox"/>
Repetitive verbalizations	<input type="checkbox"/>	Angry outbursts	<input type="checkbox"/>
Repetitive physical movements	<input type="checkbox"/>	Dangerous to self	<input type="checkbox"/>
Self-deprecation	<input type="checkbox"/>	Withdrawal from activities of interest	<input type="checkbox"/>
Insomnia/disturbed sleep patterns	<input type="checkbox"/>	Paranoid ideation	<input type="checkbox"/>
Suicide attempt/ideation	<input type="checkbox"/>		
Interpersonal Functioning			
Homicidal	<input type="checkbox"/>	Combative/Hx of Altercations	<input type="checkbox"/>
Dangerous to others	<input type="checkbox"/>	Physically abusive	<input type="checkbox"/>
Verbally abusive	<input type="checkbox"/>	Socially inappropriate behavior	<input type="checkbox"/>
Evictions due to inapprop. behavior	<input type="checkbox"/>	Resists care	<input type="checkbox"/>
Fear of strangers	<input type="checkbox"/>	Illogical comments	<input type="checkbox"/>
Reduced social interaction/isolation	<input type="checkbox"/>		
Cardio-Respiratory Support Needs			
Suctioning - tracheal	<input type="checkbox"/>	Frequency	-- select --
Suctioning - other	<input type="checkbox"/>	Frequency	-- select --
Ventilator dependent	<input type="checkbox"/>	Frequency	-- select --
Vent Type		Stable?	-- select --
Infection free?			-- select --
Pulse oximetry	<input type="checkbox"/>	Frequency	-- select --
Non-vent tracheostomy	<input type="checkbox"/>	Problems with weaning?	-- select --
Nebulizer care	<input type="checkbox"/>	At least 2 schedule/day & 1 PRN/day?	-- select --
Cardiac monitoring	<input type="checkbox"/>		
Chest physiotherapy/use of chest PT vest	<input type="checkbox"/>		
Use of cough assist device	<input type="checkbox"/>		
Apnea monitoring	<input type="checkbox"/>		
CPAP/BiPAP	<input type="checkbox"/>	Help getting device on?	-- select --
Oxygen therapy	<input type="checkbox"/>	Requires rate adjustments?	-- select --
Respiratory assessment	<input type="checkbox"/>	Multiple times/day?	-- select --
		Is respiratory pacer required?	-- select --
Nutrition-Related Support Needs			
Enteral Feeding/Tube Feeding	<input type="checkbox"/>	Frequency	-- select --
% of daily nutrition/fluids		Feeding Tube Type	-- select --
Parenteral Nutrition (TPN)	<input type="checkbox"/>		
Soft/Mechanical Soft	<input type="checkbox"/>		
Thickened Diet	<input type="checkbox"/>		
Pureed Diet	<input type="checkbox"/>		
Supplemental formula diet physician prescribed	<input type="checkbox"/>		
Diabetes management (daily)	<input type="checkbox"/>	Insulin use	-- select --
		Sliding Scale	-- select --
Weight management	<input type="checkbox"/>		
Fluid mgmt/force fluids	<input type="checkbox"/>		
Input/output monitoring	<input type="checkbox"/>		
Other nutrition treatment/Diet?	<input type="checkbox"/>	Other, Desc	
Ancillary Therapies Being Received			
Physical Therapy	<input type="checkbox"/>	Frequency	-- select --
Physical Therapy Details			
Occupational Therapy	<input type="checkbox"/>	Frequency	-- select --
Occupational Therapy Details			
Speech Therapy	<input type="checkbox"/>	Frequency	-- select --
Speech Therapy Details			



Other	<input type="checkbox"/> Other, Desc	<input type="text"/>
Other Therapy Details		
<div style="border: 1px solid black; height: 20px;"></div>		
<b>Other Support Needs</b>		
Continence Management	<input type="checkbox"/> If checked, is Continence Management for: Bowel	<input type="checkbox"/> Bladder <input type="checkbox"/>
Indwelling Catheter	<input type="checkbox"/>	
Colostomy Bag	<input type="checkbox"/>	
Seizure management	<input type="checkbox"/> Requires PRN supports involving assessment and intervention by RN?	-- select --
Dialysis	<input type="checkbox"/> Dialysis Type	-- select --    Dialysis Frequency -- select --
Wound Care	<input type="checkbox"/> Open Wound?	-- select --    Sterile Dressing -- select --
Ulcer Care	<input type="checkbox"/> Ulcer Staging	-- select --
Isolation - infection/disease	<input type="checkbox"/>	
<b>Functional Limitations</b>		
<b>ADL Limitations</b>		
Bathing - Does beneficiary need hands-on assistance?	-- select --	
Personal Hygiene - Does beneficiary need hands-on assistance?	-- select --	
Dressing - Does beneficiary need hands-on assistance?	-- select --	
Bed Mobility - Does beneficiary need hands-on assistance?	-- select --	
Mobility - Does beneficiary need hands-on assistance?	-- select --	
Transfer - Does beneficiary need hands-on assistance?	-- select --	
Toileting/Elimination - Does beneficiary need hands-on assistance?	-- select --	
Eating - Does beneficiary need hands-on assistance?	-- select --	
<b>Other Functional Limitations</b>		
Can the beneficiary ambulate without person assistance? *	-- select --	
Is the beneficiary confined to a wheelchair or bedbound?	-- select --	
Contractures	<input type="checkbox"/>	
Paralyzed	<input type="checkbox"/>	
Fall risk	<input type="checkbox"/>	
<b>Additional Comments about Treatment Needs</b>		
Additional Comments		
<div style="border: 1px solid black; height: 40px;"></div>		
<b>Informal Caregiver Availability</b>		
<b>First Name</b>	<b>Last Name</b>	<b>Relationship</b>
		<b>Lives with Beneficiary</b>
		<b>Contact Phone</b>
<div style="border: 1px solid black; height: 20px;"></div>		
<b>Caregivers Entry</b>		
Will 24-hour caregiver availability be required to ensure beneficiary safety? *	-- select --	
<b>Beneficiary Consent</b>		
The beneficiary has consented to sharing the information documented in this Service Request Form with any agency or organization responsible for enrolling or assisting the beneficiary once enrolled in the requested service or program(s). *	-- select --	
<b>Submitting Agency Identification and Beneficiary Primary Care Physician</b>		
Submitter Name	<input type="text"/>	
CAP Case Management Agency	-- select --	
Submitting Agency Name (If not a CAP Agency)	<input type="text"/>	
Address	<input type="text"/>	
City	<input type="text"/>	
State	NC	Zip <input type="text"/>
Phone	<input type="text"/>	
Fax	<input type="text"/>	
Beneficiary's Primary Care Physician *	<input type="text"/>	
Physician NPI *	<input type="text"/>	
Primary Physician Practice Name	<input type="text"/>	
Primary Care Physician Telephone	<input type="text"/>	

Required Document List		
Document		Present?
Consumer Consent (Release of Information) Form		<input type="checkbox"/>
SRF Physician Attestation		<input type="checkbox"/>

  

Supporting Documentation		
Record Date	Type	Record

[Add Document](#)

Comments

Is Request Complete? \*  Yes  No

Date SRF Completed

[Save](#) [Show Errors](#)

## Appendix B: Service Definitions and Requirements

CAP/C Waiver service definitions and the specific provider requirements for each of the following definitions:

### CASE 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.

The case management entity shall retain the following documents:

- a. Service request form;
- b. all 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.

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 a case manager to assess, plan, refer, link, monitor and provide follow-up to needed services and interventions. 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 to ensure the coordination of necessary services to maintain community placement. The CAP beneficiary has the option to select an approved case management provider, which is the sole case management provider for that CAP beneficiary. If a request is made to transfer to another case management entity, a root cause analysis will be performed within five (5) days by NC Medicaid to assure the health and well-being of the CAP beneficiary, as well as to identify utilization limits and access the performance of the newly selected case management entity. NC Medicaid shall approve the transfer of case management entity.

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 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.

There are Four Principle Activities of Case Management:

- a. assessing;
- b. care planning;
- c. referral and linkage; and
- d. monitoring and follow-up.

### **Limits, Amount And Frequency**

Service utilization limitation: 80 hours (320 units) per calendar year:

CAP beneficiary shall not receive another Medicaid-reimbursed case management service in addition to CAP case management.

Non-covered case management activities are:

- a. employee training for the Case Manager;
- b. completing time sheets;
- c. traveling time;
- d. recruiting staff;
- e. scheduling and supervising staff;
- f. billing Medicaid; and
- g. documenting case management activities.

Case management entities shall not be a direct provider of a waiver service in conjunction with case management.

### **Qualified Provider(s)**

The case management entity is an agency approved by NC Medicaid 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 designated waiver services and Medicaid State Plan services.

- 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. At the designated time that is communicated in a correspondence, 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 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;
- i. Appropriate staff to participant ratio; and
- j. Ability to authorize services within 72 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 one (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 NC Medicaid- 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 NC Medicaid-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 NC Medicaid-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 NC Medicaid-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.

## **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).

**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 Medicaid Fee Schedule.

**Non-Institutional Respite** is 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
- b. Caregiver personal time for emotional, physical or psychosocial balance.

The request for respite must fall within the guideline and definition of respite. When weekly or daily requests are made for respite, a service plan revision may be required as the needs of the beneficiary have 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, but not limited 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);
- c. coverage for school holidays if the caregiver works outside the home and there is no other caregiver available, and
- d. occasional, intermittent work obligations of the caregiver when no other caregiver is available.

This time can also be used for school days off, sick days or adverse weather days.

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

The three categories of respite services listed below correspond with the type of personal care approved in service plan:

- a. In-home Aide respite;
- b. In-home Pediatric Aide respite;
- c. Nursing respite, when the beneficiary is approved to receive nursing care.

The allotted respite hours may be used in combination with institutional respite.

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.

