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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

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

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:

• Participant goods and services and modification and technology.
• 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)

07/01/19

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: Mar 1, 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.

Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the state Medicaid agency.**

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:

   Long-Term Services and Supports

   (Do not complete item A-2)

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

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

   (Complete item A-2-a).

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

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

   a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid

Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

b. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:
As indicated in section 1 of this appendix, the waiver is not operated by a separate agency of the State. Thus this section does not need to be completed.

Appendix A: Waiver Administration and Operation

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

◉ **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

Contracted Entities:
The CAP IT system will act as the State's business management system by using programmed algorithms to process entered data from level of care evaluations, comprehensive need assessments, and service plans. The system will also act as the quality assurance system to provide real time reports and data for:
• Waiver participant enrollment.
• Waiver enrollment against approved limits.
• Waiver expenditures managed against approved limits.
• Level of care evaluation and determination.
• Waiver participant service plans.
Critical incident and grievance management

The contracted entity will also be responsible for the following:
•Real-time Dashboards: These dashboards provide real-time data concerning the waiver population, allowing the state to monitor performance measures.
•Service Request Form: This digital form requires that all the necessary information required to make a proper evaluation of an applicant's level of care is present. This includes a signed consent form from the waiver participant indicating his or her election to pursue waiver services as opposed to services in an institution.
•Level of Care Assessment (LOC): This electronic assessment takes the information provided in the Service Request Form (SRF) and assesses the applicant's ability to meet the level of care required for the CAP Waiver. Assessments where the applicant does not meet the required level of care are reviewed by Registered Nurses (RN) at the SMA for any mitigating factors that indicate potential errors in information entered in the SRF.
•Assessment of Service Needs: This electronic assessment tool provides a platform for a comprehensive, person-centered assessment of the needs of each individual waiver participant. Additionally, as this assessment tool is hosted digitally, the state retains full access to both the results of the assessment and the assessment tool.
•Electronic Service Plan: The results of the assessment provide direct input into the waiver participant's service plan, assuring that the waiver participant's service plan addresses the waiver participant's assessed needs.
•Automated Tracking of Assessment Dates: The CAP IT system automatically triggers a notice when each waiver participant approaches the anniversary of his or her previous assessment, assuring that each waiver participant is reassessed both for service needs and for LOC on an annual basis.
•Monthly and Quarterly Reporting: The CAP IT system vendor provides both monthly and quarterly reports in addition to the reports provided via the system dashboards. This provides the state with additional information to track program participation and identify issues.
•Critical Incident Report System and Complaint and Grievance Management: The CAP IT system provide access to critical incident form and workflow management to process the investigative steps.

The SMA is solely responsible for the determination of eligibility for all waiver participants; however, a contracted entity and local agencies assist the SMA with these administrative tasks. The contracted entity is an Independent Assessment Entity (IAE). The independent assessment entity will be responsible for gathering the health care information and coordinating with other health care professional to assist SMA to render a decision for level of care with the sole LOC decision being made by the SMA. The IAE will also be responsible for validation of participant service plans completed by case management entity; slot utilization management; participant waiver enrollment; and waiver expenditures managed against approved limits.

Independent Assessment Entity (IAE)- The independent assessment entity is responsible for level of care evaluations which includes the service request and assessment; validation of participant service plans completed by case management entity; slot utilization management; participant waiver enrollment; and waiver expenditures managed against approved limits. The IAE shall:
a. conduct the comprehensive assessment activities to:
1. Address all aspects of the participant's risk factor pertaining to medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational and other areas;
2. Identify conditions and needs for risk mitigation;
3. Identify informal and paid supports such as family members, medical and behavioral health providers, and community resources to assess whole person care needs;
4. Analyze in a multidisciplinary format the current assessment, previous assessment and other pertinent information to determine risk indicators, health and safety concerns and potential services to mitigate risk factors; and
5. Validate annual and change in status assessments completed by the case management entity to ensure ongoing risk factors and current complexity of need functioning level are being adequately met.

GDIT- Medicaid Management Information System is responsible for claim processing and provider enrollment and re-credentialing.

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

Appendix A: Waiver Administration and Operation

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

○ **Not applicable**

◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:

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

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

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

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

To ensure compliance with regulations, the State Medicaid Agency utilizes agencies with HCBS experience and resources/capacity to provide specific administrative functions, case management, care coordination and insight on how to ensure the six waiver assurances.
The State Medicaid Agency contracts with local/regional non-governmental non-state entity. One such entity is a case management entity (CME). The appointed CME accepts administrative roles and works collaboratively with the State Medicaid Agency in the execution of the waiver by performing the following administrative tasks:
Participant waiver enrollment, waiver enrollment managed against approved limits, waiver expenditures managed against approved levels, review of participant service plans, authorization of waiver services, utilization management, qualified providers to ensure freedom of choice and participation in quality assurance and quality improvement activities. The CME accepts and adheres to the governing Clinical Coverage policy of this HCBS program.

The appointed CME's primary responsibilities are to ensure waiver practices and to promote continuous quality improvement.
To ensure conflict of interest protections, each CME is prohibited from providing other waiver/non-waiver services when providing case management to a waiver participant when there are other readily available providers.
The case management entity is responsible for day-to-day case management needs of the waiver participant which include providing written authorization for approval/participation in the waiver. Upon the final decision of waiver participation eligibility that is confirmed and validated by the SMA, the CME provides the waiver participant and service providers a system generated notice of waiver participation and a service agreement that outlines the approved services by type in the amount, frequency, and duration. The case management entity also:
•Provide each waiver participant/primary caregiver freedom of choice among waiver services/providers
•Provide monthly monitoring of the service plan with waiver participant to ensure safe community living
•Provide direct observation of hands-on personal care services performed with the waiver participant to include personal care quarterly. An adult with a high-risk indicator score as identified in a completed assessment must have a face-to-face visit based on the risk-indicator scores and monthly multidisciplinary team meeting
•Initiate Due Process tasks when an adverse decision is made and coordinate with waiver participant, providers and due process management vendor
•Provide assistant, when requested, in verifying whether medical documentation supports nursing facility level of care
•Mitigate risk when a referral to Adult Protective Services is made.
•Provide monthly and quarterly Case Management/Care Advisement to the waiver participant.
•Review all initial and revised service plans to provide written authorization for approval and participation in the waiver
•Ensure that the policies/procedures of the waiver are upheld to maintain the health/well-being of the waiver participant
•Authorize services in the amount/duration/frequency as identified on the service plan along with a description of the
tasks. Ensure that waiver beneficiaries are aware of their right to select from among enrolled service providers and choose waiver services of their choice
The Case Management Entity is responsible for assessing which includes:
annual and change in status assessments and assessing well-being of participant monthly to identify if services plan continues to meet need
The Case management entity will perform the following on a monthly and quarterly basis:
1. Assess all aspects of the participant, including: medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational and other areas to make recommendations to the State Medicaid Agency for a change in status assessment;
2. Identify needs to prevent health and safety factors to assist in maintaining community placement;
3. Consult with informal and paid providers such as family members, medical and behavioral health providers, and community resources to ensure service plan is consistent with needs;
4. Review completed assessment from the IAE and other summary information to assist in identifying care needs, risk indicators and support system;
5. Assess periodically to determine whether a participant’s needs or preferences have changed to report to the SMA for potential assessment of need.

The case management entity is responsible for the development and monitoring of the person-centered service plan.
The case management entity is responsible for monitoring and following-up with the waiver participant and service providers to ensure services are addressing assessed needs through announced and unannounced visits when determined to be necessary on a monthly, quarterly or as needed basis to the waiver participant or responsible party's home, and service providers to ensure that the service plan is effectively implemented and adequately addresses the current needs of the waiver participant.
The CME is responsible for conducting at least quarterly face-to-face visit with the waiver participant to monitor needs to ensure that service plan is effectively implemented and adequately addresses the current needs of the participant. Face-to-face may include a social platform two out of the four quarters non-consecutive of monitoring.

Appendix A: Waiver Administration and Operation

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

The State Medicaid Agency is responsible for assessing the performance of the contracted entity, local/regional non-state entities and local/regional non-governmental non-state entity. The case management entities- (hospitals, DSSs, local health departments, case management agencies, Home Health Agencies, or federally recognized Tribes) will be monitored monthly to ensure compliance to the six waiver assurances and associated performance measures. Each case management entity will be required to maintain a 90% compliance rate of waiver practices to maintain status as the case management entity in the communities. The CAP IT system will provide the State Medicaid Agency monthly data reports on timeliness and performance in the areas of level of care, service plan, qualified provider, financial accountability, health and welfare and administrative authority. On a quarterly basis, the cumulative score will be aggregated to evaluate the performance of all appointed case management entities. The State Medicaid agency uses a representative sample when reviewing case management entities compliance rate. The representative sample consists of .95 confidence interval with a margin of error at 5%. The monitoring of these entities will be achieved through the objectives and benchmarks outlined through the contractual agreements. The State Medicaid Agency will conduct a quarterly evaluation of the performances of each entity through data analysis and compliance and satisfaction surveys. The data analysis will inform if each entity is meeting its established benchmarks and objectives and the quality assurance of the waiver. Each entity must maintain at least a 90% compliance rate of waiver processes that include waiver eligibility, service plan development, waiver utilization limits and claim reimbursement.

Each month, a performance assessment is performed on all entities to monitor performance and to address noncompliant areas. To allow for improvement in noncompliant performance areas, technical assistance will be provided each month during the monitoring quarter, until compliance is achieved. The entity will be allowed to perform under a corrective action plan for a total of two consecutive quarters before a decision is made to rescind their authority to perform the waiver requirements. During this time span, the State Medicaid Agency will provide technical assistance to assist with quality improvement of noncompliant performances. If after the two quarters of technical support (corrective action plan), noncompliance continues to exist, the State Medicaid Agency will notify the entity that within 60 days the authority to perform the waiver deliverables will be rescinded and assigned to another entity. Solicitation for another entity will be posted for an expected transition timeframe within 60 days. During the solicitation and transition timeline, the State Medicaid Agency will provide close oversight and technical assistance to the relinquishing entity to ensure the health and safety of each impacted waiver participant. If multiple qualified providers submit the required documentation, a selection committee is convened to evaluate the credentials and capacity of the organization given the needs of the service area. An established scale will be used for this evaluation. The organization with the highest score from the scale will be the appointed entity.

A monthly performance contract meeting will be held with each contracted entity. An evaluation of the scope of work will be addressed based on invoices and data. When an issue is identified, the contracted agency will be notified and requested to provide a root cause analysis and recommendations to correct the issue. An action plan will be put in place for an agreed upon time frame. If the issue continues or the contracted entity is uncooperative, a penalty may be assessed as well as a formal out of scope letter will be provided. This process may result in the dismissal of this contracted entity and the solicitation and transition to another contracted entity to perform the scope of the contract.

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

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

Appendix A: Waiver Administration and Operation

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

The State Medicaid Agency will assess performance of all appointed entities through monthly data analysis, quarterly desk-top audits and yearly accountability audits. The monitoring of those entities will be achieved through the objectives and benchmarks outlined through the clinical coverage policy. The State Medicaid Agency will conduct a quarterly evaluation of the performance of each entity through data analysis, complaints and satisfaction surveys. The data analysis will indicate if each entity is meeting its established benchmarks, objectives and maintaining the quality assurance of the waiver. Each entity must maintain at least a 90% compliance rate of waiver processes such as waiver eligibility, service plan development, waiver utilization limits and claim reimbursement.
The State Medicaid Agency will monitor on a quarterly basis, the accessibility and usability of the State's MMIS system, NCTracks to ensure claims are processing per waiver business rules. When noncompliant issue(s) are identified, a corrective action plan will be implemented. A root cause analysis will be performed to identify causes and future preventive measures.
The CAP IT system for the case management business processes will be monitored monthly to ensure accessibility and ease of use for the case manager and independent assessment entity to perform required waiver functions. The CAP IT system will also be evaluated to ensure compliance of waiver policies and procedures in the areas of waiver entrance, eligibility, assessed needs, utilization limits and health and welfare. A root cause analysis will be performed to identify causes and future preventive measures.
The case management entities are monitored monthly to ensure compliance to the six waiver assurances and its associated performance measures. Each case management entity is required to maintain a 90% compliance rate of waiver practices to maintain the community. The CAP IT system will provide the State Medicaid Agency monthly data reports in the timeliness and accuracy to policy in the areas of level of care, service plan, qualified provider, financial accountability, health and welfare and administrative authority.

