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

1. Major Changes

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

This home and community-based services waiver has been instrumental in providing supplemental services to Medicaid beneficiaries who are 18 years and older with a physical disability or who are 65 years and older with functional deficient due to age and disability. This waiver has served this population of Medicaid beneficiaries for over thirty years. This application submittal is to request renewal of the current HCBS waiver known as Community Alternatives Program for Disabled Adults for a duration of five years.
This waiver is intended to provide an array of home and community-based services to Medicaid beneficiaries who meet a nursing facility level of care, at risk of displacement (institutionalized) and choose to live in their communities with the support of HCBS.
Changes that will be implemented during this renewal waiver cycle include:
1. A specific definition for the target population and the requirement for only one waiver service to provide in-home supportive services for assistance with ADLs; or a need for linkage to community resources to ensure community integration or maintain community integration. Refer to Appendix B.
2. Introduction of another priority group to allow immediate waiver entry. This group includes an individual who is terminally ill, enrolled in the Hospice program and who is in jeopardy of going into a non-Hospice institution because care needs cannot be met by current resources. Refer to Appendix B.
3. An independent assessment entity model will be used to ensure safeguards of conflict of interest in the areas of eligibility and services. This entity will solely be responsible for determining the clinical and need-based eligibility for newly interested individuals wanting to participate in this HCBS program, and during annual reviews for individuals currently participating in this HCBS program. Refer to Appendix D
4. An alternative option of case management entities will be available for participants in each county to allow greater freedom of choice. Refer to Appendix A
5. Implementation of expansion of specific service definitions to allow for greater access to services and community integration as well as to mitigate gaps in service provision.
The waiver services with an expanded definition are:
•Community Transition Services has been subdivided to two distinct services: Community Transition and Community Integration.
• Participant goods and services have been subdivided to six distinct services: Participant Goods and Services; Individual-directed Goods and Services; Chores services-Declutter/Garbage Disposal; Non-medical Transportation; Nutritional Services and Pest Eradication.
• A new service will be added, called Coordinated Caregiving. This service will address shortages of paraprofessional and surrogate support systems for waiver participants.
• Home accessibility and adaptive services and assistive technology will have a combined budget. These two services will be referred to as equipment, modification and technology.
• Two services, CAP In-home Aide and Meal preparation and delivery will have a rate increase. Refer to Appendix C and J for full description of each waiver service.
7. An electronic interfacing will be introduced between waiver participants and service providers when electronic personal health information can be protected. Refer to Appendix D.
8. Management of grievances and complaints. Refer to Appendix F.
9. Introduction a 90-day service plan to build up to a 12 months service plan for a waiver participant who willingly places self in unsafe situations which impact health, safety and well-being. Refer to Appendix G.
10. Introduction of a 90-day service plan for when an individual requesting waiver participation only needs assistance with equipment, modification and technology.
11. Case management and financial management services will be reimbursed as a monthly unit.

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

1. Request Information (1 of 3)

A. The **State** of **North Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

CAP/DA Renewal (3.5)

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NC.0132
Waiver Number:NC.0132.R07.00
Draft ID: NC.015.07.00

D. Type of Waiver *(select only one):*

Regular Waiver

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

11/01/19

Approved Effective Date: 11/01/19

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**

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

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in42 CFR §440.160**

☒ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

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

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

1. Request Information (3 of 3)

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

Select one:

- (●) **Not applicable**
- ( ) **Applicable**

Check the applicable authority or authorities:

- ☐ **Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I**
- ☐ **Waiver(s) authorized under §1915(b) of the Act.**

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

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

- ☐ **§1915(b)(1) (mandated enrollment to managed care)**
- ☐ **§1915(b)(2) (central broker)**
- ☐ **§1915(b)(3) (employ cost savings to furnish additional services)**
- ☐ **§1915(b)(4) (selective contracting/limit number of providers)**

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

- ☐ **A program authorized under §1915(i) of the Act.**
- ☐ **A program authorized under §1915(j) of the Act.**
- ☐ **A program authorized under §1115 of the Act.**