### **Limits, Amount and Frequency**

The maximum allotted days or hours for respite include both institutional respite care and non-institutional respite; in situation of more than one CAP beneficiary in a household, respite hours are assigned per household. When acute care needs of one beneficiary in the household of two or more

CAP/C beneficiaries are identified, an assessment by the case management entity is performed to determine if individualized respite hours are needed to meet the needs of that individual CAP/C beneficiary.

Respite hours should not be used for situations in which short-term-intensive hours or an unplanned waiver service occurrence request could be approved.

Once the yearly allotment of respite hours is used, there are no more available hours until the beginning of the next fiscal year. Additional respite hours cannot be approved.

Foster care services are not billed during the period that respite is furnished for the relief of the foster care provider.

### **Qualified Providers**

#### **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.

Federally Recognized Tribes - Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2(10) be licensed or recognized under the State or local law where the provider is located shall be deemed to have been met:

- a. When a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and
- b. if the provider entity meets all applicable standards for such licensure or recognition.

The licensure or recognition shall be deemed to have been met regardless of whether the entity obtains a license or other documentation under State or local law.

### **PEDIATRIC NURSE AIDE**

A service for CAP beneficiaries who require:

- a. extensive hands-on assistance with at least three Activities of Daily Living (ADL); and
- b. at least two ADLs that include nurse aide II tasks.

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.

Services must be substantial. This means that the beneficiary's needs can only be met by certified professional such as an NA I or II. Nurse Aide services could not and shall not be provided by personal care aides or home health aides not registered with DHSR, unless participation in the waiver is through the consumer-directed model of care.

ADL care for beneficiaries under the age of three (3) years is considered age appropriate and the responsibility of the parent or responsible representative. If the needed ADL assistance includes personal care needs, the care is not for normal age-appropriate functioning, which is considered a parental responsibility.

The beneficiary has a caregiver available to provide needed services during the planned and unplanned absences of the nurse aide. If the regular informal caregiver (parent) is not available, there must be a back-up informal caregiver designated by the parent who can be physically present with the beneficiary and make judgments on the caregiver's behalf regarding the care of the beneficiary.

The supervising registered nurse of the provider agency maintains accountability and responsibility for the delivery of safe and competent care (NC 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:

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

Unplanned waiver service occurrence requests are eligible to be used with this service. Unplanned waiver services 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).

A CAP beneficiary can use up to 14 days per year of recreational leave (family vacation), 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 or RN or LPN 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*.

Pediatric Nurse Aide services, when medically necessary, shall be provided in the home, community, and 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:

- 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 when the exemption does not violate Medicaid guidelines. 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.

### **Limits, Amount and Frequency**

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 of the CAP beneficiary, caregiver availability, budget limits and other available resources.

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

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 CAP In-Home Aide services or private duty nursing. 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 program shall not perform services until competencies and trainings are verified or completed.

### **Qualified Provider**

Refer to **Subsection 6.6** for qualifications.

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

Federally Recognized Tribes - Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2(10) be licensed or recognized under the State or local law where the provider is located shall be deemed to have been met:

- a. When a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and
- b. if the provider entity meets all applicable standards for such licensure or recognition.

The licensure or recognition shall be deemed to have been met regardless of whether the entity obtains a license or other documentation under State or local law.

### **Consumer-Directed Providers**

Consumer-directed providers shall:

- a. undergo a criminal background and registry check prior to hire; and
- b. 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.

### **CAP IN-HOME AIDE SERVICE**

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

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).

Unplanned waiver service occurrence requests are eligible to be used with these services. Unplanned waiver services 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).

ADL care for children under the age of three years is considered age appropriate and the responsibility of the parent or responsible representative.

A CAP beneficiary can use up to 14 days per year of recreational leave (family vacation), 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 or RN or LPN 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, or grandparent can be hired as the employee when a CAP beneficiary is 18 years of age or older.

The employment of a spouse, parent, or grandparent 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 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 (listed above) occurring more than 10 years previous to the date of the criminal report may qualify for an exemption when the exemption does not violate Medicaid guidelines. 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.

### **Limits, Amount and Frequency**

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.

Documentation must be provided when specific training and education services are needed and documentation is provided to support training needs were met. 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.

### **Qualified Provider(s)**

Refer to **Subsection 6.6.**

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

Federally Recognized Tribes - Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2 (10) be licensed or recognized under the State or local law where the provider is located shall be deemed to have been met:

- a. When a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and
- b. if the provider entity meets all applicable standards for such licensure or recognition.

The licensure or recognition shall be deemed to have been met regardless of whether the entity obtains a license or other documentation under State or local law.

Consumer-directed providers shall:

- a. undergo a criminal background and registry check prior to hire; and
- b. 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.

## **FINANCIAL MANAGEMENT SERVICES**

Financial management services (FMS) 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 management services to reimburse the personal assistant(s) and designated providers.

The FMS:

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

The FMS must have experience and knowledge of the following:

- a. Automated standard application of payment;
- b. Check Claims;
- c. Electronic Fund Transfer;
- d. Electronic Fund Account;
- e. International Treasury Service;

- f. Invoice processing platform;
- g. Judgment Fund;
- h. Payment Application Modernization;
- i. Prompt Payment;
- j. Automated Clearing House;
- k. Cash Management Improvement Act;
- l. GFRS/FACTS I;
- m. Government wide Accounting;
- n. Intergovernmental Reconciliation;
- o. Standard General Ledger; and
- p. Tax Payer Identification Number.

### **Limits, Amount and Frequency**

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

A consumer-directed initiation (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.

A consumer-directed transition fee must be assessed for CAP beneficiaries transferring from one fiscal intermediary to another and shall not exceed 4 units. A consumer-directed transition fee must be assessed for CAP beneficiary transferring back to a previous fiscal intermediary and shall not exceed two (2) units during the transition month.

### **Qualified Provider(s)**

Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications of financial management. 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. The FMS shall maintain current and archived participant, attendant, service vendors and FMS files 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 shall also:

- a. have the capacity to provide Financial Management Services through both the Agency with Choice (AwC) and Fiscal/Employer Agent (F/EA) models
- b. be authorized to transact business in the State of North Carolina, pursuant to all State laws and regulations; and
- c. be approved as a Medicaid Provider for Financial Management Services (or in the process of applying for such approval).

## 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, acquired commercially, modified, or customized, and used for

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

This service shall be used for:

- a. 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;
- b. specialized monitoring systems;
- c. specialized accessibility and safety adaptations or additions;
- d. ceiling track system for the purpose of transfers;
- e. 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 (such as lights, door strikes and openers, HVAC, television, telephone, hospital bed, computer, small appliances, etc.). An ECU or EADL can range from a single function device to a whole house computed-based system; and
- f. Adaptive Tricycles: An item 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.

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.

### Limits, Amount and Frequency

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. When the maximum utilization limit is reached, requests for assistive technology will be denied.

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

Assistive technology for CAP beneficiaries excludes items that are covered under the Home Health Final Rule and duplicates a Medicaid State Plan service.

**Note:** Medicaid assumes no liability related to the use or maintenance of the equipment and assumes no responsibility for returning the private primary residences to its pre-modified condition. Assistive technology may not be furnished to adapt living arrangements.

Items that are not of direct medical or remedial benefit to the beneficiary or are considered recreational in nature are excluded and not authorized by the case management entity.

Items that are covered through DME, orthotics and prosthetics and home health supplies are obtained through the respective programs prior to requesting from CAP. CAP does not cover items that are covered by these programs that were denied for the beneficiary for lack of medical necessity.

Assistive Technology Service excludes the following:

- a. equipment that adds to the total square footage of the home;
- b. home improvements, renovations, and repairs;
- c. a dwelling where the owner refuses the technology;
- d. equipment that is not portable when the home is rented;
- e. service agreements, maintenance contracts, and extended warranties;
- f. equipment or technology used with swimming pools, hot tubs, spas, or saunas;
- g. items that are recreational in nature;
- h. items that have general utility to non-disabled individuals;
- i. replacement of equipment that has not been properly used, has been lost or purposely damaged; and
- j. computers, laptops, tablets, or smart phones.

### **Qualified Provider(s)**

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.

### **COMMUNITY TRANSITION SERVICES**

A service for prospective CAP beneficiaries for transitioning from a 90-day or more 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.

Community transition services are available to cover one-time expenses. These expenditures are for initial set-up expenses for a CAP beneficiary who make the transition from an institution to their own primary private residence in the community.



Community Transition Services shall 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; and
- i. Any other service, equipment, or item that is not listed above that is necessary to integrate in the community, and does not duplicate a Medicaid State Plan service.

Items and services (including rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary according to the CAP assessment. The service record must document the necessary reason for the items and services. A copy of the invoice of these items and services must be filed in service record by the case management entity and the CAP Medicaid provider. 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.

#### **Limits, Amount and Frequency**

Community transition services are available to cover one-time, initial set-up expenses, not to exceed \$2,500 over the cycle of the CAP, five (5) years. This service does not include ongoing payments for rent. A request for this service can be made on, during the assessment assignment, or after the completion of the comprehensive assessment. All service requests must be made and utilized within 90 calendar-days from the date of beneficiary's discharge from an institution.

#### **Qualified Provider(s)**

The case management entity shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

### **HOME ACCESSIBILITY AND ADAPTATION**

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

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 and the assessment

completed by a PT, OT, Rehabilitation Engineer or Assistive Technology professional must be on file with the case manager'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 upon the receipt of an invoice for this service to reimburse the contractor. 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;

Approval for floor coverings, air filtration, and generators must be based on RN assessment and MD certification.