On a quarterly basis, the cumulative score will be aggregated to evaluate the performance of all appointed case management entities. Medicaid providers of waiver services will be monitored on an annual basis through waiver claims, waiver service execution per the CAP IT system.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☒	☒
Waiver expenditures managed against approved levels	☒	☒	☒
Level of care evaluation	☒	☒	☐
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☒	☒
Utilization management	☒	☒	☒
Qualified provider enrollment	☒	☒	☐
Execution of Medicaid provider agreements	☒	☐	☐
Establishment of a statewide rate methodology	☒	☐	☐
Rules, policies, procedures and information development governing the waiver program	☒	☐	☐

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Quality assurance and quality improvement activities	☒	☒	☒

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority
The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

i. Performance Measures

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

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
AA-1 PM: Number and percent of service plans completed by the CMEs that were developed in accordance with waiver guidelines and procedures for each waiver participation year N: Number of service plans completed by the CMEs that were developed in accordance with waiver guidelines and procedures D: Total number of service plans

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:
Reports to State Staff of administrative waiver functions

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

AA-2 PM: Number/percent of waiver participants who received prior approval segments in accordance with guidelines and procedures for each approved or updated service plan for each waiver participation year N:waiver participants who received correct prior approval segments in accordance with guidelines and procedures for each approved or updated service plan D:Total service plans

Data Source (Select one):
Financial audits
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System Claim Data from Data Warehouse	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System Claim Data from Data Warehouse	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA-3 PM: Number and percent of counties that were only authorized to use their allotted utilization limits of waiver slots by the CAP IT system Numerator: counties that that were only authorized to use their allotted utilization limits of waiver slots Denominator: Total number of counties

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA-4 PM: Number and percent of waiver participants who had care coordination performed by a CME monthly and quarterly in accordance with the waiver guidelines and procedures for each waiver participation year N: Number of waiver participants who had care coordination performed by a CME monthly and quarterly D: Number of waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid**	☐ **Weekly**	☐ **100% Review**

Agency		
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
AA-5 PM: Number and percent of HCBS providers who met business qualifications (managed change request, HCBS overview training and acceptance of service authorization) prior to rendering waiver services N: HCBS providers who met business qualifications (managed change request, HCBS overview training and acceptance of service authorization) prior to rendering waiver services D: HCBS providers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: GDIT/NCTracks	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: GDIT/NCTracks	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA-6 PM: Number and percent of CAP IT registered users who had daily access to the CAP IT system to complete waiver workflow in accordance with guidelines and procedures N: CAP IT registered users who had daily access to the CAP IT system to complete waiver functions in accordance with guidelines and procedures D: Total CAP IT registered users

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
AA-A7 PM:#/% of Independent assessment entity (IAE) and CMEs that maintained a 90% compliance score through quarterly monitoring audits(desktop, site, or an analysis of data). N: IAE and CMEs that maintained a 90% compliance score through quarterly monitoring audits(desktop, site, or an analysis of data) D:Total number of Independent Assessment Entity and Case Management Entity monitored quarterly

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation*(check*	**Frequency of data collection/generation***(check*	**Sampling Approach***(check each that applies):*

each that applies):	*each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT System MMIS	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system MMIS	☐ **Annually**
	☒ **Continuously and Ongoing**

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

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

The CAP IT system is a business system employed by the State Medicaid Agency to manage the case management needs of each waiver participant, administrative responsibilities assigned to each designated entity and the State Medicaid quality framework. This system assists in the discovery of non-compliant waiver practices through aggregating and analyzing waiver activity workflow.
The CAP IT system performs the following tasks to ensure compliance to waiver policies and procedures which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- No-wrong door referral/request for services
- Service plans development
- Utilization management
- Level of care and need determination
- Notification letters
- Care coordination and management

b. Methods for Remediation/Fixing Individual Problems

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

Upon the discovery of non-compliant waiver workflow activities, the State Medicaid Agency notifies the non-compliant entity within 30-days of the discovery; requests a corrective action plan to remediate the concerns. The State Medicaid Agency provides technical assistance and training on policies and procedures. A root cause analysis must be conducted by the entity and shared with the State Medicaid Agency. The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant entity to ensure the corrective action plan is being followed throughout the duration of the plan. If the non-compliant issue continues, a freeze on accepting new waiver participants will be imposed on that entity until continuous quality is achieved. If, after 6 months of assistance and remediation strategies, and remediation strategies do not promote continuous quality, the administrative responsibilities assigned to that entity will be removed indefinitely.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☐	**Disabled (Other)**			
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

•Disability of chronic medical condition or physical disabilities that requires long-term care, or have an Alzheimer's Disease or Related Disorder; and
Have risk indicators identified in the comprehensive assessment that potentially place the individual in in jeopardy of losing community placement. Risk factors may consist of stress on the informal support system, financial hardship, inability to attend required medical appointments due to transportation barriers, need for day supports, medication management. A description of the assessed areas that identified risk is in Appendix D-1-d); and
.Require in-home supportive services and supports to perform activities of daily living or ensure community integration or maintain community integration; and
•Have a supportive network to manage intensive health care needs when 24-hour care or supervision is assessed and required, or can assume risk using an approved risk agreement that will assist to mitigate health and safety concerns.

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

○ **Not applicable. There is no maximum age limit**

◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

This HCBS program serves individuals who are 18 years and older. When a waiver participant turns 65, his participation in this program remains constant; however, the Medicaid category changes to Medicaid for the Aged. There is no disruption in service provision or participation.

Appendix B: Participant Access and Eligibility

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

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

○ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*

○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c.*

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

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

Specify the percentage:

○ **Other**

Specify:

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

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

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

  - ( ) **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

    - ( ) **Is adjusted each year that the waiver is in effect by applying the following formula:**

      Specify the formula:

    - ( ) **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**
  - ( ) **The following percentage that is less than 100% of the institutional average:**

    Specify percent:

  - ( ) **Other:**

    Specify:

Appendix B: Participant Access and Eligibility

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

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

can be assured within the cost limit:

Through coordinated case management that includes monthly and quarterly structured engagement, health and welfare of the waiver participant is assured by linking to the most appropriate services and assuring the connection to a health home.

For applicants and current participants seeking initial and ongoing participation in this waiver program, the expected care needs for home and community-based services and other Medicaid approved services, the expected annual expenditure amount for care needs must not exceed the average cost in Column N as projected in Appendix J -1. A thorough analysis of the waiver applicant's assessed needs and identification of risk indicators conducted in a multidisciplinary format initially and annually assist with ensuring the health and welfare of the applicant and the care needs are met within the average ranges of the cost limit. The average annual projected cost for both home and community-based services and other approved Medicaid services identified in the POC must be equal to or less than the expenditures amount listed below:
Year 1 of the waiver - $49046.10
Year 2 of the wavier - $50517.48
Year 3 of the wavier - $52033.00
Year 4 of the waiver- $53593.99
Year 5 of the wavier - $55201.81
Upon the completion of the assessment, and all eligibility criteria were met, a composite score (Refer to Appendix D-1e) that identifies the complexity of need will be reviewed to assist to identify care needs in the type, amount, frequency and duration of need. Risk factors are carefully discussed and planned. The waiver applicant is linked to the most appropriate formal and informal services and supports to address risk factors and to support the caregiver.
The waiver participant will also be linked to a health home to ensure efficient and effective management of health care needs.

Applicants meeting the cost limit threshold and current participants will be enrolled or maintain enrollment in the waiver. Applicants whose care needs are over the projected expenditures listed by year, will receive a cost neutrality projection of care needs performed by the Medicaid agency to determine feasibility of the waiver program managing health care needs. A 90-day service plan will be developed to assist with the efficient management and coordination of health care expenditures. A reassessment of care needs is performed one business day after the 90-day service plan expires. The plan is extended for 9 months if care needs are within the cost limits. When a decision is made that a new applicant's needs cannot be met through this waiver program, despite all attempts to manage care needs, the applicant will be provided an adverse notice with information about fair hearing process, refer to Appendix F. The applicant will also be linked to other Medicaid services and community resources.

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☒ **Additional services in excess of the individual cost limit may be authorized.**

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

A cost analysis of the total waiver budget and each waiver participant's cost expenditure are conducted quarterly. When the average per capita cost of waiver services are 75 percent over the average per capita cost of the institutional care, the SMA creates a cost analysis plan.
Upon a change in an enrolled participant status where the care needs exceed the projected limits and the care needs are significant, the participant will not be disenrolled from the waiver. A cost analysis of the total waiver cost limit for that year and each waiver participant's cost expenditure are conducted quarterly. When the average per capita cost of waiver services are 75 percent over the average per capita cost of the institutional care, the SMA will do the following:
a. Develop a cost utilization plan with a timeline of 90 calendar-days;
b. Implement a 60 calendar-day cost adjustment plan to align with the established budgetary limits for waiver participant over the 75% threshold limit; and
c. At end of the 90 calendar-days, a recommendation may be made to refer waiver participants with an average expenditure cost of 110% of the cost limit threshold to other formal supports when all attempts are made to cost adjustment impacted waiver participants' service plan within the established waiver cost limits. All attempts are made to align care expenditures by linking to other informal and formal, non-Medicaid services prior to an adverse decision. If an adverse decision is made, the impacted waiver participants are provided with a Fair Hearing.

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	13588
Year 2	13588
Year 3	13588
Year 4	13588
Year 5	13588

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)*:

○ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

◉ **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	11534
Year 2	11534
Year 3	11534
Year 4	11534
Year 5	11534

Appendix B: Participant Access and Eligibility

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

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Reserve Capacity for Community Transition and Waitlist Prioritization
Alzheimer's Disease

Appendix B: Participant Access and Eligibility

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

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

Reserve Capacity for Community Transition and Waitlist Prioritization

Purpose *(describe):*

This HCBS waiver program has a maximum number of participants approved to access services at any given time. Access to waiver services are limited to each county. Each county is assigned a maximum number of participants to serve based on the average number of Aged, Blind and Disabled individuals in that county. Once the maximum waiver allotment, referred to as slots, are reached in a county, a waitlist is created. Individuals are placed on the waitlist based on the date of the initial application for consideration for waiver participation. Due to the demand, entry to this program is on a first-come, first-serve basis. Individual choosing to participate in this HCBS program have similar needs and functional level, if a waitlist is imposed per county, a prioritization method is used. The prioritization method enables priority of access to the waiver, moving an individual to the top of an existing waitlist to mitigate substantial risk factors for individuals in a priority category including the following:
•An individual age 18 and over who is currently participating in an approved HCBS managed by NC Medicaid and wants to make the transition to CAP/DA waiver;
•An individual with an active AIDS diagnosis with a T-Count of 200;
•Active individual who is currently participating in this HCBS waiver and needs to transition to another county or case management entity
•An individual in an inactive status because of a short-term, 90-day rehabilitation placement who is transitioning back to their home community;
•An individual approved to transition from an institution using Money Follows the Person demonstration or Division of Vocational Rehabilitation transition services;
•An individual transitioning to the community using the community transition waiver service;
•An individual identified as at risk by his or her local Department of Social Services who has an order of protection by Adult
Protective Services for abuse, neglect or exploitation.
•A Medicaid beneficiary with active Medicaid who is temporarily out of the State due to a military assignment of his or her spouse or legal guardian.
•An individual who is terminally ill and enrolled in the Hospice program and who is in jeopardy of entering a non-Hospice institution because care needs cannot be met with current supportive services..
Individuals with an Alzheimer's Disease or related disorders will have a total of 320 reserve slots to meet an initiative of the State.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined through aggregate data of the number of MFP participants entering the waiver from SFY 2013-2018 as well as the number of priority slots assigned to waiver participants from SFY 2017-2018.

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

Waiver Year	Capacity Reserved
Year 1	75
Year 2	125
Year 3	150
Year 4	175
Year 5	200

Appendix B: Participant Access and Eligibility

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

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

Alzheimer's Disease

Purpose *(describe):*

Individuals with a diagnosis with Alzheimer's Disease and Related Disorders are granted priority waiver planning. This priority planning is a result of the following:
EXPAND SUPPORT FOR PATIENTS WITH ALZHEIMER'S DISEASE AND THEIR FAMILIES THROUGH COMMUNITY ALTERNATIVES PROGRAM FOR DISABLED ADULTS WAIVER SLOTS
SECTION 12H.5.(a) The Department of Health and Human Services, Division of Medical Assistance, shall amend the North Carolina Community Alternatives Program for Disabled Adults (CAP/DA) waiver to increase the number of slots available under the waiver by a maximum of 320 slots. These additional slots shall be made available on January 1, 2017.

Describe how the amount of reserved capacity was determined:

The number of slots were determined by the General Assembly based on a study written by the Institute of Medicine (IMO) and data from NC Medicaid. S.L.2016-94, Section 12H.5(a) allocated a fixed 320 slots specifically to this population.
The Department of Health and Human Services, Division of Medical Assistance, shall amend the North Carolina Community Alternatives Program for Disabled Adults (CAP/DA) waiver to increase the number of slots available under the waiver by a maximum of 320 slots. These additional slots shall be made available on January 1, 2017.