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

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

This HCBS waiver application is intended to provide a safe and supportive network of services, promote community integration, and autonomy of choice. This HCBS waiver serves Medicaid beneficiaries who are 18 years and older with a physical disabilities or who are 65 years and older with functional deficiencies due to age. This supportive network of services supplements Medicaid State Plan services to address deficiencies in the performance of ADLs, IADLs and gaps in the support systems. Waiver services include adult day health; in-home aide; equipment, modification and technology; meal preparation and delivery; respite(institutionalization and in-home); personal emergency response services; specialized medical supplies; participant goods and services; community transition and integration services; training, education and consultative services; case management; personal assistant; financial management and coordinated caregiving.
Goals: 1. To provide an alternative to institutional care for individuals in the target population who meet a nursing facility level of care and choose to remain integrated in their community or indicate a desire to transition from a facility. 2.To authorize HCBS to ensure the health, safety, and well-being of each waiver participant through person-centered planning while respecting his or her right to assume risk. 3. To provide each waiver participant access to HCBS enables freedom of choice, participation in decisions and activities related to service and provider selection and service delivery. 4. To manage the health care needs of this target population while ensuring average expenditures of HCBS are at a cost equal to or less than individuals in an institution.
Objectives: 1. To evaluate LOC and assess all individuals requesting initial participation in this waiver to ensure a person-centered plan is created to mitigate risk factors that may jeopardize community placement. 2. To ensure waiver participants reach his or her maximum potential for safety using case management services. 3. To ensure conflict of interest protections by using an independent assessor for the determination of initial eligibility. 4. To evaluate quality metrics of this HCBS waiver on a quarterly basis to ensure compliance and continuous quality improvement. Organizational Structure: Use local entities and contracted vendors to administer and monitor services to waiver participants. 1. The State Medicaid Agency – Administrator; 2. Case management entities- local day-to-day overseers of waiver participants to ensure health, safety and well-being and 3. Contracted Entities: VieBridge- CAP IT Business system; Independent Assessment Entity- Eligibility and plan of care reviewers and GDIT-MMIS. The State Medicaid Agency– provides: 1.Analysis and evaluation of six waiver assurances and associated performance measures. 2. Development of policies and guidelines for waiver participants and providers. 3. Development and management of rate methodology. 4. Management of critical incidents, complaints and grievances. 5. Management of expenditures and utilization limits. 6. Management of prior approval of services. 7. Development of guidelines for Participant's rights and responsibilities. Independent Assessment Entity (IAE): 1. Conducting level of care evaluations to determine eligibility for nursing level of care. 2. Conducting initial comprehensive assessments. 3. Providing notice of information to waiver participants by written format. 4. Providing education and outreach to waiver participants and providers about waiver access and entry. 5. Participating in Due Process proceedings when necessary. Local case management entities (CME): 1. Conducting the annual and change of status assessments and developing a person-centered plan with each waiver participant. 2. Performing core case management activities of assessing, care planning, monitoring, linking and following-up. 3. Providing written notice of information to waiver participants. 4. Providing education and outreach to waiver participants and providers about waiver access and entry. 5. Participating in Due Process proceedings when necessary. 6. Managing the health, safety, and well-being of waiver participants. Contracted IT Vendor: 1. Providing an IT platform to manage the HCBS workflow in the areas of eligibility, service plan, critical incident management and monitoring. Contracted IT Vendor- Medicaid Management Information System (MMIS): 1. Providing a process for reimbursement of claims and provider enrollment. Service Delivery Model: waiver participants must: 1. Met a level of care; 2. Be assigned an assessment slot while a comprehensive assessment is performed to identity medical, functional and psychosocial needs; 3. Have risk indicators that place them in jeopardy community placement (institutionalized); 4. Need a service plan to mitigate risk factors to maintain community placement or transition from an institution; 5. Choose to participate in this HCBS waiver by accepting a slot; and 6. Identify providers to render HCBS services. Individuals and providers approved for participation: 1. Will be provided a notification letter that includes all approved services with description in amount, frequency and duration. The notice letter also will provide information on ANE, fair hearings, freedom of choice and grievances. 2. Will be provided a service authorization to render approved services in the amount, frequency, and duration specified in the service plan. The service authorization identifies the authorized period and the tasks associated with each approved service. 3. Will be provided a prior approval segment for claim reimbursement. 4. Will be assigned a case manager to ensure approved waiver services are provided within five days of the authorization. 5. Will be assigned case manager to provide monthly monitoring of provision to ensure health, safety, and well-being.