The following are the only approved home accessibility and adaptation modifications:

- a. Wheelchair ramps, stationary or portable and wheelchair ramps with landing pads;
- 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 an existing bathroom to improve accessibility for a disabled individual, including: installation of roll in shower, sink modifications (raised, lowered, pedestal, pedal specific for beneficiary), water faucet controls, tub modifications, toilet modifications (such as raised seat or rails), floor urinal adaptations, turnaround space modifications for wheelchair and stretcher bed access, and required plumbing modifications that are necessary for the modifications listed above;
- e. Widening of doorways for wheelchair access, turnaround space modifications for wheelchair access;
- f. Bedroom modifications to widen turnaround space to accommodate hospital beds, larger or bulky equipment and wheelchairs (for example, removing a closet to add space for the bed or wheelchair);
- g. Lift systems and elevators, that are used inside a beneficiary's private primary residence and are not otherwise covered under DME;
- h. Porch stair lifts;
- i. Floor coverings when existing floor coverings contributed to documented falls resulting in injury as evidenced by hospital and emergency room visits, or when those floor coverings are contributing to asthma exacerbations, documented medical records, requiring repeated emergency room or hospital treatment;
- j. Driving surfaces when existing driving surfaces leading to the primary private residence pose an access to care issue to the beneficiary with documented gaps in service provision or documented inability to render emergency services contributing to impassable path;

- k. 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.
- l. 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 portable generator.

The home accessibility and adaptation 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;
- 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; and
- g. The move of modification or adaptation from one primary residence to another. An evaluation of the cost for labor and costs of moving modification or adaptation must be approved prior to the move.

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

**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 or renovate living arrangements.

### **Limits, Amount and Frequency**

Home accessibility and adaptation included in a combined vehicle modification and assistive technology budget of \$28,000 per beneficiary per the cycle of the CAP, which is renewed every five years. When the maximum utilization limit is reached, requests for home modification will be denied. **The case management entity shall track all costs of home accessibility and adaptation aids billed and paid, in order to avoid exceeding the \$28,000 limit over the cycle of the CAP waiver (five years).**

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded and not authorized by the case management entity.

Home accessibility and adaptation for CAP beneficiaries excludes items that are covered under the Home Health Final Rule.

Items that are covered through DME, orthotics and prosthetics and home health supplies 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 improvements, renovations, or repairs;
- c. homes under construction;
- d. a dwelling where the owner refuses the modification;
- e. the modification in a rented residence when the requested modification is not portable;
- f. purchase of locks;
- g. service agreements, maintenance contracts, insurance, and extended warranties;
- h. roof repair, central air conditioning;
- i. swimming pools, hot tubs; spas, saunas, or any equipment, modification or supply for the purpose of swimming pools, hot tubs, spas, or 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;
- m. plumbing, other than the plumbing described in letter(d); and
- n. approved vendor shall not be the spouse, parent, primary caregiver or legal guardian of the CAP beneficiary.

Medicaid is the payer of last resort; if the beneficiary has private insurance that covers the item, the case management entity verifies and documents the insurance coverage. The item must be billed through the private insurance payer.

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.

### **Qualified Provider(s)**

The case management entity shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

## **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 necessary item or service ordered by a physician that will aid in the prevention or diversion of an institutional placement.

Participant goods and services are items that are intended to:

- a. increase the beneficiary's ability to perform ADLs or IADLs; and
- b. decrease dependence on personal assistant services or other Medicaid-funded services.

These services, equipment, or supplies are purchased by the case management entity.

### **Limits, Amount and Frequency**

The cost of participant goods and services for a CAP beneficiary, when necessary for the prevention or diversion of an institutional placement, must not exceed \$800.00 annually (July - June). NC Medicaid consultants shall review all requests for participant goods and services and may request additional supporting information for any item over \$200.00. Products and items listed on the State Medicaid Plan are prohibited from being reimbursed by this service unless approved by NC Medicaid.

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded and not authorized by the case management entity.

Participant goods and services for CAP beneficiaries excludes items that are covered under the Home Health Final Rule.

Items that are covered through DME, orthotics and prosthetics and home health supplies 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.

Participant goods and services excludes the following:

- a. items that are recreational in nature;
- b. items that have general utility to non-disabled individuals;
- c. service agreements, maintenance contracts, and excluded warranties;
- d. equipment used with swimming pools, hot tubs, spas, and saunas;
- e. replacement of equipment that has not been properly used, has been lost or purposely damaged;
- f. computer lap top, tablet, or smart phone;
- g. pharmacy related items, and
- h. outdoor monitoring systems.

### **Qualified Providers(s)**

The case management entity shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

## **SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES**

Specialized medical equipment and supplies are:

- a. Adaptive car seat: An item used for safe transport, documented by an assessment of need
- b. Vehicular transport vest: An item for safe transport, documented by an assessment of need.

Specialized medical equipment and supplies consists of the following:

- a. The performance of assessments by the case management entity to identify the type of equipment needed by the beneficiary.
- b. Training by the CAP provider to the beneficiary or caregivers in the operation and maintenance of the equipment or use of the supply.
- c. Repair of the equipment determined by the case management entity is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment.

### **Limits, Amount and Frequency**

Specialized medical equipment and supplies for CAP beneficiaries excludes items that are covered under the Home Health Final Rule.

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 plan year.

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded and not authorized by the case management entity.

Specialized medical equipment and supplies for CAP beneficiaries excludes items that are covered under the Home Health Final Rule.

Items that are covered through DME, orthotics and prosthetics and home health supplies 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.

Specialized medical equipment and supplies excludes the following:

- a. items that are commercial and have general utility to non-disabled individuals;
- b. service agreements, maintenance contracts, and excluded warranties;
- c. equipment used with swimming pools, hot tubs, spas, and saunas; or
- d. replacement of equipment that has not been properly used, has been lost or purposely damaged.

### **Qualified Provider(s)**

The case management entity shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

## **TRAINING, EDUCATION AND CONSULTATIVE 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. The purpose of this service is to enhance the decision-making ability of the beneficiary, to improve the mental health and social interaction of the beneficiary, enable the beneficiary to independently care for him or herself; or to enhance or aide in the ability of the family member or personal care assistant under the consumer-directed care program in caring for the CAP beneficiary.

Training, education and consultative services consist of information, techniques, and supportive services to maintain health, safety and well-being of the CAP beneficiary. All training, education and consultative services are documented in the service plan as a goal with the expected outcomes. This service covers conference registration, enrollment fees for classes and office fees for therapies that are not covered under Medicaid State Plan therapy.

Service is provided by community colleges, universities, counselors or an organization with a training or class curriculum approved by NC Medicaid and documented in the CAP beneficiary's service record.

### **Limits, Amount and Frequency**

Service is limited to \$500 per fiscal year (July 1- June 30) when the service prevents or diverts an institutional placement.

This service does not include the cost of travel, meals, or overnight lodging to attend a training event or conference.

Personnel hired through a Home Care Agency, Home Health Agency, Hospice Agency are excluded from utilizing this service.

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded and not authorized by the case management entity.

Items that are covered through DME, orthotics and prosthetics and home health supplies 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.

Training, education, and consultative services exclude the following:

- a. services that are recreational in nature
- b. services that have general utility to non-disabled individuals; or
- c. reimbursement for registration fees when participation occurred prior to the service request.

### **Qualified Provider(s)**

The case management entity shall verify and approve providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

## **VEHICLE MODIFICATION**

Vehicle modification is a service for a CAP beneficiary that enables increased independence and physical safety through transport. The intent of a vehicle modification is to adapt, alter, or install controls or

services to an unmodified motor vehicle such as an automobile or van that is a CAP beneficiary's primary means of transportation. The vehicle must be owned by the CAP beneficiary or the primary caregiver prior to the initiation of the modification. Vehicle modifications 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 Modifications are covered for an unmodified vehicle:

- 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 by a 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 or scooter hoist;
- m. Cushions;
- n. Wheelchair or scooter transporting mobility devices;
- o. Ramp; and
- p. Devices for securing oxygen tanks.

Vehicle modifications may be approved for a previously modified vehicle when the modification is intended to meet the beneficiary's care needs and allows for physical safety through transport. The service does not cover the purchase or lease of the vehicle itself, but the actual cost of the installed modifications. When a vehicle is pre-modified or previously modified, the following modifications, adaptations, controls or services are covered:

- a. The ramp or lift that allows entrance to and egress from the vehicle;
- b. tie-downs for wheelchairs;
- c. rubberized flooring to prevent skidding and provide a stationary position through transport; and
- d. kneeling systems.

Vehicle modification for CAP beneficiaries excludes items that are covered under the Home Health Final Rule.

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 must be submitted as indicated in **Subsection 5.7.1**.

### **Limits, Amount and Frequency**

**Vehicle modification** is included in a combined **home modification and assistive technology** budget of \$28,000 per beneficiary per the cycle of the CAP, which is renewed every five years. When the maximum utilization limit is reached, requests for **vehicle modification** will be denied. 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 cycle of CAP waiver.

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 – 10 years old, or for vehicles with 80,000 miles or more.

The vehicle that is adapted must belong to the individual parent or the legally responsible representative, refer to **Appendix F**.

The service will reimburse the cost of the depreciated value of a previously modified vehicle, see above, when an assessment of the previously modified vehicle is in good condition. The assessment will include:

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

Those items that are not of direct medical or remedial benefit to the beneficiary or are considered recreational in nature are excluded and not authorized by the case management entity. Approval for vehicle modifications is based upon medical need; there is no entitlement of services up to the program limit (\$28,000).

Vehicle modification equipment and supplies for CAP beneficiaries exclude items that are covered under the Home Health Final Rule.

All equipment purchased through the CAP Waiver uses a selection process to ensure the most efficient use of Medicaid funds.

Items that are covered through DME, orthotics and prosthetics and home health supplies 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.

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.

**Exclusions:**

Vehicle modification excludes the following:

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

**Qualified Provider(S)**

The case management entity shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.

## Appendix C: Determination Nurse Aide Hours of Support

### BASIC FORMULA

The approval of hours is person-centered and is based on the CAP beneficiary's care needs, the caregiver's availability, medical necessity and other available formal and informal resources. The hours will be authorized on a weekly basis based on the care needs of the CAP beneficiary.