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

Waiver Year	Capacity Reserved
Year 1	320
Year 2	320
Year 3	320
Year 4	320
Year 5	320

Appendix B: Participant Access and Eligibility

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

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

- ◉ **The waiver is not subject to a phase-in or a phase-out schedule.**
- ○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

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

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

local/regional non-state entities:

Waiver capacity is limited to each county and is managed and allocated by the State Medicaid Agency. Each of the State's 100 counties are assigned a maximum number of participants to serve through this HCBS waiver based on the average number of Aged, Blind and Disabled population in the county. This per county allotment is initially evaluated at each waiver renewal. On a quarterly basis, an analysis is conducted to identify capacity utilization per county in order to make decisions about temporary or permanent reassignments based on demand and underutilization of slots. The statewide allotment capacity for this HCBS waiver is 11,214 which is set by the North Carolina General Assembly. A reserve capacity of 320 is used to target individuals with Alzheimer's Disease and Related Disorders. Of this total number, each county is assigned a designated allocation. The slots are managed by State Medicaid Agency county rather than statewide. The State Medicaid Agency is also responsible for approving the assignment of an individual to a priority slot.

Entities involved in the administration and oversight of this HCBS waiver dually assist in managing the allocation of waiver capacity.

The State Medicaid Agency is responsible for allocating the slots countywide and reallocating the slots when a county is not utilizing the slots to its maximum allotment. An analysis is performed quarterly to assess usage of allocated slots per county. If a county's utilization rate is less than 75% of it maximum allotment, the county must provide an action plan to the State Medicaid Agency on how the slots will be filled if a waitlist has been established for that county. Utilization rates that are <74% the max allotment per county and the county does not have a waitlist or compelling evidence as to why the slots cannot be filled, the State Medicaid Agency will arrange for the slots to be assigned to other counties with a large waitlist and extended wait times on either a temporary reassignment or permanent basis. When that temporary-reassigned slot is vacated through attrition, the State Medicaid Agency will evaluate the ongoing permanent need for additional slots in that county or reassign that slot back to the original county.

The CAP IT system is responsible to manage the approved slot allocation for each county. The CAP IT system has the total capacity for each county programmed and when an individual is approved for a slot or is disenrolled from the program for any reason, the slot count is automatically and immediately adjusted.

The case management entity will enter the required documentation in the CAP IT system to inform the CAP IT system of new applicants, waiver participants who may meet a priority group, and participants who require disenrollment from HCBS waiver to allow the electronic management of county waiver allotment.

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

Physically disabled or aged individuals who are interested in participating in this HCBS waiver, who can meet a level of care and are assessed to have risk indicators that place them in jeopardy of losing their community placements (institutionalized) are eligible to enter this HCBS waiver. When waiver capacity is available, entrance into this HCBS waiver is available to all assessed individual needing supplemental and supportive services of this wavier.
This HCBS waiver has the capacity to serve a total of 11, 534 unduplicated participates at any given time. When the capacity of this HCBS waiver is reached, clinically eligible individuals (determined to be eligible only for a level of care) are placed on a waitlist based on that county's capacity. As discussed in B-3e, waiver capacity is allotted by county and Medicaid eligibility is determined by local county government. If a level of care eligible individual is placed on a waitlist, he or she is place in the chronological order of his or her approved service request form (initial application). When his or her name reaches the top of the waitlist, an assessment of need is conducted to validate level of care continues to be met and there is an indication of need for supplemental and supportive services of this HCBS waiver. If a waitlist is imposed, each individual's SRF is analyzed to determine if he or she is eligible to be assigned to a priority category for quick entry into this HCBS waiver. If a level of care is approved for an individual who falls into one of these priority categories, he or she is prioritized to the top of a waitlist or immediately assigned a HCBS-assessment determination slot to advance the evaluation of risk indicators. These priority categories include the following, as listed in B-3c:
•An individual age 18 and over who is currently participating in an approved HCBS managed by NC Medicaid and wants to make the transition to CAP/DA waiver;
•An individual with an active AIDS diagnosis with a T-Count of 200;
•Active individual who is currently participating in this HCBS waiver and needs to transition to another county or case management entity
•An individual in an inactive status because of a short-term, 90-day rehabilitation placement who is transitioning back to their home community;
•An individual approved to transition from an institution using Money Follows the Person demonstration or Division of Vocational Rehabilitation transition services;
•An individual transitioning to community using the community transition waiver service;
•An individual identified at risk by his or her local Department of Social Services who has an order of protection by Adult
Protective Services for abuse, neglect or exploitation.
•An individual with Alzheimer' Disease or Related Disorder.
•A Medicaid beneficiary with active Medicaid who is temporarily out of the State due to a military assignment of his or her spouse or legal guardian.
•An individual who is terminally ill, enrolled in the Hospice program and who is in jeopardy of entering a non-Hospice institution because care needs cannot be met with current supportive services.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

  Select one:

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

    Specify percentage:
- ☒ **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- ☒ **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- ☐ **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- ☐ **Medically needy in 209(b) States (42 CFR §435.330)**
- ☒ **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- ☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

  Individuals receiving under 42 CFR 435.135 (Passalong)

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

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

  Select one and complete Appendix B-5.

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

    Check each that applies:

    - ☐ **A special income level equal to:**

      Select one:

      - ○ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

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

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

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

Specify percentage amount:

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

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

is not visible.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

The SMA is solely responsible for the determination of the initial and annual LOC for all waiver participants; however, a contracted entity will assist the SMA with this administrative task. An Independent Assessment Entity will be responsible for evaluating initial level of care and reasonable indication of need for waiver services through the oversight of the SMA, refer to Appendix A-3 and D for specific details.
An independent assessment entity is an independent organization that does not perform case management services, and is not directly or indirectly affiliated with the prospective or enrolled waiver participant. The independent assessment entity makes initial and ongoing level of care decisions about waiver participation by completing the SRF and needs-based comprehensive assessment eligibility enrollment paperwork.
The State Medicaid agency will provide second-level reviews known as registered nurse (RN) exception reviews when the independent assessment entity is not able to definitively decide on level of care.
A SMA-employed RN will conduct a second-level review known as registered nurse (RN) exception review when the independent assessment entity identifies that LOC may not be met based of the SMA algorithms of determining LOC and the health information entered in the CAP IT system.

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

Registered Nurse (RN). An RN who holds a current NC license with a minimum of 3-4 years of LTSS and HCBS experience.

The RN must also possess knowledge and skills/abilities:

Assessment practices
Motivational interviewing
population awareness (disability and culture)
Skills and Abilities to:
1. Apply interviewing skills such as active listening, supportive responses, open-and closed-ended questions, and summarizing.
2. Develop a trusting relationship to engage participant and natural supports.
3. Engage waiver participants 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 participant preferences.
6. Consult other professionals and formal and natural supports in the assessment process.
7. Discuss findings and recommendations with the participant in a clear and understandable manner.
8. Identify and evaluate a participant's existing and accessible resources and support systems.
9. Document in a written format to easy of understanding and specific information of assessment activities concern communication within the confines of the timelines.

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

This HCBS waiver targets individuals who meet an HCBS nursing facility level of care (LOC) (comparable to Medicaid Agency State Plan nursing facility level of care) due to a medical diagnosis or physical disability. Professional judgment and a thorough evaluation of the waiver participant'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 potential and actively approved waiver participant to ensure community integration and prevention of institutionalization because of chronic medical and physical disabilities.
A LOC assessment must be completed at initial enrollment and during the annual continued need review.
An initial LOC is established using a Service Request Form (SRF). This form is consistent with the Medicaid State Plan nursing facility LOC criteria. The SRF has identifying mandatory fields that capture demographic information, diagnoses, medications, nursing interventions, dietary concerns, ancillary therapies, behavioral concerns, falls and other related medical needs to analyze health care information to yield a LOC decision. This form screens three core areas: targeted population, level of care and priority group. If the responses to the questions align with the target population and level of care, the SRF is approved which is a clear indication that nursing facility level of care has be meet. During an annual review for LOC, the comprehensive assessment verifies the level of care continues to be met. When the comprehensive assessment cannot clearly validate LOC is met, a SRF is initiated to establish or re-establish the LOC.

This HCBS waiver will utilize the following level of care criteria to evaluate and reevaluate LOC:
HCBS Nursing Facility Level of Care Criteria must require a need for any one of the following:
1. Need for services, by physician judgment, requiring:
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 waiver participant 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 participant's medical condition becomes stable as noted in the treatment plan. 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. A coordinated plan that assist a participant to achieve independence in activities of daily living (i.e. bathing, eating, toileting, dressing, transfer and ambulation);
b. Use of preventive measures or devices to prevent or delay the development of contractures, such as positioning, alignment, range of motion, and use of pillows;
c. Ambulation and gait training with or without assistive devices; or
d. Assistance with or supervision of transfer so, the participant 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 participant's nutritional status.
6. Administration or control of medication as required by state law to be the exclusive responsibility of licensed nurses:
a. Drugs requiring intravenous, hypodermoclysis or nasogastric tube administration;
b. The use of drugs requiring close observation during an initial stabilization period or requiring nursing skills or professional judgment on a continuous basis; or
c. Frequent injections requiring nursing skills or professional judgment.
7. Nasogastric or gastrostomy feedings requiring supervision and observation by an RN or LPN:
a. Primary source of nutrition by daily bolus or continuous feedings;
b. Medications per tube when beneficiary on dysphagia diet, pureed diet or soft diet with thickening liquids; and
c. Tube with flushes.
8. Respiratory therapy: oxygen as a temporary or intermittent therapy or for a participant 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 a 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.
Or, HCBS Nursing Facility LOC may be established by having two (2) or more conditions in Category I OR one (1) or

more conditions from both Category I and II.
Conditions that must be present in combination as listed above may justify HCBS nursing facility level of care:
Category I: (Two or more, or at least one in combination with one from Category II)
1. Ancillary therapies: supervision of participant's performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of plaster casts.
2. Chronic recurrent medical problems that require daily observation by licensed personnel or other personnel for prevention and treatment.
3. Blindness
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 as prescribed by a primary care physician; or
7. Frequent falls due to physical disability or medical diagnosis
8. Behavioral problems symptoms due to cognitive impairment and depressive disorders such as:
a. Wandering due to cognitive impairments
b. Verbal disruptiveness;
c. Physical aggression;
d. Verbal aggression or physical abusiveness; or
e. Inappropriate behavior (when it can be properly managed in the community setting)

Category II: (One or more conditions from both Category I and II)
1. Need for teaching and counseling related to a disease process, disability, diet, or medication.

2. Adaptive programs: re-training the participant to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the participant's participation in the program and document the participant's progress.

3. Factors to consider along with the participant's medical needs are psychosocial determinants of health such as:
A. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders and progress notes or by nursing or therapy notes);
B. Age;
C. Length of stay in current placement;
D. Location and condition of spouse or primary caregiver;
E. Proximity and availability of social support; or
F. Effect of transfer on individual, 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).

LOC determination is based on scoring algorithms based on the information captured on the SRF. Scoring involves the following steps:
Step 1. Determine if one clinical indicator under nursing facility LOC criteria is met in addition to at least one individual clinical indicators is flagged as present from Category I, in the Service Request Form (SRF). If no, go to step 2.
Step 2. Determine if one clinical indicator under nursing facility LOC criteria is met in addition to two or more individual clinical indicators are flagged as present from Category I and II, in the Service Request Form (SRF). If no, go to step 2
Step 3. Determine if no clinical indicator is present under nursing facility LOC criteria, but three or more individual clinical indicators are flagged as present from Category I and II, in the Service Request Form (SRF).

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

○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**

◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain

how the outcome of the determination is reliable, valid, and fully comparable.

This HCBS program uses a different instrument from that of the State Medicaid Plan and has been using this instrument since 2013. This instrument has been proven to be reliable and valid. This LOC instrument is called a Service Request Form (SRF). The LOC instrument is a comparable to the FL-2 form the State uses for nursing facilities. The SRF is robust and versatile to allow a better assessment of the needs of individuals living in the community. This instrument assesses for mental illness and substance abuse to promote holistic, comprehensive whole person planning. The instrument is automatic and provides a real-time decision of eligibility using scoring algorithms.