3. Components of the Waiver Request

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

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid

eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the state uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant-Direction of Services. When the state provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

- (●) **Yes. This waiver provides participant direction opportunities.** *Appendix E is required.*
- ( ) **No. This waiver does not provide participant direction opportunities.** *Appendix E is not required.*

F. Participant Rights. Appendix F specifies how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the state has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Improvement Strategy. Appendix H contains the Quality Improvement Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost-Neutrality Demonstration. Appendix J contains the state's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

A. Comparability. The state requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the state requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

- ( ) **Not Applicable**
- ( ) **No**
- (●) **Yes**

C. Statewideness. Indicate whether the state requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state. *Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the state. Participants who reside in these areas may elect

to direct their services as provided by the state or receive comparable services through the service delivery methods that are in effect elsewhere in the state.
Specify the areas of the state affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

A. Health & Welfare: The state assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The state assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The state assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The state assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,

2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the state employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The state assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid state plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The state assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the state's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The state assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The state assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid state plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The state assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The state assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the state has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the state has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including state plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the state that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The state does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the state has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery

processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

Stakeholder engagement began in October 2017 to solicit recommendations from stakeholders on best-practice administrative efficiencies; strategies to fill gaps in the service systems; best-practice home and community-based service to offer more flexibility and innovation to maintain community integration; and streamline business rules to reduce extended wait time and burdensome steps.

Statewide face-to-face listening sessions were held in the months of Oct. -Dec. 2017. The theme of the comments included:

1. Better coordination of transportation
2. More pay for in-home aides to address the worker shortage
3. Flexibility in using approved home and community-based services to address social determinants of health.

Work sessions were held with the Eastern Band of Cherokee Indians to solicit their ideas and recommendation throughout this engagement process.

Four external work groups were formed in January 2018 to address items pertaining to eligibility, service definitions, care coordination and incident management. These work groups consisted of HCBS providers, family members, representatives from the Eastern Band of Cherokee Indians and waiver participants as well as DHHS personnel.

The waiver application was posted for a 30-day public comment period starting on January 4 – February 4, 2019. The waiver application was posted in an electronic format and a hardcopy was posted at the Department of Social Services in each county of North Carolina. Current waiver applicants/caregivers were provided a crosswalk of the proposed changes and were invited to participate a webinar to learn more about the proposed changes. During the public posting period, a waiver application crosswalk was published, and informational sessions were held to provide a high-level overview on how to review the waiver application and to solicit comments from the attendees. A total of five audience-based sessions (two case management sessions, HCBS providers, DSS/DHHS/OST and waiver participant/caregiver) were held. A total of 854 stakeholders attended the informational sessions. A total of 1,480 stakeholders accessed the waiver application crosswalk. A total of 300 comments were received from these engagement formats.

Of the comments received, Appendix B, C and D were updated to provide additional clarity in the areas of cost limit, special circumstances or extraordinary conditions for legal guardian and the roles and responsibilities of the independent assessment entity and the case management entity in the development of the service plan.

A summary of the comments is listed below by associated Appendices in the waiver application:

Main Section comments and responses:

1. Do the changes to CAP/DA also include consumer-direction participants? No. No changes were required to be made to the waiver application.

2. Is it possible that someone who is receiving services will no longer qualify due to changes that are being proposed? Changes will not impact currently eligibility. No changes were required to be made to the waiver application.

Appendix A:

1. What role will NC Medicaid play once the IAE is up and running? Administrative Oversight. No changes were required to be made to the waiver application.

2. Will it be a different assessment for new clients, CNRs, or COS? NC Medicaid response - No. No changes were required to be made to the waiver application.

3. A new independent entity will do the assessment, but will the SW still do the POC or will they complete the whole process? The case management entity will be responsible to assist with the development of the service plan. Minor revision made to the waiver application to ensure clarity of roles of the Independent Assessment Entity and the Case Management Entity.

4. Will active waiver participants have to be assessed by the independent assessment entity? Will only individuals applying for CAP/DA from now forward have to have an assessment by the independent entity? The IAE will assess new initial applicants wishing to participate in CAP/DA. Minor revision made to the waiver application to ensure clarity of roles of the Independent Assessment Entity and the Case Management Entity.

5. Can the case manager attend with the IAE nurse to complete the initial assessment to better coordinate services? NC Medicaid response- No. No changes were required to be made to the waiver application.