The number of hours of nurse aide hours authorized for a CAP beneficiary is illustrated below. The case management entity or designated entity assesses the CAP beneficiary's care needs and the caregivers' availability and determines the number of hours available using the following formula:

#### *Work Time*

Actual hours worked  
+ ½ to 2 hours commute per day (actual commute time)  
– # hours other support available  
= X hours max per week

The approval of hours is based on the care needs of the CAP beneficiary. All of the hours authorized are contingent upon interventions being provided for the CAP beneficiary's care needs. For example, a CAP beneficiary may have interventions done during the day, but sleeps through the night with no interventions needed; night covered care would not be covered because beneficiary's care needs can be met at night by primary caregiver(s). Hours are only authorized when there are medically necessary interventions taking place.

Parents or responsible parties who work must provide employment verification. The Case Manager verifies the caregiver's employment schedule. Verification consists of a written statement on employer letterhead or company generated verification. The statement verifies the caregiver is employed, and details the hours and schedule of employment. Hours for work are not approved unless employment verification is provided. If a caregiver is self-employed, the substitute work verification form prepared by NC Medicaid may be used instead. If this form is used, the case manager or another independent party shall be reasonably sure that the information in it is accurate. If a caregiver does not meet the criteria for use of the form, the form is not permitted to be used as work verification and hours for work are not approved.

Work time will not be approved for volunteer work.

### WORKING AT HOME

Caregiver availability will be assessed on a case-by-case basis according to the caregiver's physical proximity to the child and the caregiver's flexibility in being able to address care needs during work hours or to arrange work hours around care needs.

### ATTENDING SCHOOL

Caregivers attending school in pursuit of a diploma or a degree for purposes of employment may count their school time as work time. Time will be calculated as follows: actual time spent in class per week, plus commute time if applicable. The school transcript must be provided.

### **CAREGIVER'S OVERTIME AND ON-CALL**

CAP hours will not be authorized to cover caregiver's overtime hours. CAP hours will not be authorized to cover caregiver's on-call time.

### **WORK AND SCHOOL OR MULTIPLE JOBS**

The primary caregiver will need to make other arrangements for care coverage when hours worked due to work, school, or multiple jobs is not sufficient to provide care coverage.

### **MULTIPLE SIBLINGS**

Additional assistance cannot be provided by CAP because of the presence of siblings in the home. The hours approved are based on the medical needs of the CAP beneficiary not the demands of other siblings or family members.

## Appendix D: Beneficiary Rights and Responsibilities

### Beneficiary Rights and Responsibilities

By signing this 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 participant.

I understand:

- a. The CAP Waiver is an alternative option to institutionalization. I must meet a nursing facility LOC initially and annually to participate in this program. If I am under the age of 21 and requesting to participate in CAP/C, I must also meet all eligibility requirements for Medical Fragility.
- b. I agree to select this program as an alternative to institutionalization.
- c. 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.
- d. The CAP Waiver supplements rather than replaces the formal and informal services already available to me and my family.
- e. 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. I am able to freely select the option that is best for me and my family.
- f. If I freely select to participate in the consumer-directed model of care, I or my designated representative must meet and maintain the qualification for consumer-directed care, I or my designated representative must be willing and emotionally able 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.
- g. The CAP Waiver provides an array of services, known as waiver services, to meet my assessed needs to keep me integrated in the community.
- h. 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. Any provider also includes a case management entity.
- i. 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.
- j. 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.
- k. 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 adverse decision.

- l. 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.
- m. If I have a Medicaid spend down, deductible or premium, I must incur the established medical expenses before my Medicaid benefits are made available. I must also pay my identified providers the cost of these incurred medical expenses to prevent a gap in my care provision.
- n. The CAP Waiver allows my waiver services to be provided by individuals and agencies of my choosing. However, for waiver beneficiaries between the ages of 0-17, the following identified parties can not 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 and received payment through payroll: an appointed guardian or appointed Health Power of Attorney or Power of Attorney or executor the estate.
- o. The CAP Waiver is required to protect my health, safety, and well-being, at all times, while I participate in the program, and I am able to assume some risks in my decision-making. This assumed risk must be outlined in an Individual Risk Agreement (IRA) or emergency back-up plan. When choices are made that expose me to an 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.
- p. I understand that as a participant in the consumer-directed model of care I assume full responsibility and risks that would be assumed by an in-home care agency. I am responsible for making informed decisions regarding the planning and care coverage of my health needs as well as maintain a safe workplace.
- q. The CAP Waiver may initiate disenrollment from the waiver when any one of the following occurs:
  1. The beneficiary's Medicaid eligibility is terminated;
  2. The beneficiary's physician does not recommend nursing facility;
  3. The SRF does not result in an approved LOC;
  4. DSS removes the CAP evidence code due to non-eligibility for Medicaid or program participation;
  5. The CAP 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 two verbal attempts;
  6. 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;
  7. The beneficiary's health, safety, and well-being cannot be mitigated through a risk agreement and other interventions;
  8. The beneficiary or primary caregiver will not participate in development of or sign the service plan;
  9. 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 frequent changes to the coverage schedule without contacting the case management entity for approval or ongoing evaluation of need; or

10. 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, as signed by the CAP beneficiary.
11. A beneficiary who is participating in the consumer-directed option may be disenrolled from this option when any one of the following is confirmed:
  - i. Misappropriation of Medicaid dollars by repeatedly authorizing timesheets when the employee or personal care assistance did not perform approved hours as listed in the plan of care;
  - ii. The beneficiary or responsible party is unable to recruit, hire and maintain employee(s) or personal care assistance(s) to meet health care needs outlined in a comprehensive assessment;
  - iii. The beneficiary or responsible party repeatedly fails to report critical incidents of abuse, neglect and exploitation; or
  - iv. Failure to gain the required competencies for self, responsible representative or employee (personal care assistance) within the established timeline when documented deficiencies are identified.
- r. I, or the primary responsible party, will receive an enrollment letter of my approval to participate in the waiver program. Failure to comply with the directives written in this letter within the designated timeframe may jeopardize my enrollment and participation in the CAP waiver.
- s. I, or the primary responsible party, must maintain monthly telephone contact and monthly-to-quarterly face-to-face contacts with the assigned case manager for the purpose of care coordination to include referrals, linkage, assessments and care planning, and monitoring of health, safety and well-being.
- t. I, or the primary responsible party, will receive an annual letter of appointment to complete my annual continued need review for ongoing 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.
- u. NC Medicaid 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 participant.

Signature: \_\_\_\_\_  
Beneficiary or Responsible Party

Date: \_\_\_\_\_

Signature: \_\_\_\_\_  
Case Manager

Date: \_\_\_\_\_



## Appendix E: Individual Risk Agreement

### INDIVIDUAL RISK AGREEMENT

The risk(s) that have been identified below have been determined and the CAP beneficiary has chosen to assume responsibility in addressing the risk. The details of the risk(s) have been explored and the beneficiary understands how the specified risks may impact the beneficiary's health, safety and well-being. The Case Management Entity and the CAP Waiver beneficiary have negotiated an agreement with measurable time frames. Risks that have been identified will be continuously monitored and re-evaluated throughout the length of the agreement. The CAP beneficiary is aware of the possible consequences of not addressing risks as outlined in their agreement.

Name –CAP Waiver Beneficiary	Name – CAP Case Management Entity
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Name(s) – Individuals involved in risk identification and reduction discussion

1. Describe the risk(s) identified by case management entity [e.g., exhibited behavior that is deemed to be verbally/physically abusive to others, non-compliance of the service plan; or risk/hazard(s) in the person's environment (pest infestation, lack of sufficient water supply, etc.)].

2. Describe case management entity's identified adverse outcome/harm that may result from the CAP beneficiary's failure to address the risk(s) (e.g., decline in physical/emotional health, injury to self or others, etc).

3. Describe the CAP beneficiary's understanding of identified risk(s) and his/her plan for addressing it.

4. What alternative measures may be used by the case management entity, the CAP beneficiary, or by his or her informal supports to minimize risk, reduce adverse outcome(s) identified in #2 above? (e.g., durable medical equipment, adaptive equipment; increased personal care hours, improve network of informal supports)

5. Briefly describe the agreement reached including consequences of failure to work toward a solution.

The risks identified by the agency have been explained to me. I accept the risk(s) associated with my choice, decision or preferred course of action.

\_\_\_\_\_  
SIGNATURE – CAP Beneficiary / Legal Responsible Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
SIGNATURE –Case Management Entity

\_\_\_\_\_  
Date Signed

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## Appendix F: Glossary of CAP Terms

### Activities of Daily Living (ADLs)

Basic personal care usually performed by an individual during the course of the day including ambulation, bathing, bed mobility, dressing, eating, personal hygiene, toilet use, and transfers. CAP beneficiaries must require extensive assistance with a minimum of two ADL's that are not age appropriate personal care needs; and are unable to perform these tasks independently. Assistance with these activities are directly linked to the beneficiary's medical condition or diagnosis described and documented on a validated assessment. These tasks are usually performed by unlicensed paraprofessionals and do not constitute skilled medical or skilled nursing care. However, if a CAP beneficiary requires nursing services, the nurse would be expected to perform or assist the beneficiary with his or her ADLs.

### Administrative Authority

The requirement the Medicaid agency maintain its authority over rules, regulation and policy that govern how the waiver is operated. The operation of the waiver can be decentralized and local agencies can be designated to play important roles in facilitating the access of individuals to the waiver, including performing waiver operational functions.

### Assessment Assignment

Participants who have met the basic eligibility requirement of level of care and have been assigned a waiver slot. The participant is approved for an assessment to identify clinical need for waiver participation and the development of a service plan.

### Assurance

The commitment by a state to operate an HCBS waiver program in accordance with statutory requirements.

### At-Risk of Institutionalization

A participant who is a member of the target population and meets nursing facility level of care (LOC) criteria with assessed acuity of needs ranging from intermediate to hospital level 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.

### Average Waiver Cost Limits

To maintain cost neutral service provision of that of institutional care, a mandatory requirement of a 1915 (c) HCBS waiver, the average cost limit for this waiver is \$129,000, per beneficiary, per year. This average cost of a beneficiary's care needs may be less than, equal to or more than the specified average cost.

### Beneficiary

An individual receiving Medicaid benefits.