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

The process is the same as the initial Level of care evaluation

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**

Specify the other schedule:

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

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

Specify the qualifications:

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

The level of care reevaluation is performed annually. This reevaluation is included in the reassessment of need evaluation that is referred to as the continued need review (CNR). The annual reevaluation is conducted each year in the month the waiver participant was initially approved to participate in this HCBS program. The CAP IT system is primarily responsible to ensure the timely reevaluation of level of care. Two months prior to the anniversary date of each waiver participant's level of care determination, the CAP IT system, releases the CNR, paperwork to the assigned assessment entity to initiate the revaluation of level of care and needs. The reevaluation must be completed by the last day of the month in which the anniversary occurs to maintain ongoing eligibility for level of care.

A reevaluation notification alert is transmitted two months in advance to the case management entity. Thirty days prior to the required reevaluation, the case management entity is provided another alert of the urgency to complete the reevaluation. The State Medicaid agency is also made aware of the reevaluation and can track all reevaluations to ensure timely review. When a reevaluation is not completed timely, a corrective action is issued with a timeline to complete the reevaluation. For circumstance beyond the case management entity control such as a significant change in the participant status where the reevaluation cannot be conducted, a decision may be made to postpone the reevaluation and suspend services until the reevaluation may be performed. The waiver participant signs a rights and responsibilities form that addresses the requirement for level of care reevaluation and the potential need to suspend services when level of care cannot be established.

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

The records for evaluation and reevaluation of level of care are kept in an electronically-retrievable format in the CAP IT system. This system has a safe storage for all files entered in this system. The initial approval of level of care is also kept in an electronically-retrievable format in the Medicaid Management Information System (MMIS). These records are kept for five years after the end of each waiver year when the evaluation or reevaluation was performed. The case management entity may also keep a paper file or an electronic copy in a participant case file, although this maintenance is not a requirement.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
LOC-A1 PM: Number and percent of individuals who had an initial LOC evaluation to determine clinical eligibility for waiver participation N: Number of individuals who had an initial LOC evaluation to determine clinical eligibility for waiver participation D: Total number of individuals

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system Data from Data Warehouse	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC-A2 PM: Number and percent of individuals who had a LOC evaluation processed within the established time frame N: Number of individuals who had a LOC evaluation processed within the established time frame D: Total number of individuals

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other**	☐ **Annually**	☐ **Stratified**

Specify: CAP IT system		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC-A3 PM: Number and percent of LOC decisions made by the IAE that were processed in accordance with waiver guidelines and procedures for each waiver participation year N: LOC decision completed in accordance with waiver requirements D: Total Number of LOC decisions

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
CAP IT System	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC-A4 PM: Number and percent of waiver participants who had an initial LOC prior approval segment submitted by the CAP IT system prior to the receipt of a waiver service N: Number of waiver participants who had an initial LOC prior approval segment submitted by the CAP IT system prior to the receipt of a waiver service D: Total number of waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System MMIS	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system MMIS	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measures

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

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

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

Performance Measures

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

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

Performance Measure:
LOC-C1 PM: Number and percent of initial requests for waiver participation that were processed using the SRF N: Number of initial requests for waiver participation that were processed using the SRF D: Number of initial requests

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system IAE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system IAE	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC-C2 PM: Number and percent of initial LOC determinations that were processed within the established time frame N: Number of initial LOC determinations that were processed within the established time frame D: Total initial LOC determinations

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample**

		Confidence Interval =
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC-C3 PM: Number and percent of service request forms that received an

exception review when the LOC algorithms did not indicate initial approval of LOC N: Number of service request forms that received an exception review when the LOC algorithms did not indicate initial approval of LOC D: Total number of service request forms did not indicate initial approval of LOC

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system IAE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system IAE	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC-C4 PM: Number and percent of waiver participants with a LOC prior approval to indicate waiver participation eligibility N: Number of waiver participants with a LOC prior approval to indicate waiver participation eligibility D: Total number of waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

CAP IT system data from Data Warehouse		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: Data from Data Warehouse CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
LOC-C5 PM: Number and percent of comprehensive assessments performed by the IAE that were completed in accordance with waiver guidelines and procedures for each waiver participation year N: Number of comprehensive assessments performed by the IAE that were completed in accordance with waiver guidelines and procedures D: Total Number of comprehensive assessments

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
CAP IT system	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

The CAP IT system is a business system employed by the State Medicaid Agency to manage the LOC determination decisions for all interested individuals and active waiver participants on an initial and annual basis. This system assists in the discover of non-compliant LOC practices through aggregating and analyzing LOC workflow.
The CAP IT system performs the following tasks to ensure compliance to LOC policies and procedures which allows the State Medicaid Agency to quickly discovery areas of noncompliance:

- No-wrong door referral
- Service request forms workflow- referral, consent forms, physician attestation and mandatory fields
- RN exception reviews to reassess health care information, when applicable
- Notification letters to providers and waiver participants
- Comprehensive assessment of needs
- Prior approval segments
- Workflow timelines and alerts

b. Methods for Remediation/Fixing Individual Problems

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

Upon the discovery of non-compliant waiver workflow activities in the area of LOC, the State Medicaid Agency notifies the non-compliant entity within 30-days of the discovery; requests a corrective action plan to remediate the concerns and a summary of the root cause. The State Medicaid Agency provides technical assistance and training on policies and procedures in the noncompliant area(s). The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant entity to ensure the corrective action plan is being followed through the duration of the action plan. If the non-compliant issue continues, a freeze on performing LOC activities for waiver participants is imposed on that entity until continuous quality is achieved. If, after 3 months of assistance and remediation strategies have not promoted quality improvement, the entity assigned that LOC responsibility will be terminated indefinitely.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **Other** Specify: CAP IT system CSRA/NCTracks	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

An individual approved to participate in this HCBS program is provided information about the waiver, how the waiver is administered and his or her choice to participate. Upon the clinical and need-based approval for entry into this HCBS program, each applicant is provided an Introductory Letter that includes information about freedom of choice including a choice to participate in this HCBS program, choice of available services offered through the waiver and freedom to select any qualified provider including a case management entity to render approved HCBS services in the amount, frequency and duration listed in an approved person-centered service plan. A list of Medicaid approved providers in the waiver participant's catchment area is included in the Introductory Letter to allow advance consideration for the selection and execution of choice of providers. This list of providers is referred to as Freedom of Choice of Providers. The waiver participant selects a provider from that list. Upon selection, a referral is forwarded to the selected Medicaid provider for initiation of services. A selected provider is provided an electronic service authorization upon acknowledgment of ability to initiate the enrollment for the approved waiver service. If the selected provided is not able to coordinate the enrollment for the approved services within 5 business days, the waiver participant is requested to select another provider.
Choice of case management entity is provided upon the analysis of a comprehensive assessment that identifies risk indicators that place the potential waiver participant in jeopardy to be displaced (institutionalized) from his or her home/community, the potential or current waiver participant is requested by the Independent assessor or NC Medicaid to select a case management entity for an assignment to manage his or her day-to-day needs while enrolled in this HCBS program. Choice of the case management provider is offered to the waiver participant during the initial approval process, annually and when a desire is voiced to change to another case management entity.
During the development of the service plan, the selected case management entity provides the waiver participant additional information about rights and responsibilities as a waiver participant and how he or she has the freedom to select any qualified provider, at any time, including a case management entity to render the approved waiver service(s) as outlined in the person-centered service plan. The waiver participant is required to list the selected providers on a designated Freedom of Choice form. The form is also signed and dated by both the waiver participant and the assigned case manager. The form must be updated annually and when a request is made to change provider.
Case management entities perform few core administrative responsibilities in the execution of this HCBS program, refer to Appendix C and D that comports with freedom of choice and interest free case management.

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

Written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of five years.
Waiver Freedom of Choice forms are maintained in the CAP IT systems and at the offices of the case management entities in a beneficiary file.
Provider(s) shall comply with the following in effect at the time the service is rendered:
All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

Appendix B: Participant Access and Eligibility

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

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

The State Medicaid Agency complies with ADA requirements and Title VI, Section 1557for the provision of reasonable accommodation for individuals requesting entry into or who are current participants of this HCBS program. Accommodations made available include, but are not limited to providing individuals who are deaf, deaf-blind, or hard of hearing with auxiliary aids and services, such as sign language interpreters and services for the blind. The State Medicaid Agency uses services from sister Divisions to make these accommodations available.
The State Medicaid Agency has language interpreters available to interpret for potential participant and current participant when requested or determine to be a need.
The State Medicaid Agency also translates vital documents (documents used to gather or communicate critical information for obtaining federal and state services/benefits) according to the Title VI of the Civil Rights Act of 1964. Examples of the vital documents that may be translated include the following:
1. Applications for waiver entry
2. Consents forms
3. Notices of rights
4. Notice advising of free language assistance
5. Letters or notices that require a response from the waiver participant or primary caregiver

These types of accommodation are no-cost language services that are available or assessible for the waiver participant.
In accordance with Title VI, each provider of waiver services including case management entities shall establish a plan to adequately provide services to non-English speaking waiver participants. The provider shall identify the necessary resources and individuals to implement the plan. Identification of necessary resources may include referring the waiver participant to other services provider agency or businesses with staff available to meet the language needs of the waiver participant.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Adult Day Health**		
Statutory Service	**CAP In-Home Aide**		
Statutory Service	**Coordination of care - case management and care advisement**		
Supports for Participant Direction	**Financial Management Services**		
Supports for Participant Direction	**Personal Assistance Services**		
Other Service	**Community Integration Services**		
Other Service	**Community Transition**		
Other Service	**Coordinated Caregiving**		
Other Service	**Equipment, Modification and Technology**		
Other Service	**Individual Goods and Services**		
Other Service	**Meal Preparation and Delivery**		
Other Service	**Nutritional Services**		
Other Service	**Participant Goods and Services**		
Other Service	**Personal Emergency Response Services**		
Other Service	**Pest Eradication**		
Other Service	**Respite Services**		
Other Service	**Specialized Medical Supplies**		
Other Service	**Training/Education and Consultative Services**		

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through

the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
04 Day Services	04050 adult day health
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service for a waiver participant to attend a certified Adult Day Health Care Facility. The service cares for persons who do not have other appropriate day supports and/or who need a structured day program of activities and services with nursing or other supervision. It is an organized program of services during the day in a community group setting. The program supports the waiver participant's independence and promotes social, physical, nutritional needs(meals are provided as part but shall not constitute a "full nutritional regimen" (3 meals per day); and emotional well-being.
Physical, occupational and /or speech therapies are not be components of this service.
Transportation is not provided as a component of this service. Transportation is provided through non-emergency medical transportation.

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

Services are organized and provided for a minimum of four hours per day on a regularly scheduled basis for one or more days per week.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Federally Recognized Tribes
Agency	Adult Day Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Federally Recognized Tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the IHCIA, 25U.S.C 1647a, provides that a health program or entity operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and every five years thereafter by State Medicaid Agency; DHHS fiscal agent and MMIS (GDIT/NCTracks)

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:

Agency

Provider Type:

Adult Day Health Center

Provider Qualifications

License *(specify):*

10A NCAC 06R and 10A NCAC 06S
Meet Medicare requirements for Tribal Governments

Certificate *(specify):*

Certified by the North Carolina Division of Aging and Adult Services, according to NC General Statute 131-D-6. Certification process is conducted by NC Division of Aging under NC Administrative Code Title 10, Chapter 42, Subchapter 42E and 42Z. As provided under Subchapter 42S, local departments of social services are responsible for ongoing monitoring and annual recertification.
Meet Medicare requirements for Tribal Governments

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

1.NC Division of Aging and Adult Services
2.DHHS fiscal agent and MMIS (GDIT/NCTracks)

Frequency of Verification:

Initially and annually- NC Division of Aging and Adult Services
Initially and every five years- State Medicaid Agency; DHHS fiscal agent and MMIS (GDIT/NCTracks)

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

CAP In-Home Aide

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

In-home aide service is a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal care services may be provided on an episodic or on a continuing basis. In-home aide services provide hands-on assistance with ADLs and basic home management tasks. The need for assistance is identified through a comprehensive assessment that evaluates physical, social, environmental, and functional condition. Hands on assistance is provided for seven keys ADLs: bathing, dressing, eating, toileting, hygiene, mobility and transfer, and key IADLs to include: light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication, and money management). Such assistance also may include the supervision of participants as provided in the service plan.

Personal care aide services must fall within the Nurse Aide I scope of nursing practice. Personal care aide services may be provided in the community, home, workplace, or educational settings at the discretion of the Home Care Agency. Personal care aide services can be provided in the workplace for waiver participants who meet the specified qualifications. Level I tasks, which consists entirely of home management tasks, are covered only when provided in conjunction with Level II Personal Care tasks. Typical Level II tasks will include oxygen therapy, break-up and removal of fecal impaction, sterile dressing change, wound irrigation, I.V. fluid assistive activities, nutrition activities, suctioning, tracheostomy care, elimination procedures and urinary catheters. Typical Level I tasks include paying bills as directed by the participant; essential shopping, cleaning and caring for clothing; performing basic housekeeping tasks such as sweeping, vacuuming, dusting, mopping and washing dishes; identifying medications for the participant; providing companionship and emotional support; preparing simple meals; and shopping for food, clothes, and other essential items.