6. What is the process for the IAE to take approved SRFs from CME wait list for completing initial assessments? The e-CAP system will electronically manage service requests. When a name from the wait list reaches the assessment and assignment workflow step, the e-CAP system will notify the IAE to initiate the assessment. Prior to the rollout of the IAE, specific deadline dates will be implemented to redirect service request workflow from the CME to the IAE. No changes required to be made to the waiver application.

7. How will the IAE and the Medicaid application integrate? The IAE will start the Medicaid application by completing an on-line Medicaid application to complete preliminary identifying information such as name, DOB, and other essential information to open and active Medicaid application. The applicant will need to work closely with the Department of Social Services (DSS) to provide other essential information to finalize the Medicaid application. No changes required to the waiver application.

8. Is the IAE involved at any other point along the client's involvement in CAP other than initial approval? The IAE will be primarily responsible for all eligibility decision which includes the SRF and initial assessments. The IAE will also perform quarterly quality reviews of annual and change in status assessments & SP. No changes required to be made to the waiver application.

Refer to optional attachment under the Public Input section for a continuation of public comments and responses.

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

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

7. Contact Person(s)

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

Last Name: Staton

First Name: Betty

Title: State Plan Administrator

Agency: DHHS- North Carolina Medicaid, Division of Health Benefits

Address: 2501 Mail Service Center

Address 2: 1985 Umstead Drive

City: Raleigh

State: **North Carolina**

Zip: 27699-2501

Phone: (919) 527-7093 **Ext:** ☐ **TTY**

Fax: (919) 733-6608

E-mail: betty.j.staton@dhhs.nc.gov

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **North Carolina**

Zip:

Phone:

Ext: ☐ **TTY**

Fax:

E-mail:

8. Authorizing Signature

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

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

Signature: Betty Staton

State Medicaid Director or Designee

Submission Date: Sep 19, 2019

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

Last Name: Richard

First Name:

Dave

Title:

Deputy Secretary for NC Medicaid

Agency:

NC Department of Health and Human Services - Division of Health Benefits

Address:

2501 Mail Service Center

Address 2:

1985 Umstead Drive, Kirby Building

City:

Raleigh

State: **North Carolina**

Zip:

27699-2501

Phone:

(919) 855-4101 **Ext:** ☐ **TTY**

Fax:

(919) 733-6608

E-mail:

Dave.Richard@dhhs.nc.gov

Attachments

Attachment #1: Transition Plan

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

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

Specify the transition plan for the waiver:

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

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

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

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

The state assures that this waiver amendment or renewal will be subject to any provisions or requirements included in the state's most recent and or approved home and community-based settings Statewide Transition Plan. The state will implement any CMS required changes by the end of the transition period as outlined in the home and community-based settings Statewide Transition Plan.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Public Comments and NC Medicaid responses continuation:
Appendix B
1. What is the maximum number of people who can be served on the CAP-DA waiver? 11,524.
2. If an assessment is completed by the IAE and the county's CME slots are full will the beneficiary go on the wait list or have options to go to another county's CME? Each county will be provided a specific number of slots. The management of slots and a waitlist will be county-specific.
3. Have the cost limits for CAP been adjusted from what they were? Participants in the waiver will not have an individual cost limit. The cost of care will be evaluated based on the projections outlined in Appendix J. Minor changes were made to the waiver application to provide clarity.
Appendix C
1. Under this new CAP/DA waiver, case monitoring will no longer be monthly or quarterly, but based on an intensity of need scale. What is the intensity of need scale? And how is it used to determine the frequency of case monitoring? The intensity of need scale is a composite score of complexity of need in the areas of ADLs, risk factors, informal and formal supports, age, medication and diagnosis.
2. In coordinated caregiving, caregivers are paid a per diem payment. How is the provider agency paid for the skilled oversight? Is coordinated caregiving a combined payment? Does the state have a sense of how much of the per diem will be for the caregiver and how much covers the provider agency's responsibilities? The provider of this service will be provided the daily rate. The provider will provide a stipend to the live-in caregiver.
3. In coordinated caregiving, the provider agency is expected to provide skilled nursing services? In addition to paying a caregiver per diem, how will 33.91 cover these services? The skill indication is based on the complexity of need score of the beneficiary, essential to hands-on care needs of the beneficiary, not skilled services.
4. Will the live-in caregiver receive payment as well as the beneficiary will also receive IHA services and other CAP services such as ADH at the same time? The live-in caregiver under Coordinated Caregiving will receive a stipend for performing ADLs for the waiver beneficiary which is like in-home aide services. Specific CAP services may be excluded for individuals enrolled in Coordinated Caregiving at the low or high levels. Minor changes were made to the waiver application to provide clarity.
5. Will the live-in caregiver have to give up employment outside of the home? No, when the employment does not impact the care needs of the waiver participant.
6. With Coordinated care should the provider be required to do 24 hr. care? No. Minor changes were made to the waiver application to provide clarity.
7. Will family members still be eligible to provide IHA services? Yes. Minor changes were made to the waiver application to provide clarity.
8. On Page 53 of the proposed waiver it states a legal guardian cannot be hired as a PCA for a client’s care. Can this be grandfathered in for a current client situation? A legal guardian is not authorized to receive payment for performing personal care services. However, under special circumstances and extraordinary conditions, a legal guardian may be paid to perform specific personal care services. Minor changes were made to Section C-2.
9. Will a legal guardian be able to work through an In-Home aide agency and get paid for providing care for the beneficiary? If no, will they be grandfathered in? Relatives can perform personal care tasks and receive payment when all qualifying conditions are met. This requirement has not changed. Legal guardians may be paid to perform personal care tasks and receive payment when special circumstances/extraordinary conditions are met. Changes made to C-2 to provide additional clarity.
10. What are the qualifying conditions for a responsible individual to perform personal care services and receive reimbursement? The qualifying conditions for an individual to provide in-home aide services through the CAP/DA are: a. Must be 18 years of age or older; b. Be a relative or individual who is not acting as the legal guardian or legal representative of the beneficiary. Minor changes made to the waiver application to provide additional clarity.
11. The "extraordinary circumstances" only applies to "responsible" relatives (spouse) who have a duty to provide care. Legal Guardians only "shall make provision for the ward's care” NCGS 35A-1241(a)(1). Relatives can perform personal care tasks and receive payment when all qualifying conditions are met. This requirement has not changed. Legal guardians may be paid to perform personal care tasks and receive payment when special circumstances/extraordinary conditions are met. Changes made to C-2 to provide additional clarity.
Appendix D
1. Will the IAE determine the amount of IHA hours that a beneficiary receives, or will the CME determine this when developing the POC. No, the IAE will not determine the amount of IHA hours. A complexity of care analysis will be provided to the CME to develop the SP.
2. Can a beneficiary choose a CME outside of the county they reside? For example, our CME is the only CME in our county so can beneficiaries choose a CME outside of our county to provide their services? Yes, if that CME is willing to and able to provide case management services in that county.
of expenditures, to manage the waiver participant while living in the community.
3. How will you determine a beneficiary cost of expenditures at initial service plan when the POC is not created until it is passed to the CME? The assessment determines eligibility to participate in the waiver. The SP identifies the services, both informal and formal and the cost.

Appendix E
Do you go through the new employment training before or after being officially hired? Do you get paid during training? Training is should be provided prior to hire.
Appendix F
Current Rights and Responsibilities does not include information about the recipient's responsibility to report hospitalizations and critical incidents. Also, does not mention the importance of reporting changes in address, phone number or needs. I would like to suggest that these items be added. Comment was noted.
Appendix G

If a beneficiary and their caregiver have been problematic, not following SP or IRA, and decide they want to switch to a new CME, is there going to be a process to let new CME know of issues/problems? Yes.
Appendix J

Just to have a base knowledge of cost neutrality, what is the cost of an individual in an institutional care?
With the increased number of potential clients; how do you plan to control the budget? The number of participants served by this waiver has not increased.

Waiver application posted for a 10-day public comment period on June 5, 2019 to seek comments regarding the changes made to the application given the technical guidance received from CMS. The following comments were received:
1. What are the requirements for the legal guardians receiving payment for providing personal care services. Information was provided on requirements.
2. What will be the effective date of the renewed application.
3. How to develop a plan of care for pest eradication. Information was provided
4. Can nursing services be contracted out and will a background check still be required? A response was provided for yes.
5. Will waiver participants and case managers be informed if the cost of care is more than the cost projections. Yes
6. Will the cost limits remain the same for the new definition for pest eradication? yes
7. The service definition for CAP In-Home Care describes 7 ADLs areas, must the participant needs assistance with all 7 ADLs areas to be eligible? No