### **Budget Authority**

A concept of consumer-direction that allows a waiver beneficiary the opportunity to exercise choice and control over a specified amount of waiver funds. The waiver beneficiary has decision-making authority regarding who will provide a service, when the service will be provided and how the service will be provided consistent with the waiver's service specifications and other requirements. The waiver participant has the authority to make changes in the distribution of funds among the waiver services included in the budget.

### **Case Management Entities**

Appointed agencies to act as the lead entities in a county. The appointed entity is the local entry point and approval authority for CAP services. The lead entity is appointed by NC Medicaid to be responsible for the day-to-day case management functions for potential and eligible CAP beneficiaries. These agencies may include county departments of social services, county health departments, hospitals, or a qualified case management entity. The appointed case management entity shall be an entity capable of providing case management and lead entity services.

#### Case management entity Mandated Requirements

Qualified Case Management Entities must have:

- a. A resource connection to the service area so to provide continuity and appropriateness of care;
- b. Experience in Pediatrics and physical disabilities;
- c. Policies and procedures in place that aligns with the governance of the state and federal laws and statutes;
- d. 3 years of progressive and consistent home and community based experience;
- e. Ability to provide case management by both social worker and Nurse;
- f. Physical location;
- g. Computer technology/IT web-based connectivity to support the requirement of current and future automated programs;
- h. Meet the regulatory criteria under DHHS/DHRS
- i. Staff to participant ratio (appropriate case mix); and
- j. Implementation of services within 5 days of POC approval.

### **Care Coordination**

Collaborative engagement with various providers to improve healthcare interventions while utilizing information and information systems to help achieve person-centered goals. The purpose of care coordination is to manage care needs, reduce duplication of efforts, ease expected and unexpected transitions and limit gaps of service provision. Care coordination is important because it provides the ability to identify service preferences to meet emerging strengths, needs, and goals while increasing efficiency and communication to improve clinical outcomes and ensure beneficiary satisfaction.

### **Community Alternative Programs (CAP)**

A Medicaid CAP Waiver authorized under § 1915(c) of the Social Security Act and Medicaid funds; to provide home and community based services to Medicaid beneficiaries who require institutional care, but

for whom care can be provided cost effectively and safely in the community with CAP services. CAP beneficiaries must meet all Medicaid eligibility requirements. CAP Programs consist of the following:

- a. Community Alternatives Program for Children: CAP/C
- b. Community Alternatives Program for Disabled Adults: CAP/DA
- c. Community Alternatives Program for Disabled Adults choosing to self-direct: CAP/Choice

### **Community Alternative Program for Children (CAP/C)**

A Medicaid HCBS Waiver authorized under § 1915(c) of the Social Security Act serving **medically fragile and medically complex children ages 0- 20 years** who are at risk of institutionalization.

### **Community Integration**

The setting (living arrangement, place of services and types of services):

- a. Supports full access to the greater community;
- b. Is selected by the individual from among settings options;
- c. Ensures individual rights and privacy, dignity and respect, and freedom from coercion and restraints;
- d. Optimizes autonomy and independence in making life choices; and
- e. Facilitates choice regarding services and who provides them.

### **Consumer-Directed Care**

An alternative care option offered under the CAP Waiver. Consumer-directed is a self-directed care model for CAP beneficiaries and their caregivers who wish to remain at their primary private residence and have increased control over their own services and supports. It offers beneficiaries the choice, flexibility and control over the types of services they receive, when and where the services are provided, and by whom the services are delivered.

### **Comprehensive Multidisciplinary Needs Assessment**

A collaborative process that is used to obtain information about an individual, including his or her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. The assessment supports the determination that an individual requires CAP services as well as the development of the service plan.

### **Disenrollment**

The voluntary or involuntary dismissal from participation in CAP.

### **NC Medicaid**

An agency under the umbrella of the Department of Health and Human Services whose goal is to provide public health insurance to North Carolina's most vulnerable citizens. NC Medicaid is designated as the administrative authority over the CAP/C Waiver. NC Medicaid develops policies and procedures based on federal guidelines for operating the program and is required to oversee the management and operation

by the local lead agencies and other appointed entities. NC Medicaid is also required to provide training and technical assistance to lead entities.

### **e-CAP Web-based Tool**

A Web-based software application developed by an approved Medicaid contractor to support the operations of CAP Waiver under the provision of 1915 (c) HCBS.

### **Emergency Back-Up plan**

Provision for alternative arrangements for the delivery of services that are critical to a beneficiary's well-being in the event that the identified caregiver or provider responsible for furnishing the service fails or is unable to deliver them. The emergency back-up plan must also include disaster planning.

### **Employer Authority**

A concept of consumer-direction that allows a waiver beneficiary to exercise the choice and control over individuals who furnish waiver services authorized in the service plan. Under the employer authority model there are two options:

- a. Agency with Choice also known as co-employment- This option makes arrangements for an organization to assume responsibility for employing and paying workers; reimbursing allowable services through Medicaid; withholding; and filing and paying Federal, state and local income and employment taxes.
- b. Common Law Employer- This option designates the waiver beneficiary as a common law employer of workers who furnish services and supports and assumes all responsibilities associated with being the employer of workers. The fiscal agent performs employer-related tasks on behalf of the participant but does not serve as the common law employer of the hired direct staff. This option is the used in the CAP/C program.

### **Family**

Family is an informal support system and is defined as one or more of the following:

- a. The beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent;
- b. Anyone who has legal responsibility for the minor beneficiary;
- c. Grandparents of the beneficiary;
- d. Siblings of the beneficiary;
- e. The spouse of an adult (18 years of age or older) beneficiary; or
- f. Anyone who has legal responsibility for an adult (18 years of age or older) beneficiary.

The Case Manager is responsible for verifying legal guardianship when that person is not the parent of a minor or when an adult beneficiary has a legal guardian. The Case Manager is not expected to keep copies of this documentation or submit the documentation to NC Medicaid.

Family, as defined here, shall not be the paid provider of any CAP service or supply.

### **Financial Management Services**

Financial Intermediary (FI) support is provided to CAP beneficiaries who direct some or all of their CAP services. This support may be furnished as a CAP service or conducted as an administrative activity. When used in conjunction with the employer authority, this support includes operating a payroll service for CAP beneficiary's employed workers and making required payroll withholdings. When used in conjunction with the budget authority, this support includes paying invoices for waiver goods and services and tracking expenditures against the consumer-directed budget.

### **Free Choice of Provider**

Requires that a Medicaid eligible individual may seek care from any willing and qualified service provider as defined under the State's Medicaid Plan in accordance with 42 CFR 431.51(a)(1).

### **Freedom of Choice**

The right afforded to a beneficiary to choose to participate in the CAP Waiver and to select any and all CAP services assessed to meet their needs.

### **Freedom of Choice of Provider Form**

A form signed by the waiver beneficiary or responsible party that clearly outlines the selected provider of their choice.

### **Health and Welfare**

The safeguard and protection against abuse, neglect and exploitation of a beneficiary who is participating in the CAP Waiver, in accordance with 42 CFR 441.302 (a).

### **Home and Community Based Services**

Services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of 42 CFR 441, subpart G.

### **Home and Community-Based Final Rule**

New requirements for providing home and community-based services. The HCBS Final rule ensures the Medicaid's home and community-based services program provide full access to the benefits of community living and offer services in the most integrated settings.

### **Home Accessibility and Adaptation**

Equipment and physical adaptations or modification to the CAP beneficiary's private primary residence that are required to promote health, safety and well-being. Medically necessary items are identified in an approved Service Plan.

### **Individual**

A person applying for initial participation in the CAP waiver regardless of Medicaid eligibility.

### **Individual Risk Agreement**

An agreement that outlines the risks and benefits to the beneficiary of a particular course of action that might involve risk to the beneficiary, the conditions under which the 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 beneficiary or responsible party to assume responsibility for his or her personal choices, through surrogate decision makers, or through planning team consensus.

### **Informal Support System**

An informal support system, is defined as one or more of the following:

- a. The beneficiary's parent, stepparent, grandparent, foster parent, custodial parent, adoptive parent, sibling or other relative;
- b. The spouse of an adult (18 years of age or older) beneficiary; or
- c. Friends, neighbors, church member or anyone providing emotional physical or financial support.

### **Institutional Care**

Refers to specific benefits authorized in the Social Security Act. These are hospital and the long-term care services. Institutions assume total care of the individuals who are admitted. Institutions must be licensed and certified by the state, according to federal standards. 42 CFR 440.40.

### **Institutional Respite Care**

Institutional respite care is the provision of temporary support to the primary caregiver(s) of the CAP/C beneficiary by taking over care of the CAP/C beneficiary for a limited period of time. The provision of this service takes place in a Medicaid certified nursing facility or a hospital with swing beds. This service may be used to meet a wide variety of needs, including family or caregiver emergencies, relief of the caregiver, and planned vacations or special occasions when the caregiver needs to be away from home for some extended period of time.

### **Instrumental Activities of Daily Living (IADL's)**

Normal day-to-day home maintenance activities performed by a CAP/C beneficiary or responsible party. These activities are necessary for maintaining a beneficiary's immediate environment and include: primary private residence (home) maintenance, housework, laundry, meal prep, medication management, money management, phone use, shopping, errands and transportation.

### **Level of Care for the CAP Waiver**

A disability of medical and physical abnormalities includes primary medical diagnoses that are chronic in nature. The overriding medical condition is primarily physical rather than psychological, behavioral, or developmental (if the primary medical condition is cognitive, the diagnosis will primarily result from a medical condition that impairs cognition). The individual needs in-home supports and services similar to that provided in an institution. The beneficiary requires interventions to engage in activities of daily living in order to prevent adverse physical and medical consequences that may require institutional placement to maintain health, safety, and well-being.