Assurance: The services under the waiver's personal care aide are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. Because this service is different than state plan services in the scope, nature, and supervision requirements, waiver participants between the ages of 18-20 years old are included to receive this service.

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

The number of hours of this CAP service is authorized based on person-centered needs.
A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide CAP In-Home Aide to a waiver participant. Exclusions apply when (a) there is a staffing shortage in remote areas of the state; or (b) the lack of a qualified provider who can furnish services at usual times during the day because of the complexity of the waiver participant's care needs.
Also refer to C-2 for extraordinary circumstances for a legal guardian to provide this service.

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

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

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

☒ **Legally Responsible Person**
☒ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homecare Agency Licensed by the State of North Carolina
Individual	Home Care Agency and Federally Recognized Tribes

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: CAP In-Home Aide

Provider Category:
Agency
Provider Type:

Homecare Agency Licensed by the State of North Carolina

Provider Qualifications

License *(specify)*:

NC General Statute 131E-135 through 142 in accordance with Title 10 of the North Carolina Administrative Code
(10 NCAC 31.0900 - .1400)
Meet Medicare requirements for Tribal Governments

Certificate *(specify)*:

Other Standard *(specify)*:

Workers providing Level III Personal Care tasks must be certified as a Nurse Aide I by the NC Board of Nursing. Staff performing Level II tasks are required to be trained to provide in-home aide services. There are no requirements for licensing or certification for Level II staff.
Currently, State Medicaid Agency only reimburses CAP In-Home Care Services at one rate, regardless of Level.

Verification of Provider Qualifications

Entity Responsible for Verification:

1.NC Board of Nursing
2.NC Division of Medical Assistance.
3.Tribal Governments

Frequency of Verification:

Annually

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: CAP In-Home Aide

Provider Category:

Individual

Provider Type:

Home Care Agency and Federally Recognized Tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the IHCIA, 25U.S.C 1647a, provides that a health program or entity operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation
NC DHHS fiscal agent and MMIS (GDIT/NCTracks)
State Medicaid Agency
NC Board of Nursing

Frequency of Verification:

Initially and every five years
State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

Coordination of care - case management and care advisement

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service that directs and manages the special health care, social, environmental, financial, and emotional needs of a waiver participant to maintain the waiver participant's health, safety, and well-being and for continual community integration. Case management services are available to assist waiver participants in gaining access to needed medical, social, educational, and other services. Case management includes the following principal components: assessing, care planning, referral or linkage and monitoring and follow-up.
The case management service definition will be modified to include the following statement: Individuals transitioning out of an institutional setting may receive pre-transition case management activities to assist with the transition to a home setting. The pre-transition activities are limited to 30-days or 60-days (for MFP) prior to the waiver participation approval date. These services are not billable until after the applicant has transitioned home and meet all remaining eligibility requirements to participate in the waiver.
The case manager performs the following:
- assesses well-being of beneficiary monthly to identify if services plan continues to meet need.
- Assists with the development and approval of the person-centered service plan.
- Links and refers to community resources.
- Monitors formal and informal services to ensure health, safety and well-being
- Follows-up to ensure services are meeting assessed needs

Assessing includes the following:
1. Assess all aspects of the beneficiary, including medical, physical, functional, psychosocial, behavioral, financial, social, cultural, environmental, legal, vocational, educational and other areas to make recommendations to the IA for a change in status assessment;
2. Identify needs to prevent health and safety factors to assist in maintaining community placement;
3. Consult with informal and paid providers such as family members, medical and behavioral health providers, and community resources to ensure service plan is consistent with needs;
4. Review completed assessment from the IAE and other summary information to assist with identifying care needs, risk indicators and support system;
5. Assess periodically to determine whether a beneficiary's needs or preferences have changed to report to the IAE for potential assessment of need.

Care Planning include the following:
• Development and periodic revision of a person-centered care to identify 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 waiver participant.

Care Planning Knowledge include the following:
1. The values that underlie a person-centered approach to providing services to maintain integration and prevent institutionalization within the context of the beneficiary's culture and community.
2. Models of chronic disease management and preventative interventions.
3. Biopsychosocial theories of practice, evidenced-based standards of care, and practice guidelines.
4. Processes used in a variety of models for multidisciplinary planning to promote beneficiary and family involvement in case planning and decision-making.
5. Services and interventions appropriate for assessed needs for the development of a service plan.
6. Person-centered practices, beneficiary focused
7. Emergency safety planning

Referral/Linkage includes the following:
- Activities to refer and link a waiver participant with medical, behavioral, social, and other programs, services, and supports to address identified needs and achieve goals specified in the care plan.

Referral/Linkage knowledge includes:
1. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, recreation, housing resources, peer support.

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 beneficiaries.
2. Maintain consistent, collaborative contact with other health care providers and community resources.
3. Initiate services in the care plan to achieve the outcomes derived for the beneficiary's goals.
4. Assist and advocate for the beneficiary in accessing a variety of community resources.

Monitoring and follow-up include:
• Activities and contacts with the waiver participant, responsible party, and service providers that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the waiver participant.
Monitoring and follow-up knowledge:
1. Outcome monitoring and quality management.
2. Models of chronic disease management and preventive intervention.
3. Peer support groups

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

Case management services shall not exceed $377/month ($56.56/hr. X 80 hours) per calendar year (January 1-December 31) per waiver participant for combined use of both case management and care advisor services. The SMA has a process in place for a case management entity to request additional case management units/hours per calendar year when the original allocation is exhausted for the following reasons:
1. The waiver participant experiences a natural disaster and requires additional case management support to link to housing and other needed supports; or
2. The waiver participant is experiencing a crisis that requires the case manager to perform at least weekly monitoring, planning and linking activities to ensure health, safety and well-being.

A waiver participant shall not receive another Medicaid-reimbursed case management service in addition to CAP case management. The following activities are non-coverable: employee training for the case manager; completion of time sheets; travel time; staff recruitment; staff scheduling and supervision; billing Medicaid claims; case management activity documentation; any form of case management activities for an individual not approved to participate in CAP to include preparation for due process.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Case Management Entities

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Coordination of care - case management and care advisement

Provider Category:
Agency
Provider Type:

Case Management Entities

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An enrolled Medicaid provider with three or more years of case management and HCBS experience.
Qualifications:
a. A direct connection to the service area to provide continuity and appropriateness of care;
b. Experience with adults 18 years and older with medical-complexities or physical disabilities;
c. Policies and procedures that align with the CAP/DA policies and procedures;
d. Three (3) years of progressive and consistent home and community based services experience; a provisional status may be granted to new agency without required experience- over-the-shoulder monitoring by State Medicaid Agency for 12 consecutive months; if no deficiencies after the 12th month, only quarterly monitoring and QA will be required for the next 24 months. If performance requirements are met, no intensive supervision will be required
e. Ability to provide case management services through approved qualified professionals;
f. Architectural requirement to support the requirement of current and future automated programs;
g. Adequate staff to participant ratio based on acuity of need for each case manager's caseload (appropriate case mix); best-practice is 40 participants for one FTE; and
h. Ability to collaborate with network of providers, to ensure services can be rendered within five (5) days of submission of the service authorization;
i. Ability to make home visits as required and requested. Provider enrollment and recertification and claim submission training provided by NCTracks (GDIT)

Participate in initial and annual refresher trainings to include:
a. Person-centered training;
b. Abuse, neglect, exploitation;
c. Program integrity (PI);
d. Conflict resolution;
e. Mental Health First Aid;
f. Critical incident reporting;
g. Health, Safety and Well-being and Individual Risk Agreement;
h. Medicaid Due Process Appeal Rights and EPSDT;
i. Consumer-Direction;
j. Quality Assurance and Performance Outcomes
k. Cultural Awareness; and
l. Motivation interviewing or a similar training

In addition, the case manager or care advisor shall complete other required trainings sponsored by their organization annually:
a. Bloodborne Pathogens and Infection Control;
b. Health Insurance Portability Accountability Act (HIPAA)
c. End of Life planning;

Verification of Provider Qualifications

Entity Responsible for Verification:

Case managers are qualified providers for case management and responsible for the development of the service plan. Case managers are required to have at a minimum a 4-year degree in social work or a human service profession or be a registered nurse at an RN or LPN level, licensed to practice in the state. Additional qualification information is described in Appendix D-1. All case managers must meet the hiring requirements of their organization and successfully pass a background check that includes an abuse registry check.
State Medicaid Agency will verify credentials of the case managers and NC DHHS fiscal agent and MMIS (GDIT/NCTracks) will verify credential of the case management entity.

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Management Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- (●) **Service is included in approved waiver. There is no change in service specifications.**
- ( ) **Service is included in approved waiver. The service specifications have been modified.**

○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A service provided for waiver participant who is directing his or her own care to ensure that consumer-directed funds outlined in the service plan are managed and distributed as intended. Financial managers provide education and training to orient the waiver participant to the roles and requirements of the consumer-directed model of care. Financial managers facilitate the employment of the personal assistant(s) employee and the requirements of the consumer-directed model by completing the following tasks:

- Serving as the participant's Power of Attorney for Internal Revenue Service's (IRS) processes;
- Submitting payment of payroll to employees hired to provider services and supports;
- Providing payroll statements on at least a monthly basis to the personal assistant(s);
- Ordering employment related supplies and paying invoices for approved waiver related expenses;
- Deducting all required federal, state taxes, including insurance and unemployment fees, prior to issuing payment;
- Administering benefits to the personal assistant(s) as directed by the waiver participant;
- Filing claims for self-directed services and supports;
- Maintaining separate accounts on each participant's consumer-directed services;
- Tracking and monitoring individual budget expenditures;
- Producing expenditure reports as required by the state Medicaid agency; and
- Completing criminal record history checks, age verification, and health care registry checks on the personal assistant(s).

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

$93.00 per month is the maximum limit for financial management services.
When financial management services are being shared due to a waiver participant transferring from one FM provider to another in one planning month, $46.50 is the maximum limit per each FM provider for that planning month.

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

☒ **Participant-directed as specified in Appendix E**

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Fiscal management agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Fiscal management agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The FMS must have experience and knowledge of the following:
- Automated standard application of payment;
- Check Claims;
- Electronic Fund Transfer;
- Electronic Fund Account;
- Invoice processing platform;
- Judgment Fund;
- Payment Application Modernization;
- Prompt Payment;
- Automated Clearing House;
- Cash Management Improvement Act;
- GFRS/FACTS I;
- Government wide Accounting;
- Intergovernmental Reconciliation;
- Standard General Ledger;
- Tax Payer Identification Number
- 3 years of experience in developing, implementing, and maintaining a record management process for establishing and maintaining current and archived participant, attendant, and service vendors files;
- 3 years of financial management experience;
- 3 years of basic accounting and payroll experience;

The FMS provider must meet statutory guidelines to include:
- Approved as a NC Medicaid provider;
- Authorized to transact business in North Carolina (pursuant to all State laws and regulations);
- Be approved by the IRS to act as an employer agent Section 3504 of the IRS Code and IRS Revenue Procedure 70-6;
- Bonded;
- Knowledge of laws and rules that regulate expenditure of public funds;
- Ability to utilize an accounting system that operates effectively on a large scale;
- Ability to effectively track individual budgets;
- Ability to develop, implement, and maintain an effective payroll system that adheres to all applicable tax requirements;
- Ability to conduct required criminal history and health care registry checks;
- Ability to develop, implement, and maintain a record management process for establishing and maintaining current and archived participant, attendant, and service vendors files;
- Ability to maintain all files in a secure and confidential manner for the prescribed time as required by the Federal and State rules and regulations, including HIPAA requirements;
- Ability to develop policy and procedures to indicate how all processes will be implemented and maintained; and
- Ability to provider FMS through multiple self-direction models including: Agency with Choice and Fiscal/Employer Agent models.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC DHHS fiscal agent and MMIS (GDIT/NCTracks

Tribal Governments

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Other Supports for Participant Direction

Alternate Service Title (if any):

Personal Assistance Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Personal assistance service is a range of assistance to enable waiver participants to accomplish tasks that they would normally do for themselves if they did not have a disability. This assistance may take the form of hands-on assistance (actually performing a task for the person) or cuing to prompt the participant to perform a task. Personal assistance services may be provided on an episodic or on a continuing basis. Personal assistance services provide hands-on assistance with ADLs and basic home management tasks. The need for assistance is identified through a comprehensive assessment that evaluates physical, social, environmental, and functional condition. Hands on assistance is provided for seven keys ADLs: bathing, dressing, eating, toileting, hygiene, mobility and transfer, and key IADLs to include: light housework, laundry, meal preparation, transportation, grocery shopping, using the telephone, medication, and money management). Such assistance also may include the supervision of participants as provided in the service plan.
Personal assistant services may be provided in the community, home, workplace, or educational settings at the discretion of the participant or designated representative.
Personal Assistant Services is personal care attendant under participant-directed care option of the waiver. Participant-directed care allows eligible beneficiaries to hire the provider of their preference. The eligible beneficiary is the employer of record, hence requiring an FI to file Medicaid claims on their behalf. The FMS is credentialed by DMA to file claims on behalf of the eligible beneficiary and then reimburse the hired personal assistant.