## Medically Fragile

Medical fragility is used to identify medical conditions primarily for CAP beneficiaries between the ages of 0-20 years who have all of the following qualifying conditions:

- a. A primary medical (physical rather than psychological, behavioral, cognitive, or developmental) diagnosis(es) to include chronic diseases or conditions including but not limited to 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. To meet this criterion, a physical medical condition must be the primary debilitating condition; and
- b. A serious, ongoing illness or chronic condition requiring prolonged hospitalization (more than 10 days, or 3 admissions) within 12 months, ongoing medical treatments (refer to **Appendix F**), nursing interventions, or any combination of these;

To meet this criterion, the individual must have either of the following:

1. A documented hospital stay as described above that is primarily related to the primary physical medical condition listed above. Emergency room visits do not meet the qualification for this criterion; or
2. Ongoing treatment directly administered and monitored by a nurse or physician, including but not limited to intravenous infusion, oxygen titration (when verified), insulin management when not routinely included in the disease management, seizure management that requires judgment for medication or intervention (does not include seizure logs), nasogastric tube, wound care that requires medication, debridement, sizing and dressings, or prescribed medication that requires frequent and ongoing judgment to administer due to varying dosages (does not include regular or routine medication administration); and
- c. A need for life-sustaining devices or life-sustaining care to compensate for the loss of bodily function including but not limited to endotracheal tube, ventilator, suction machines, dialysis machine, J-Tube and G-Tubes, oxygen therapy, cough assist device, and chest PT vest.

To meet this criterion, the individual must have either of the following:

1. Documented life-sustaining devices as listed above; or
2. Care to compensate for loss of bodily function, including but not limited to Malone Antegrade Continence Enema (MACE), in and out catheters, an enema prescribed by a physician on a regularly scheduled basis (daily or 3-5 times per week), anal digital stimulation order by a physician on a regularly scheduled basis (daily or 3-5 times per week), Vagus Nerve stimulation (VNS) swipe, sever contractures and rigidity of the arms and hands that require guided movement for eating Oropharyngeal suctioning, or requires repositioning at least every two hours.

## Medical Treatment

Treatments are medical care services other than routine office visits, follow-up appointments, or management of a health care plan, that directly prevent or ameliorate health deterioration; services aimed at preventing or delaying acute episodes of physical illness; and must be provided by a registered nurse or medical doctor.



## NC Tracks

A web-based service for North Carolina's health care providers and consumers as part of the multi-payer system for NC Department of Health and Human Services, that allows provider enrollment in the Medicaid program and claim submittal to Medicaid program.

## Non-Institutional Respite Services

Non-institutional respite care is the provision of temporary support to the primary unpaid caregiver(s) of the CAP beneficiary by taking over the tasks of primary caregiver for a limited period of time.

## Nursing

Professional skilled nursing services is defined as assessment, judgment, intervention and evaluation of interventions that require the education, training, and experience of a registered nurse (RN) or a licensed practical nurse (LPN) who holds a current valid license issued by the North Carolina Board of Nursing to practice nursing as under NCGS 90-171, and 21 NCAC 36. Skilled nursing does not include those tasks that can be delegated to unlicensed personnel (21 NCAC 36). Services must be substantial. This means the beneficiary requires interventions that can be performed only by a licensed nurse in accordance with the North Carolina Nurse Practice Act (NCGS 90 171; NCAC 36). Services must be continuous. Skilled nursing assessment, interventions, or both are performed by a licensed nurse usually at least every 2-4 hours during the hours that Medicaid-covered nursing are provided.

## Parent or Legally Responsible Representative

The Parent or Legally Responsible Representative is defined as a person acting for and legally authorized to execute a contract for the CAP applicant or beneficiary, such as but not limited to a legal guardian, parent, stepparent, custodial parent, adoptive parent, grandparent or a sibling of a minor child, or holder of medical power of attorney. Except for parents of minor children, legal authorization requires a separate legal document. The Case Manager is responsible for verifying legal guardianship when that person is not the parent of a minor or when an adult CAP beneficiary has a legal guardian. The Case Manager is not expected to keep copies of this documentation or submit the documentation to NC Medicaid.

Parent or legally responsible representative, as defined here, shall not be the paid provider of any CAP service or supply.

**Note:** Throughout this policy, wherever the term "parent(s)" appears, "parent(s), legally responsible representative, or both" is implied.

## Participant

A Medicaid beneficiary who has been approved to participate in the CAP waiver.

## Participant Notice

Written notification to the agency or agencies providing regular State Plan services to inform of CAP approval and participation. The notice documents and verifies the non-CAP home and community care services the participant is receiving (or will be receiving pending Medicaid approval) and reminds the provider to coordinate any changes with the case management entity.

### **Personal Care Aide**

A personal care aide is a certified professional provided through a licensed home care agency that provides hands-on assistance to individuals receiving personal care under this clinical coverage policy.

### **Personal Care Assistant**

A personal care assistant is a paraprofessional provided through the consumer-directed option under the CAP/Choice who provides hands-on assistance to individuals receiving personal care under this clinical coverage policy. This personal care assistant is hired by the beneficiary or responsible party to provide help with personal care and home maintenance.

Personal Maintenance Tasks are basic activities of daily living that must be performed to assure and support one's health, safety, and well-being.

### **Person-Centered Planning**

The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.

### **Primary Private Residence (Home)**

The primary private residence that a beneficiary owns or rents in his own right or the primary private residence where a beneficiary resides with other family member, parents, grandparents, or friends. CAP beneficiaries' primary residence can include a foster care type setting. A primary private residence is not licensed or regulated as any kind of group home or other board and care facility. No more than four unrelated people can live in the primary private residence of an approved CAP beneficiary. Refer to *Adult Medicaid Manual* for a description of living arrangement for Medicaid refer to: <http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/MA2510.htm>

### **Quarterly**

Three calendar months.

### **Responsible Party**

A person who may act on behalf of the CAP beneficiary; a responsible party may be: a legal representative who is legally authorized to execute a contract for the beneficiary (examples: Power of Attorney, Health Power of Attorney, legal guardian, financial planner) or an individual (family member or friend) selected by the beneficiary to speak for and act on their behalf. For ages 0-20 the responsible party is considered to be the beneficiary's parent, stepparent, foster parent, custodial parent, or adoptive parent. Anyone who has legal responsibility for the minor beneficiary.

### **Restorative Nursing**

Restorative nursing is nursing interventions that promote the beneficiary's ability to adapt and adjust to living independently as safely as possible.

Restorative nursing focuses on achieving and maintaining optimal physical, mental and psychosocial functioning. Generally, restorative nursing is initiated when a beneficiary is discharged from formalized physical, occupational or speech therapy.

### **Service Request Form (SRF)**

An individual being considered for the CAP Waiver must be a member of the targeted population and meet the required level of care consistent with a nursing facility. A service request form replaces the FL-2 form and must be completed to determine the basic clinical eligibility criteria for medical fragility and level of care for potential CAP participation. This form has a scoring logic for assessing medical fragility and level of care.

### **Significant Change in Acuity**

For purposes of requiring a different level of care determination, a significant change or decline in condition is defined as one of the following:

- a. start or discontinuation of a tracheostomy tube;
- b. start or discontinuation of tube feedings;
- c. increase or decrease in seizure activity such that a revision to the service plan is needed;
- d. increase or decrease in need for ADL assistance such that a revision to the service plan is needed;
- e. a change in status that requires more skilled care or monitoring.

### **Staff to Participant Ratio**

A sufficient number or responsible persons to safely meet the needs of participants, including full or part-time direct service staff member. When identifying the appropriate staff to participant ratio, consideration of participants with greater needs must be emphasized.

### **Willingness and Capability (Consumer-Directed Model of Care)**

Readiness to assume the role of employer as evidenced by the completion of the required forms, documentation, and training; current and past collaboration and cooperation with the case management entity, financial management agency, and NC Medicaid; understanding Medicaid guidelines; being aware of fraud, waste, and abuse; and having access to an informal support system.

## Appendix G: Consumer-directed Self-Assessment Questionnaire

The self-assessment questionnaire is used to determine your capability to direct your care in the consumer-direction option of the Community Alternatives Program. The tools in the self-assessment questionnaire will identify areas that you are knowledgeable and areas that you may need additional help. These tools will also assist you in identifying your personal care needs and the required skills your hired employee will need to assure your health, safety, and well-being. Once you complete the self-assessment questionnaire, you will make it available to your case management entity. The self-assessment questionnaire includes the following sections:

- Is Consumer-Direction Right for Me?
- What Are My Health Care Needs?
- What Areas Do I Need Help?
- Thinking Like an Employer (Techniques, Tools, and Processes)
- Finding the Right Employee to Meet My Care Needs
- Competency Validation of Direct Care Staff

Beneficiary name: \_\_\_\_\_

Person completing form: \_\_\_\_\_

Individual acting as employer: \_\_\_\_\_

*For CAP participants under 18 years of age or those with a representative, the self-assessment questionnaire will be completed by the legally responsible guardian or the appointed representative.*

## Self-Assessment Questionnaire Completion Guide

### Purpose

The self-assessment questionnaire is used to determine your capability to consumer-direct. The self-assessment will also be used to identify your training needs and validate the competencies of your direct care staff. This tool will provide guidance to you, as the individual acting as the employer, in completing the self-assessment questionnaire.

### Who Completes the Self-Assessment?

The self-assessment questionnaire shall be completed by the individual acting as the employer.

*Beneficiaries 0-17 years old:* to be completed by the parent or guardian

*Beneficiaries 18 years old and older:* to be completed by the beneficiary

*Beneficiaries 18 years old and older requiring a representative:* to be completed by the representative

### Sections of the Self-Assessment

#### **Is Consumer-Direction Right for Me?**

- Complete section during consumer-direction orientation.
- Answer questions related to health care needs from the perspective of the beneficiary.
- Answer questions related to managing care, finances, and employer responsibilities from the perspective of the individual acting as the employer.

#### **What are My Health Care Needs?**

- Complete section after consumer-direction orientation.
- List the supports and services the beneficiary requires to maintain his or her quality of life.
- List how each item will meet the beneficiary's needs.
- List individuals (in addition to the beneficiary's primary caregiver) who will provide help to the beneficiary.