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

The number of hours of this CAP service is authorized based on person-centered needs.
To comply with Fair Labor Standards Act, a relative, unpaid paid staff and when approved, a legal guarding, may be paid overtime for hours worked greater than 40-hour week.
A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide personal care services to CAP beneficiaries unless an approval is granted as outlined in C-2-e.
An individual hired to perform these tasks must have a criminal background check and assessed competencies.

Tasks, amount, frequency and duration must be clearly outlined in job duites.
A personal assistant is restricted for hire when:
The following findings are on their background check:
1. Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
2. Felony health care fraud;
3. More than one felony conviction;
4. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
5. Felony or misdemeanor patient abuse;
6. Felony or misdemeanor involving cruelty or torture;
7. Misdemeanor healthcare fraud;
8. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
9. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
10. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Personal assistance

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Personal Assistance Services

Provider Category:
Individual
Provider Type:

Personal assistance

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual provider of personal assistant services must meet the following qualifications:
• At least 18 years of age
• Not a representative, guardian, Power of Attorney, or legally responsible person to the participant
• Deemed competent to provide assistance with the tasks indicated on the participant's comprehensive assessment by the participant or by the designed representative as indicated on the self-assessment questionnaire
• Have a criminal history and health care registry check free from the following findings:
o Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
o Felony health care fraud;
o More than one felony conviction;
o Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
o Felony or misdemeanor patient abuse;
o Felony or misdemeanor involving cruelty or torture;
o Misdemeanor healthcare fraud;
o Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
o Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
o 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.
A potential personal assistant with offenses that are not outside of Medicaid guidelines nor related to abuse, neglect, criminal sexual conduct, or exploitation may qualify for an exemption and be eligible for employment under the direction of the participant or designated representative if the offense occurred 10 years or more prior. A potential personal assistant who has findings from the health care registry checks that prevents him or her from working in the health care field is permanently banned from providing services to a waiver participant.

Verification of Provider Qualifications

Entity Responsible for Verification:

Employment application reviewed and accepted by the FMS provider when all qualifications are met

Frequency of Verification:

Initially and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Community Integration Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17030 housing consultation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Services for active waiver participants who are in jeopardy of losing their community placement due to tenancy related issues. Community Integration services may cover a one-time, non-reoccurring expense. The following are allowable activities for Community Integration:
The Assistance in Community Integration service enables waiver participants to maintain their own housing as set forth in the participant's approved plan of care (POC). Services must be provided in the home or a community setting. The service includes the following components:
1. Conducting a community integration assessment identifying the participant's preferences related to housing (type, location, living alone or with someone else, identifying a roommate, accommodations needed, or other important preferences) and needs for support to maintain community integration (including what type of setting works best for the individual, assistance in budgeting for housing/living expenses, assistance in obtaining/accessing sources of income necessary for community living, assistance in establishing credit and in understanding and meeting obligations of tenancy).
2. Assisting participant with finding and securing housing as needed. This may include arranging for or providing transportation.
3. Assisting participant in securing supporting documents/records, completing/submitting applications, securing deposits, and locating furnishings.
4. Developing an individualized community integration plan based upon the assessment as part of the overall Person Centered Plan. Identify and establish short and long-term measurable goal(s), and establish how goals will be achieved and how concerns will be addressed.
5. Participating in Person-Centered plan meetings at re-determination and/or revision plan meetings as needed.
6. Providing supports and interventions per the Person-Centered Plan (individualized community integration portion). Identify any additional supports or services needed outside the scope of Community Integration services and address among the team.
7. Supports to assist the individual in communicating with the landlord and/or property manager regarding the participant's disability (if authorized and appropriate), detailing accommodations needed, and addressing components of emergency procedures involving the landlord and/or property manager.
8. Assistance in Community Integration will provide supports to preserve the most independent living arrangement and/or assist the individual in locating the most integrated option appropriate to the individual.

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

Room and board fees are excluded
• Ongoing payment for rent are excluded
• Not to exceed $2500 per waiver participant for the life of the waiver cycle

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

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

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Suppliers
Agency	Property Managers

Appendix C: Participant Services

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

Service Type: Other Service

Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

Retail Suppliers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Integration Services

Provider Category:

Agency

Provider Type:

Property Managers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services
Category 2:	**Sub-Category 2:**
17 Other Services	17990 other
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope)*:

Community Transition services are for prospective waiver participants transitioning from an institutional setting to a community setting. This service may be used in any duration or type, up to the maximum allotted amount, at the start of a community transition and up to 1 year after the original transition date to pay for necessary and documented expenses for the waiver participant to establish or maintain a basic living arrangement within one year of the transition to community.

Services for prospective waiver participants transitioning from an institutional setting to a community setting. This service may be used for a duration of 1 year of the transition to community to pay for necessary and documented one time-expenses for the waiver participant to establish a basic living arrangement.
Community Transition Services are furnished only to the extent that they are reasonable and necessary as determining through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan and the person is unable to meet such expense or when the services cannot be obtained from other sources. Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.
Community transition services may cover the following:
- Essential furnishings, and household products including furniture for the bedroom or living room, window coverings, food preparation items, and bed/bath linens
- Residential application fees
- Security deposits required to obtain a lease on an apartment or home
- Set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating)
- Environmental health and safety assurances, such as pest eradication; allergen control; one-time cleaning prior to occupancy

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

- Room and board fees are excluded
- Payment for rent is excluded
- Not to exceed $2500 per waiver participant for the life of the waiver cycle

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

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

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Suppliers
Individual	Independent Contractors
Agency	Property Management Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Agency
Provider Type:

Retail Suppliers
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provide or render this service.
Verification of Provider Qualifications
Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.
Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:
Individual
Provider Type:

Independent Contractors
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Property Management Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers of this service must have the capacity to provide items and services of sufficient quality to meet the intended need; as verified by the Case management entity. The case management entity does not provider or render this service.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to the service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Coordinated Caregiving

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09020 caregiver counseling and/or training
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Coordinated Caregiving includes supportive services that assist with the acquisition, retention, or improvement of skills related to living in the community which includes such supports as adaptive skill development, assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), linkage to local resources such as adult educational opportunities, social and leisure skill development, protective oversight and supervision. The setting for this service is in the waiver participant's own home or waiver participant's relative/related family/friend's home.

This service is intended to promote the waiver participant's independence and provides in-home supportive services for personal care and basic home management tasks due to the waiver participant's inability to perform these tasks independently as result of a disabling condition. Coordinated caregiving integrates the waiver participant into the usual activities of family and community life. In addition, there will be opportunities for learning, developing and maintaining skills in the areas of social and recreational activities and personal enrichment.

Coordinated Caregiving is provided by a supportive worker who resides in the home of the waiver participant or in the caregiver's home. Coordinated Caregiving is provided in a private residence and affords all the rights, dignity and qualities of living in a private residence including privacy, comfortable surroundings, and the opportunity to modify one's living area to suit one's individual preferences. Payment to the caregivers complies with DOL.

The Home Environment Requirements:

The home shall provide living arrangements to meet the individual needs of the waiver participants, the supportive staff and other caregivers.

The home must have a living room, kitchen, dining area and bathroom.

The home must have operable windows, two exterior doors with locks, fire alarms, fire extinguisher and an emergency first aid kit.

Waiver Participant Care Plan

Provider agency shall assure a care plan is developed for each waiver participant in conjunction with the waiver participant assessment to be completed within 30 days following the service plan. The care plan shall be an individualized.

The care plan shall be revised as needed based on further assessments of the waiver participant and caregiver.

The care plan shall include the following:

A statement of the daily care or service to be provided to the participant based on the assessment or reassessment;

A statement of the education and coaching to be provided to the caregiver

The assessor shall sign the care plan upon its completion.

Mail-Waiver participants shall receive their mail promptly and it must be unopened unless there is a written statement that the supportive worker is authorized to open and read the waiver participant's mail.

Laundry-Laundry services must be provided to waiver participants without any additional fee

Telephone - A telephone must be available in a location providing privacy for waiver participants to make and receive a reasonable number of calls of a reasonable length

Personal Space -Personal space must be provided for the waiver participant to secure his personal valuables.

Management of waiver participant's funds -Waiver participant shall manage their own funds unless there is a written agreement designating a POA or legal guardian, legal representative or payee.

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

The supportive worker is paid a stipend to provide the oversight and supervision needed to maintain community placement. An individual serving as the waiver participant's power of attorney, guardian, or representative may not be a provider of coordinated caregiving. The reimbursement rate does not include room and board. Settings such as a foster care setting, an alternative family living setting, or a provider owned home are prohibited.
A waiver participant receiving coordinated caregiving services at the low to moderate service level shall not receive any of the following services: personal care services,respite and home delivered meals.
A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide CAP In-Home Aide to a waiver participant. Exclusions apply when (a) there is a staffing shortage in remote areas of the state; or (b) the lack of a qualified provider who can furnish services at usual times during the day because of the complexity of the waiver participant's care needs.
Also refer to C-2 for extraordinary circumstances for a legal guardian to provide this service.

A waiver participant receiving coordinated caregiving services at the high service level shall not receive any of the following services: personal care services, respite, Personal Emergency Response System, and home delivered meals. A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide CAP In-Home Aide to a waiver participant. Exclusions apply when (a) there is a staffing shortage in remote areas of the state; or (b) the lack of a qualified provider who can furnish services at usual times during the day because of the complexity of the waiver participant's care needs.
Also refer to C-2 for extraordinary circumstances for a legal guardian to provide this service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	HCBS Agency approved by NC Medicaid
Agency	Federally Recognized Tribes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Coordinated Caregiving

Provider Category:
Agency
Provider Type:

HCBS Agency approved by NC Medicaid

Provider Qualifications

License *(specify):*

None

Certificate *(specify):*

None

Other Standard *(specify):*

Live-in Caregiver Qualifications:
Must be at least 18 years of age, in good health and able to follow written and verbal instruction;
Must pass criminal and registry background check
Provider Qualifications:
Agency providers must be enrolled as an NC Medicaid Provider
Agency providers must demonstrate 3 years of delivering HCBS to elders and adults with disabilities and their caregivers.
Agency providers must develop, implement and provide ongoing management and support of a person-centered service plan that addresses the waiver participant's level of service needs which includes an agreement with caregivers describing their roles and responsibilities for the care and support provided to the waiver participant.
Agency providers must conduct monthly home visits based on the waiver participant's assessed needs and caregiver coaching needs.
Agency providers must provide to the caregiver a minimum of 8 hours of annual training that reflects the waiver participant's and caregiver's assessed needs. Training may be delivered during monthly home visits, through secure electronic communication methods or in another manner that is flexible and meaningful for the caregiver.
Agency providers must provide education and coaching to lay caregivers that is based on the participant's and caregivers' assessed needs, including managing health-related needs; personal care; cognitive, behavioral and social needs of waiver participants and, including interventions to reduce behavioral problems for waiver participants with mental disabilities and who need restorative services. Training and coaching must occur at a minimal monthly.
Agency providers must work with waiver participant and caregiver to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care and ensure that caregivers understand how to manage medical and other incidents and emergencies as they may occur and report such situations to the provider agency, as soon as possible.
Must have the ability to perform competency evaluation on hired staff
Must perform background checks to include on all hired live-in caregivers to validate no finding entered the registry or convictions that are outlined on the HCBS banned list.
Must assure the health and safety needs of the waiver participant are met in conjunction with the case manager.
Must ensure that coaching to the live-in caregiver includes the importance of providing nutritionally balanced meals and healthy snacks each day to the waiver participant, as dictated by their medical/nutritional needs.
Must engage in regular review of caregiver notes to understand and respond to changes in the waiver participant's health status and identify potential new issues to better assist with the coordination of care to avoid unnecessary hospitalizations or emergency room use

Competency Validation of Caregivers
Provider agency shall assure that each caregiver has the demonstrated competency to perform the personal care activities specified in the CAP service authorization.
Documentation Requirement -Documentation to support service rendered that includes:
Electronic caregiver notes that record and track the participant's status, and updates or significant changes in their health status or behaviors and participation in community-based activities and other notable or reportable events
Medication management records, when applicable
Critical incidents
Grievances and complaints
Home visits conducted by provider agency
Education, skills training and coaching conducted with the caregiver
Multidisciplinary team meetings demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers and other caregivers or individuals important to the waiver participant regarding changes in the participant's health status and reportable events.
Qualified caregivers
Least Restrictive Environment Requirements
The provider agency must assure that the participants access to common areas and supports available as

part of living in the community. A participant's access may be restricted only when the participant's service plan determines the need to assure the participant's safety as documented in the comprehensive assessment.
Transportation. The provider must assure, whenever possible, the provision of transportation by the live-in caregiver for the waiver participants to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the waiver participant's choice. The waiver participant is not to be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members and transportation, medical and non-medical.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC DHHS fiscal agent and MMIS (GDIT/NCTracks)
State Medicaid Agency

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Coordinated Caregiving

Provider Category:

Agency

Provider Type:

Federally Recognized Tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the IHCIA, 25U.S.C 1647a, provides that a health program or entity operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law.