#### **What Areas Do I Need Help?**

- Complete section after consumer-direction orientation.
- Place a check by the appropriate response to indicate your current knowledge level of each topic.

#### **Thinking Like an Employer (Techniques, Tools, and Processes)**

- Complete section after consumer-direction orientation.
- Provide a detailed response to each question related to employer responsibilities.

- Provide a response detailing the tasks you want your employee(s) to perform
- List times of each day of the week the beneficiary requires assistance.

#### **Finding the Right Employee**

- Complete section after consumer-direction orientation.
- Place a check by the appropriate response to indicate the importance of each topic related to providing care to the beneficiary.
- Indicate the source you intend to use to obtain an employee(s).

#### **Competency Validation of Direct Hired Staff**

- Complete once an employee(s) has been identified.
- Complete section for all employees.
- Circle the tasks that are required to address the beneficiary's health care needs.
- Provide a detailed response to indicate how the employee demonstrates the ability to complete the identified tasks.
- Check the appropriate response to indicate if your employee: has the skills to meet the beneficiary's care needs, has some skills to meet the beneficiary's care needs, or does not have any skills to meet the beneficiary's care needs.
- List trainings you will provide to the employee(s) if he or she does not have the skills to meet the beneficiary's care needs.

- 1. The individual acting as the employer shall make the completed self-assessment questionnaire available to the case management entity by the agreed upon time.**
- 2. The case management entity will evaluate the responses of the self-assessment questionnaire to determine the employer's readiness to consumer-direct.**
- 3. Additional training and another completion of the self-assessment questionnaire may be recommended by the case management entity or the Division of Medical Assistance based upon the results of the self-assessment.**

### Is Consumer-Direction Right for Me?

Consumer-direction offers freedom and independent thinking. Complete this section below during your orientation session to help decide if consumer-direction is right for you.

Date consumer-direction enrollment process initiated: \_\_\_\_\_

#### Why are you interested in consumer-direction?

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#### What do you wish to achieve by directing your care?

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#### What can the consumer-direction option provide for you that an in-home agency cannot?

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1. Do you want to be an employer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
2. Are you able to dedicate approximately 2-4 hours per year for consumer-direction training?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
3. Are you able to dedicate approximately 6-7 hours per week for managing your employee and completing employer related tasks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
4. Do you prefer to decide what employees will provide your care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
5. Do you know what documents should be completed when hired as an employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
6. Do you know how to decide a pay rate based upon an employee's skill set?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
7. Have you ever written a job description based on current demand of need?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
8. Do you feel comfortable telling an individual what you like and don't like about the services he or she provides?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
9. Are you comfortable providing job performance corrections to your employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
10. Are you able to be firm and set limits with friends, family, and neighbors you may hire?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure

5

CAP Consumer-Direction Self-Assessment Questionnaire  
7/2017  
DMA-3072



<p>11. Do you know what the responsibilities of being an employer are? If yes, list 3.</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
<p>12. Have you ever created a task list to help meet your daily needs?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
<p>13. Do you know how to review medical documents to understand what your care needs are?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
<p>14. Do you feel assertive enough to make your needs known to your employee?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
<p>15. Do you know how to research services to help meet your needs? If yes, list the source(s) used.</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
<p>16. Do you know what skills are needed to provide your care?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
<p>17. Have you ever had to provide step-by-step training instructions to someone to assist in meeting your health care needs?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
<p>18. Do you know how public funds are wasted, abused, or obtained fraudulently? If yes, list 2 ways.</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure

_____			
19. Do you have an emergency and disaster plan written to describe how to care for you when a crisis occurs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
20. Do you have a solid network of reliable individuals you can select from to hire an employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
21. Have you ever had to review timesheets or payroll documents?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
22. Do you know signs of abuse, neglect, or exploitation? If yes, list three. _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure
23. Do you have Internet access? If so, how do you access the Internet (i.e. computer, smartphone, library)? _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
24. Is knowing the criminal background important when selecting an employee?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Not Sure

**Do you know what Community Alternative Program (CAP) services are?**

Yes  No

**If yes, list the information you know about CAP services.**

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**Who do you think you will hire to provide the services you need?**

- \_\_\_\_\_ a friend(s)  
\_\_\_\_\_ a family member(s)  
\_\_\_\_\_ someone from a religious group; church community  
\_\_\_\_\_ someone from the local Center for Independent Living  
\_\_\_\_\_ someone from a local adult service agency  
\_\_\_\_\_ someone from an advertisement in a newspaper or online  
\_\_\_\_\_ someone from a technical school  
\_\_\_\_\_ someone from a home health agency  
\_\_\_\_\_ not sure

**Do you have a support network (family, friends, or neighbors who will offer support and help in caring for you)?**

Yes  No

**If no, how will you build a support network?**

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**How long will it take you to build your support network?**

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*To be completed by the case management entity*

**Date orientation completed:** \_\_\_\_\_

Following orientation, beneficiary/individual acting as the employer is interested in moving forward in consumer-direction enrollment.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Beneficiary/individual acting as the employer provided with the remaining documents of the self-assessment questionnaire and instructions on how to complete.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**What Are My Health Care Needs?**

In this section, identify items that are important to you in meeting your health care needs?

**What are your health care needs?**

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**List the help you need to ensure your health and well-being.**

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**Describe how each item listed above will meet your health care needs?**

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### What Areas Do I Need Help In?

In this section, you will rate your knowledge and experience of each listed item to identify what areas you need help in understanding. Check the response that applies to your current knowledge and experience level.

**No knowledge/experience**

I have no knowledge or experience in this area.

**Minimal knowledge/experience**

I have some knowledge and experience in this area.

**Substantial knowledge/experience**

I have advanced knowledge and experience in this area.

**Extensive knowledge/experience**

I have expert knowledge and experience in this area.

	No knowledge/experience	Minimal knowledge/experience	Substantial knowledge/experience	Extensive knowledge/experience
Making decisions independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding basic information about state and federal tax laws related to employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finding a dependable employee(s) to provide care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advertising for an employee(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deciding how much to pay an employee(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No knowledge/experience	Minimal knowledge/experience	Substantial knowledge/experience	Extensive knowledge/experience
Screening applications and interviewing potential employee(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding the results of criminal and health care registry background checks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Training an employee(s) in providing care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Setting requirements for and employee(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assessing the quality of service provided by your employee(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reviewing an employee(s) work tasks and timesheets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communicating information to your employee(s) about the quality of service provided	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No knowledge/experience	Minimal knowledge/experience	Substantial knowledge/experience	Extensive knowledge/experience
Knowing when to terminate an employee(s) for poor job performance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning for back-up or emergency care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being able to identify a true emergency and the appropriate individual(s) to contact	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making decisions about services to receive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identifying my care needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding my medications (e.g. when to administer, how much, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowing what services/resources are available in the community and how to obtain them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	No knowledge/experience	Minimal knowledge/experience	Substantial knowledge/experience	Extensive knowledge/experience
Obtaining services in a cost-effective manner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding how to read medical documents related to my health care needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obtaining other services needed for my care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding my health insurance benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creating a person-centered plan of care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understanding the role and responsibilities of a care advisor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	No knowledge/experience	Minimal knowledge/experience	Substantial knowledge/experience	Extensive knowledge/experience
Knowing when to ask others for help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing my care with limited assistance from my case management entity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading and comparing financial reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tracking and monitoring monthly usage of Medicaid services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knowing how to follow up with the appropriate individuals to resolve problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Familiarity with Health Insurance Portability and Accountability Act (HIPAA) and maintaining patient confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Thinking Like an Employer

*(Tools, Techniques, Processes)*

**What skills and qualifications will you look for in an employee(s) to meet your health needs?**

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**What items, based on your current needs, will you include in your tasks list?**

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**What tools will you use to monitor the performance of your employee(s)?**

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**How often will you monitor the performance of your employee(s)?**

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**What techniques will you use to resolve conflict involving your employee(s)?**

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**How will you make certain that timesheets and other required documents of the employee(s) are correct and turned in timely?**

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**How will you secure employment documents in a safe and confidential location?**

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**How will you ensure Medicaid dollars are used wisely?**

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---

**If your employee(s) is not available; how will you arrange for care?**

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**What specific information must be included in a job description to hire someone to provide services to address your health care needs?**

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**What checks and balances will you put in place to prevent Medicaid waste, fraud, and abuse?**

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Circle the task that is needed to address your care needs. Describe the assistance the employee(s) must provide to help with each selected task.

<b>Task</b>	<b>Description of Help Needed</b>
<b>Bathing/Assistance in the bathroom</b>	
<b>Dressing</b>	
<b>Mobility</b>	
<b>Eating</b>	
<b>Personal hygiene</b>	

<b>Task</b>	<b>Description of Help Needed</b>
<b>Toilet use</b>	
<b>Transfers</b>	
<b>Housekeeping</b>	
<b>Laundry</b>	
<b>Meal preparation</b>	
<b>Correspondence/mail, money management</b>	
<b>Shopping</b>	

<b>Task</b>	<b>Description of Help Needed</b>
<b>Transportation</b>	
<b>Community involvement</b>	
<b>Other</b>	
<b>Other</b>	

List the days and times you need help with the tasks described.

<b>Monday</b>	a.m.
	p.m.
<b>Tuesday</b>	a.m.
	p.m.
<b>Wednesday</b>	a.m.
	p.m.
<b>Thursday</b>	a.m.
	p.m.
<b>Friday</b>	a.m.
	p.m.
<b>Saturday</b>	a.m.
	p.m.
<b>Sunday</b>	a.m.
	p.m.



### Finding the Right Employee

How important are the following items when choosing an employee(s) to provide your services? In this section, check the response that most closely describes the importance of each item.