Certificate *(specify):*

Other Standard *(specify):*

Caregiver Qualifications:
Must be least 18 years of age, in good health and able to follow written and verbal instruction;
Must pass criminal and registry checks
Provider Qualifications:
Agency providers must be enrolled as an NC Medicaid Provider
Agency providers must demonstrate 3 years of delivering HCBS to elders and adults with disabilities and their caregivers.
Agency providers must develop, implement and provide ongoing management and support of a person-centered service plan that addresses the waiver participant's level of service needs which includes an agreement with caregivers describing their roles and responsibilities for the care and support provided to the waiver participant.
Agency providers must conduct monthly home visits based on the waiver participant's assessed needs and caregiver coaching needs.
Agency providers must provide to the caregiver a minimum of 8 hours of annual training that reflects the waiver participant's and caregiver's assessed needs. Training may be delivered during monthly home visits, through secure electronic communication methods or in another manner that is flexible and meaningful for the caregiver.
Agency providers must provide education and coaching to lay caregivers that is based on the participant's and caregivers' assessed needs, including managing health-related needs; personal care; cognitive, behavioral and social needs of waiver participants and, including interventions to reduce behavioral problems for waiver participants with mental disabilities and who need restorative services. Training and coaching must occur at a minimal monthly.
Agency providers must work with waiver participant and caregiver to establish backup plans for emergencies and other times when the principal caregiver is unable to provide care and ensure that caregivers understand how to manage medical and other incidents and emergencies as they may occur and report such situations to the provider agency, as soon as possible.
Must have the ability to perform competency evaluation on hired staff
Must perform background checks to include on all hired live-in caregivers to validate no finding entered the registry or convictions that are outlined on the HCBS banned list.
Must assure the health and safety needs of the waiver participant are met in conjunction with the case manager.
Must ensure that coaching to the live-in caregiver includes the importance of providing nutritionally balanced meals and healthy snacks each day to the waiver participant, as dictated by their medical/nutritional needs.
Must engage in regular review of caregiver notes to understand and respond to changes in the waiver participant's health status and identify potential new issues to better assist with the coordination of care to avoid unnecessary hospitalizations or emergency room use

Competency Validation of Caregivers
Provider agency shall assure that each caregiver has the demonstrated competency to perform the personal care activities specified in the CAP service authorization.
Documentation Requirement -Documentation to support service rendered that includes:
Electronic caregiver notes that record and track the participant's status, and updates or significant changes in their health status or behaviors and participation in community-based activities and other notable or reportable events
Medication management records, when applicable
Critical incidents
Grievances and complaints
Home visits conducted by provider agency
Education, skills training and coaching conducted with the caregiver
Multidisciplinary team meetings demonstrating collaboration and communication with other service providers and healthcare professionals (as appropriate), waiver care managers and other caregivers or individuals important to the waiver participant regarding changes in the participant's health status and reportable events.
Qualified caregivers
Least Restrictive Environment Requirements
The provider agency must assure that the participants access to common areas and supports available as

part of living in the community. A participant's access may be restricted only when the participant's service plan determines the need to assure the participant's safety as documented in the comprehensive assessment.
Transportation. The provider must assure, whenever possible, the provision of transportation by the live-in caregiver for the waiver participants to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the waiver participant's choice. The waiver participant is not to be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members and transportation, medical and non-medical.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and every five years thereafter, verified by MMIS

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Equipment, Modification and Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service that provides equipment, physical adaptations, minor modifications, product systems, devices, supplies, monitoring systems, specialized accessibility, adaptations, or safety adaptions, as identified during the comprehensive assessment, to improve, maximize or enhance the participant's mobility, safety, independence, and integration into the community or to improve the waiver participant's environmental/community accessibility, or address 24/7 participant coverage concerns.

This service may cover:

- Installation, maintenance, and repairs of ramps; grab bars; and handrails
- Widening of doorways/passages for wheelchair or walker accessibility
- Modification of bathroom facilities to improve accessibility for a disabled individual, including toilet, shower/tub (including hand-held showers), and sink fixtures or modifications; water faucet controls; floor urinal adaptations; plumbing modifications; and modification for turnaround space
- Bedroom modifications to accommodate hospital beds and/or wheelchairs
- Kitchen Modifications to improve accessibility for an individual living independently with a disability including cabinets, sink fixtures or modifications, water faucet controls, related plumbing modifications, and modification for turnaround
- Floor coverings for ease of ambulation
- Hydraulic, manual, or electronic lifts, including portable lifts or lift systems that can be removed and taken to a new location and are used primarily inside the participant's home
- Non-skid surfaces- car or home
- Lift chairs
- Door handle replacements;
- Door modifications – car or home
- Installation of raised roof or related alterations to existing raised roof system to approve head clearance;
- Lifting devices- car or home;
- Devices for securing wheelchairs or scooter- cars;
- Adapted steering, acceleration, signaling and breaking devices only when recommended a by physician and a certified- car
- driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel;
- Handrails and grab bars- home;
- Seating modifications- car;
- Lowering of the floor of the vehicle when the vehicle is not pre-manufactured with a lowered floor;
- Transfer assistances-car;
- 4-point wheelchair tie-down-car;
- Wheelchair/scooter hoist-car;
- Cushions- car or home when not covered by State Plan;
- Wheelchair or scooter lift;
- Ramp- car or home
- Devices for securing oxygen tank-car
- Necessary modifications, not otherwise identified by this list and that were identified during as assessment, that will prevent an out of home placement. These types of modifications must align with one of the listed items under this definition, but not currently expressed because of unfamiliarity of need/modification requirements. These types of modifications can only be approved by the State Medicaid Agency.
- Smart home devices when the waiver participant will live alone. These smart devices will control light switches, thermostatic, smart bulbs, controllers for televisions and entryways, clocks and other small appliances as identified in an assessment due to the disability of the waiver participant.

This service does not duplicate State Plan Services. Assurance: The services under the waiver's Equipment, Modification, and Technology are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- Addition of square footage to the home;
- Home renovations;
- A dwelling where the owner refuses portable modification;
- The modification in a rented residence that is not portable;
- Purchase of locks;
- Modification during new construction;
- Roof repair or roof replacement,
- Central air conditioning,
- Swimming pools, hot tubs; spas, saunas
- Items that meet the definition exclusions for general utility to non-disabled individuals;
- Replacement of equipment that has not been properly used, has been lost or purposely damaged per written documentation or through observation;
- Computer desk and other furniture; and
- items that meet the definition exclusions for recreational in nature

$13,000 over the 5-year cycle of the waiver

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

☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Contractor
Agency	Durable medical equipment provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Equipment, Modification and Technology

Provider Category:

Agency

Provider Type:

Independent Contractor

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:

The Independent Contractor must hold an applicable state and or business license and demonstrate the capacity to make the needed modifications and install equipment according to applicable local and state building codes and be an enrolled NC Medicaid Durable Medical Equipment and Supplies provider. Providers must have the ability to install items according to the manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Prior to service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Equipment, Modification and Technology

Provider Category:

Agency

Provider Type:

Durable medical equipment provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The DME vendor must hold an applicable state and or business license and demonstrate the capacity to make the needed modifications and install equipment according to applicable local and state building codes and be an enrolled NC Medicaid Durable Medical Equipment and Supplies provider. Providers must have the ability to install items according to the manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Initially and every five years thereafter by MMIS
Case management entity to verify prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Individual Goods and Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service for the waiver participant directing care that provides services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan, and the waiver participant does not have the funds to purchase the item or service or the item or service is not available through another source. This service helps assure health, safety, and well-being when the waiver participant or responsible party does not have resources to obtain the necessary item or service that will aid in the prevention or diversion of institutional placement. Individual goods and services are items that are intended to: increase the waiver participant's ability to perform ADL's or IADL's and decrease dependence on personal assistant services or other Medicaid-funded services.
Individual Directed Goods and Services must be documented in the service plan and the goods and services that are purchased under this coverage must be clearly linked to an assessed waiver participant need established in the service plan.

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

The cost of participant goods and services shall not exceed $800.00 per waiver participant in a fiscal year (July 1-June 30). Items that are $200.00 or less may be approved by the Case management entity. Items that exceed $200.00 must be approved by a DMA consultant.

• Items that are not of direct medical or remedial benefit to the waiver participant
• Items covered under the Home Health Final Rule
• Items covered through Medicaid State Plan DME, orthotics, prosthetics, and home health supplies
• Items that meet the definition exclusions for recreational in nature
• Items that meet the definition exclusions for general utility to non-disabled individuals
• Service agreements, maintenance contracts, that are not related to the approved service, and Warranties
• Equipment used with swimming pools, hot tubs, spas, and saunas that are not approved in the person-centered service plan or included in the exclusion definition
• Replacement of equipment that has not been properly used, has been lost, or purposely damaged per written documentation or through observation
• Technology hardware such as computer, laptop, tablet, or smart phone when considered recreational in nature or of general utility per the definition
• Pharmacy related items that are not approved in the service plan
• Outdoor monitoring systems that are not approved in the service plan and are included in the recreational in nature or general utility definition

Experimental or prohibited treatments are excluded.

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

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

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Retail Vendor
Agency	Durable Medical Equipment Provider

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:
Individual
Provider Type:

Individual

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual provider of transportation shall have a valid drivers' license, car insurance that covers liability and his or her own.

Verification of Provider Qualifications
Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:
Agency
Provider Type:

Retail Vendor

Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Retail vendor must hold the applicable business retail requirements to sale or furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Individual Goods and Services

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License *(specify):*

meet all applicable licensure requirements per NC Medicaid Provider Enrollment requirements

Certificate *(specify):*

Other Standard *(specify):*

business approved by the Case management entity or FMS provider to provide the approved service, equipment or supplies of sufficient quality to meet the need for which it is intended.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management entity
DHHS Fiscal Agent
State Medicaid Agency
FMS
Tribal Governments

Frequency of Verification:

Initially and every five years thereafter by MMIS
Case management entity to verify prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Meal Preparation and Delivery

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service for a waiver participant who requires special assistance with nutritional planning per an assessment of needs. This service is often referred to as “Meals on Wheels” and provides for the preparation and delivery to the waiver participant’s home of one nutritious meal per day. 10A NCAC 06K.0101

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

Oral nutritional supplements are excluded
1 meal per day

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nutrition
Agency	Federally recognized tribes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meal Preparation and Delivery

Provider Category:

Agency

Provider Type:

Nutrition

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

10A NCAC 06K.0101
Meet Medicare requirements for Tribal Governments

Other Standard *(specify)*:

Agencies/organizations that meet Division of Aging and Adult Services requirements for home delivered meals.
Meet Medicare requirements for Tribal Governments

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Aging and Adult Services
Tribal Governments

Frequency of Verification:

Annually and five years thereafter by MMIS

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Meal Preparation and Delivery

Provider Category:

Agency

Provider Type:

Federally recognized tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the IHCIA, 25U.S.C 1647a, provides that a health program or entity operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and as required and five years thereafter by MMIS.

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Nutritional Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service for a waiver participant that provides coverage for physician ordered health supplements, vitamin or mineral supplements, herbal preparations and over-the-counter medications (OTC) that are directly related to the primary physical medical condition and are determined medically necessary but are not available under the State Plan. These nutritional services are necessary to assist the waiver participant to maintain community placement and for the management of health and safety as identified in the person-centered service plan.

Assurance: The services under the waiver's Nutritional Services are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

This service is not intended to cover prescription drugs or prescriptions with a rebate.
The cost of this service shall not exceed $800.00 per waiver participant in a fiscal year (July 1-June 30). Participants goods and services and individual goods and services are excluded when this service is approved and reimbursed to it maximum limits during each qualifying fiscal year.
This service is not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase health supplements, vitamin or mineral supplements, herbal preparations and over-the-counter medications (OTC) and these nutritional services are not available through another source.