	Mandatory	Preferred	Not Required
The employee is someone I know well or has been referred by someone I know well.	_____	_____	_____
The employee is flexible in addressing unanticipated job requirements.	_____	_____	_____
The employee is a team player.	_____	_____	_____
The employee is available to work the days and times I request with little negotiation in schedule.	_____	_____	_____
The employee is punctual; arrives on schedule and completes tasks in a timely fashion.	_____	_____	_____
The employee can successfully communicate with me.	_____	_____	_____
The employee follows my instructions with little to no re-direction.	_____	_____	_____
The employee is willing to accept the pay rate that I establish.	_____	_____	_____
The employee is enthusiastic about the work they provide.	_____	_____	_____

	Mandatory	Preferred	Not Required
The employee will provide requested information timely (e.g. employment verification, timesheets).	_____	_____	_____
The employee has experience providing care for individuals with needs similar to mine.	_____	_____	_____
The employee is open to learn new things.	_____	_____	_____
The employee knows the appropriate supplies and equipment needed for my care.	_____	_____	_____
The employee provides services only to me (no other employment).	_____	_____	_____
The employee has their own transportation.	_____	_____	_____
The employee is knowledgeable of my medical condition.	_____	_____	_____
The employee can pass a criminal and health care registry background check (no prior convictions).	_____	_____	_____
The employee is familiar with CAP and other services/resources in the community.	_____	_____	_____
The employee responds well to positive and negative feedback.	_____	_____	_____
The employee is willing to work over 40 hours a week.	_____	_____	_____



**Competency Validation of Direct Care Staff**

Beneficiary name: \_\_\_\_\_

Name of individual acting as employer: \_\_\_\_\_

Name of direct care employee being validated: \_\_\_\_\_

	Yes	No
Is your potential employee at least 18 years old?		
Is your potential employee a parent, step-parent, foster parent or significant other of a parent?		
Is your potential employee a power of attorney, guardian, or representative?		
Does your potential employee make decisions on your behalf?		
Does your potential employee sign documents on your behalf?		
Does your potential employee live in the home with you?		

As a participant in the consumer-direction option of CAP, I understand that an employee(s) is not required to be a licensed health care professional to provide my care needs. I take fully responsibility of hiring, training, and supervising the employee(s) I hire.

Directions to complete form: Circle the skill that is needed to address the beneficiary's care needs. Describe how the employee demonstrates the ability to complete the selected tasks. Complete for each employee.

Skill	The employee demonstrates the competency to provide this skill by:
bathing	
grooming	
feeding/meal prep	
transfers/ambulation	
positioning	
toileting	
fall prevention	
incontinence care	

Skill	The employee demonstrates the competency to provide this skill by:
enema	
vital signs	
therapy reinforcement	
pain assessment	
dressing change	
G-tube/J-tube	
mic-key button	
IV fluids/site check	
administering medication	
diabetic/insulin monitoring	
nebulizer treatment	
cardiac monitoring	

Skill	The employee demonstrates the competency to provide this skill by:
edema	
neurological check	
seizure precautions	
VNS swipe	
respiratory suction/oral	
pulse oximeter	
chest PT	
oxygen administration	
oxygen titration	
Bipap/Cpap	
apnea monitoring	
respiratory pacer	

Skill	The employee demonstrates the competency to provide this skill by:
naso-pharyngeal suctioning	
catheter care	
wound care	
other	
<b>CPR Validation</b>	
<b>Date of CPR certification:</b>	
<b>Expiration date of CPR certification:</b>	

Based on the responses of this Competency Validation of Direct Care Staff, my hired employee:

Has the competencies to meet my assessed needs.



Does not have the competencies to meet my assessed needs, but will have the competencies with training in the following areas:

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My signature indicates that I have completed the competency validation of direct care staff on the employee(s) that I intend to hire. I have determined that my employee(s) has the competencies to complete the tasks required for my care and I agree to provide training to my employee(s) to build competencies, if needed. I take full responsibility for my employee(s) and monitoring the tasks completed by my employee(s).

\_\_\_\_\_  
Individual acting as employer name:

\_\_\_\_\_  
Beneficiary name:

\_\_\_\_\_  
Individual acting as employer signature:

\_\_\_\_\_  
Date signed:

The care advisor's signature indicates that he or she has reviewed the completed competency validation of direct care staff.

\_\_\_\_\_  
Care advisor name:

\_\_\_\_\_  
Care advisor signature:

\_\_\_\_\_  
Date signed:

## Appendix H: Emergency Back-Up plan

(DMA Form No. 3072)

### My Emergency Back-Up Plan

In the event my Personal Care provider is not available to provide my care as listed in my service plan, I will arrange for \_\_\_\_\_ to assist with my care.

\_\_\_\_\_ will understand my care needs as to immediately provide the personal care I need.

\_\_\_\_\_ Contact information is:

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

24/hour Contact Availability \_\_\_\_  Yes \_\_\_\_  No

**\*\*FOR POLICE, FIRE, MEDICAL EMERGENCIES DIAL 911\*\***

The address of this house is: \_\_\_\_\_

\_\_\_\_\_

Major cross streets near this address are: \_\_\_\_\_

The phone number is: \_\_\_\_\_

My Physician is \_\_\_\_\_

My Primary Caregiver is \_\_\_\_\_

My Emergency Contact is \_\_\_\_\_

My medications are kept: \_\_\_\_\_

**Important phone numbers:**

Pharmacy: \_\_\_\_\_

Poison Control: \_\_\_\_\_

Primary Caregiver: \_\_\_\_\_

Family at home: \_\_\_\_\_

Family at work: \_\_\_\_\_

Neighbor: \_\_\_\_\_

Care Advisor: \_\_\_\_\_

**My Plan**

If my personal assistant(s) does not report to work or I need 24 hour care coverage and I cannot make arrangements with my identified informal/formal back-up, My plan is to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I have a medical or critical appointment and my personal assistant(s) cannot assist with transportation, My plan is to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If I need help with taking my medication and will rely on my personal assistant(s) and my personal assistant is not available to help me, My plan is to:

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If I am on a special diet or special medication plan such as sliding scale insulin or PEG, etc. and my personal assistant(s) cannot help me, My plan is to:

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If there is a natural disaster in my area, my plan is to:

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If I have to go into a hospital or nursing facility for a short period of time, My plan is to:

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## Appendix I: Decision Tree for Determining Medical-Fragility

### Decision Tree for Determining Medical-Fragility Criteria for the Community Alternatives Program for Children

To be considered for participation in the Community Alternatives Program for Children (CAP/C) 1915 (c) Home and Community-Based Services Waiver, clinical and needs-based eligibility must be met. The Service Request Form (SRF) assists in establishing clinical-based eligibility for the medical fragility criteria. To meet the eligibility requirements for medical fragility, all components of the medical fragility criteria must be met which is outlined below and in **Subsection 2.1.2** of this policy.

Medical Fragility eligibility criteria:

- a. **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; and**

Has a primary medical diagnosis \_\_\_ Yes \_\_\_ No

If yes, list medical diagnosis \_\_\_\_\_

Criterion A Met \_\_\_ Yes \_\_\_ No

- b. **A serious, ongoing illness or chronic condition requiring prolonged hospitalization (more than 10 calendar-days, or 3 hospital admissions) within 12 months, or has ongoing medical treatments, nursing interventions, or any combination of these that must be provided by a registered nurse or medical doctor; and**

Has prolonged hospitalization \_\_\_ Yes

Number of documented hospital admissions: \_\_\_\_\_ or

Longest length of hospital admission within 365 days: \_\_\_\_\_

Does not have prolonged hospitalization \_\_\_ No,

but has an **ongoing medical treatment, nursing interventions, or any combination of these that must be provided by a registered nurse or medical doctor listed on the SRF such, as check the applicable intervention/s:**

- Intravenous Infusion (IV)
- Oxygen titration
- Insulin management when not routinely currently included in the disease management
- PRN Injections requiring frequent and ongoing judgement (injections that are not routinely scheduled)
- Seizure management that requires judgement for medication or intervention
- Nasogastric tube
- Wound care that requires medication, debridement, sizing and dressings
- Medication prescribed that requires frequent and ongoing judgement to administer due to varying dosages
- Other, describe: \_\_\_\_\_

Has medical treatments, nursing interventions, or any combination of these that must be provided by a registered nurse or medical doctor \_\_\_\_\_ Yes \_\_\_\_\_ No

**Criterion B Met** \_\_\_\_\_ Yes \_\_\_\_\_ No

- c. **A need for life-sustaining devices such as endotracheal tube, ventilator, suction machines, dialysis machine, Jejunostomy Tube and Gastrostomy Tube, oxygen therapy, cough assist device, and chest PT vest; or a need for life-sustaining care to compensate for the loss of bodily function.**

Has life-sustaining device(s) \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, list device(s): \_\_\_\_\_

Does not have life-sustaining device(s) \_\_\_\_\_ No,

But has a need for life-sustaining care to compensate for loss of significant bodily function listed in the SRF such as (check the applicable care or intervention/s):

- Malone Antegrade Continence Enema (MACE)
- In and Out catheters
- Enema prescribed by a physician on a regularly scheduled basis (daily or 3-5 times per week)

- Anal digital stimulation ordered by physician on a regularly scheduled basis (daily or 3-5 times per week)
- Vagus Nerve Stimulation (VNS) swipe
- Severe contractures and rigidity of the arms and hands that requires guided movement for eating
- Oropharyngeal suctioning
- Requires ordered repositioning at least every two hours
- Other, please describe: \_\_\_\_\_

Has a need for life-sustaining care to compensate for the loss of bodily function \_\_\_\_ Yes  
\_\_\_\_ No

Criterion C Met \_\_\_\_ Yes \_\_\_\_ No

**Referral Decision:**

\_\_\_\_ a, b and c were met; this child meets the Medical-fragility criteria. The referral is approved.

Because either \_\_\_\_ a, \_\_\_\_ b, or \_\_\_\_ c was not met; this child does not meet the Medical-fragility criteria because [ list reason why]. This referral has been denied.

\*The items listed above are examples of ongoing nursing interventions, devices or treatments that compensate for bodily functions; there may be other qualifying medical treatment(s) or interventions(s) that are not listed in this document.

Appendix I: Created June 20, 2017; updated September 10, 2017