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

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

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

- ☐ **Legally Responsible Person**
- ☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Nutritional Services

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Retail vendor must hold the applicable business retail requirements to sale or furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Participant Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service for the waiver participant who is not directing their own care that provides services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase the item or service or the item or service is not available through another source. This service helps assure health, safety, and well-being when the waiver participant or responsible party does not have resources to obtain the necessary item or service that will aid in the prevention or diversion of institutional placement. Participant goods and services are items that are intended to: increase the waiver participant's ability to perform ADL's or IADL's and decrease dependence on personal assistant services or other Medicaid-funded services.

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

The cost of participant goods and services shall not exceed $800.00 per waiver participant in a fiscal year (July 1-June 30). Items that are $200.00 or less may be approved by the Case management entity. Items that exceed $200.00 must be approved by a DMA consultant.

• Items that are not of direct medical or remedial benefit to the waiver participant
• Items covered under the Home Health Final Rule
• Items covered through Medicaid State Plan DME, orthotics, prosthetics, and home health supplies
• Items that meet the definition exclusions for recreational in nature
• Items that meet the definition exclusions for general utility to non-disabled individuals
• Service agreements, maintenance contracts, that are not related to the approved service, and Warranties
• Equipment used with swimming pools, hot tubs, spas, and saunas that are not approved in the person-centered service plan or included in the exclusion definition
• Replacement of equipment that has not been properly used, has been lost, or purposely damaged per written documentation or through observation
• Technology hardware such as computer, laptop, tablet, or smart phone when considered recreational in nature or of general utility per the definition
• Pharmacy related items that are not approved in the service plan
• Outdoor monitoring systems that are not approved in the service plan and are included in the recreational in nature or general utility definition

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

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

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual
Agency	Durable Medical Equipment Provider
Agency	Retail Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Goods and Services

Provider Category:
Individual
Provider Type:

Individual

Provider Qualifications
License *(specify)*:

Certificate *(specify):*

Other Standard *(specify):*

An individual provider of transportation shall have a valid drivers' license, car insurance that covers liability and his or her own.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Goods and Services

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Provider

Provider Qualifications

License *(specify):*

meet all applicable licensure requirements per NC Medicaid Provider Enrollment requirements

Certificate *(specify):*

Other Standard *(specify):*

A business approved by the Case management entity or FMS provider to provide the approved service, equipment or supplies of sufficient quality to meet the need for which it is intended.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management entity
DHHS Fiscal Agent
State Medicaid Agency
FMS
Tribal Governments

Frequency of Verification:

Initially and every five years thereafter by MMIS
Case management entity to verify prior to service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Participant Goods and Services

Provider Category:
Agency
Provider Type:

Retail Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Retail vendor must hold the applicable business retail requirements to sale or furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

PERS is an electronic device that enables waiver participants to secure help in an emergency. The participant may also wear a portable "help" button to allow for mobility. The system is connected to the participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein.
A service that pays the monthly service charges or monthly rental charges for a system used to alert a central monitoring facility of medical emergencies that may threaten the waiver participant's health, safety, and well-being. The emergency response provider must have the capability to provide a 24-hour monitoring system in accordance with the service definition.

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

Installation and maintenance are not covered.

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

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Response Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Personal Emergency Response Services

Provider Category:
Agency
Provider Type:

Emergency Response Agencies

Provider Qualifications

License *(specify)*:

UL/ETL Approved Devices
Emergency care providers
Alarm system contractor
Meet Medicare requirements for Tribal Governments

Certificate *(specify)*:

Other Standard *(specify)*:

Provider must have the capability to provide a 24-hour monitoring system in accordance with service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case Management entity
DHHS Fiscal Agent
Tribal Governments

Frequency of Verification:

Initial and every five years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Other Service

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

specified in statute.

Service Title:

Pest Eradication

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service for waiver participants that provides a one-time pest eradication treatment. This service is coverable when the waiver participant is living in his or her own home, when not already included in a lease, and when the eradication is for the management of health and safety as identified in the person-centered service plan. The eradication procedure is limited to one time per year.
Assurance: The service under the waiver's Pest Eradication is limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

This service is not intended for monthly, routine or ongoing treatments.
The cost of this service shall not exceed $1600.00 per waiver participant over the course of two State fiscal years (July-June); $800.00 maximum for each fiscal year. Participants goods and services and individual goods and services are excluded when this service is approved and reimbursed to it maximum limits during each qualifying fiscal year.
This service is not otherwise provided through this waiver or through the Medicaid State Plan; and the waiver participant does not have the funds to purchase the pest eradication and the treatment is not available through another source.

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

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

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

- ☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail Vendor

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Pest Eradication

Provider Category:

Agency

Provider Type:

Retail Vendor

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Retail vendor must hold the applicable business retail requirements to sale or furnish one of the listed items under this definition. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the items listed in the service definition.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Case management entity to verify prior to authorizing the retailer to render the service and upon service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Respite Services

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09011 respite, out-of-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09012 respite, in-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

A service for a waiver participant that provides temporary relief to the primary unpaid caregiver(s) by taking over the care needs of the participant for a limited time. This service may be used to meet a wide variety of needs, including family emergencies; planned special circumstances when the primary unpaid caregiver needs to be away for an extended period (such as vacations, hospitalizations, or business trips); relief from the daily responsibility of caring for an individual with a disability, or the provision of time for the primary unpaid caregiver to complete essential personal tasks.
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).

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

Institutional and In-home Respite Services shall not exceed 30 calendar days or 720 hours in one fiscal year (July 1-June 30) for combined use of Institutional Respite Care and In-Home respite care. A day of institutional respite counts as 24 hours towards the annual limit. Any hours not used at the end of the fiscal year may not be carried over into the next fiscal year.
A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide CAP In-Home Aide to a waiver participant. Exclusions apply when (a) there is a staffing shortage in remote areas of the state; or (b) the lack of a qualified provider who can furnish services at usual times during the day because of the complexity of the waiver participant's care needs.
Also refer to C-2 for extraordinary circumstances for a legal guardian to provide this service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care Providers
Agency	Federally recognized tribes

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Services

Provider Category:

Agency

Provider Type:

Home Care Providers

Provider Qualifications

License *(specify)*:

TITLE 10: CH22, 0.0100
10 NCAC 06B .0101
Meet Medicare requirements for Tribal Governments

Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Health Service Regulation
DHHS fiscal agent (GDIT/NCTracks)
Tribal Governments

Frequency of Verification:

Initially and every five years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Respite Services

Provider Category:

Agency

Provider Type:

Federally recognized tribes

Provider Qualifications

License *(specify):*

Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the IHCIA, 25U.S.C 1647a, provides that a health program or entity operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law.

Certificate *(specify):*

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Medicaid

Frequency of Verification:

Initially and five years thereafter by MMIS

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Specialized Medical Supplies

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14032 supplies
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Supplies that are necessary to avoid institutionalization and promote continuous community integration often prescribed by a physician.
- Oral Nutritional Supplement: Provided to promote the health and well-being by increasing the ability to perform ADLs and IADLs.
- Incontinence Supplies: These supplies assist with bowel and bladder management and skin integrity.
- Medication Dispensing Box provides assists the CAP beneficiary in knowing when to take their medication.

Assurance: The services under the waiver's Specialized Medical Equipment are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Federally recognized Tribes may render this service all qualifying conditions are met - Section 221 of the IHCA, 25 U.S.C 1621t, exempting a health care professional employed by an Indian tribe or tribal organization performs services, provided the health care professional is licensed in any state. Section 408 of the IHCIA, 25U.S.C 1647a, provides that a health program or entity operated by an Indian tribe or tribal organization shall be deemed to have met a requirement for a license under state or local law if such program meets all the applicable standards for such licensure, regardless of whether the entity obtains a license or other documentation under such state or local law.

When a CME qualifies as a DME vender, because of conflict of interest protections, the case management entity is not authorized to provide specialized medical supplies unless that entity meets the threshold for rural service regions as described in Appendix D-2. Case management entity is only authorized to assist with the development of the service plan and to provide the selected service provider a written service authorization. This information will be included in the waiver application.

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

A signed physician's order certifying medical need.

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

- ☐ **Participant-directed as specified in Appendix E**

☒ **Provider managed**

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

☐ **Legally Responsible Person**
☐ **Relative**
☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Vendors
Agency	Specialized Medical Goods Supplier

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:
Agency
Provider Type:

Durable Medical Equipment Vendors

Provider Qualifications

License *(specify):*

The DME vendor must hold an applicable state and or business license.

Certificate *(specify):*

Other Standard *(specify):*

The DME vendor must demonstrate the capacity to provide the service according to the service plan and manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Initially and every five years thereafter by MMIS
Case management entity to verify prior to service delivery

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Supplies

Provider Category:

Agency

Provider Type:

Specialized Medical Goods Supplier

Provider Qualifications

License *(specify):*

The Specialized Medical Goods Suppliers must hold an applicable state and or business license

Certificate *(specify):*

Other Standard *(specify):*

The Supplier must demonstrate the capacity to render the service according to the service plan and according to the manufacturer's specifications and requirements. The case management entity does not provide or render this service. The case management entity approves the provider/vendor to render the equipment, modification or technology.

Verification of Provider Qualifications

Entity Responsible for Verification:

Case management entity, State Medicaid Agency and Tribal Governments will verify if the selected provider meets the requirements to render the approved items listed and approved under this definition.

Frequency of Verification:

Initially and every five years thereafter by MMIS
Case management entity to verify prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

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

Service Title:

Training/Education and Consultative Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

09 Caregiver Support	09020 caregiver counseling and/or training

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

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

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

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

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

Service Definition *(Scope):*

A service that provides supportive services to the waiver participant, the waiver participant's unpaid primary caregiver, or unpaid support system. The purpose of the supportive service is to enhance the decision-making ability of the waiver participant, enhance the ability of the waiver participant to independently care for him or herself, or enhance the ability of the primary caregiver in caring for the waiver participant. These service activities which include training and counseling services for individuals who provide unpaid support, training, companionship or supervision to waiver participants. All training and education services must be documented in the participant's person-centered care plan as a goal with the expected outcomes. This service may cover conference registration and enrollment fees for classes.
The services under the waiver's training/education and consultative services are limited to additional services not otherwise covered under the State Plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization. This service may not be used to provide training to a paid caregiver.

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

This service is limited to $500 per fiscal year. Individuals who are paid service providers cannot be trained or educated using this service.
An organization with a training or class curriculum approved by the SMA including Universities, Colleges and Community Colleges shall provide training and education services.

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

- [x] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Trainers and Educators

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Training/Education and Consultative Services

Provider Category:
Individual
Provider Type:

Trainers and Educators

Provider Qualifications

License *(specify):*

Certificate *(specify):*

1) Universities, Colleges, and Community Colleges
2) An organization with a training/class curriculum approved by the Division of Medical Assistance.
3) Meet Medicare requirements for Tribal Governments

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Tribal Governments
Case Management entities

Frequency of Verification:

Prior to class or training

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - ☒ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
  - ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*

☐ **As an administrative activity.** *Complete item C-1-c.*

☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

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

Case Management Entities

Appendix C: Participant Services

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

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

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

◉ **Yes. Criminal history and/or background investigations are required.**

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

Criminal History and/or Background Investigations specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who are providing personal care type services in the capacity of an in-home aide or a personal care assistance. This HCBS waiver offers a waiver participant to direct his or her care using the consumer-direction model of care. The waiver participant has the autonomy to select the direct support staff (personal assistants) of his or her choice. The selected support worker (personal assistants) must undergo a criminal history record check prior to being hired to render the supplemental and supportive services. This HCBS waiver elicit the services of a financial management entity to conduct the criminal history record check of all direct support (personal assistants) staff under the consumer-direction option. During the recruitment and employment verification phase for consumer-direction, a state criminal history record check is conducted only in North Carolina if residency is verified for 5 years or more. A national criminal history record check is conducted if residency in North Carolina is for less than 5 years. The standards of obtaining a national criminal history record checks are from a public or private entity that regularly conducts criminal history record checks utilizing public records from a State agency. The standards of obtaining a state criminal history record checks are from a N.C. county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank or a public or private entity that regularly conducts criminal history record checks utilizing public records from a State agency.
In-home aides who are hired by an agency, a criminal record check and registry check must be completed by that agency prior to hire. The agency follows the guidelines determined by their regulatory agency, Department of Health Services Regulations for administering background checks.

To ensure that mandatory background checks are completed as required, the financial management entity obtains consent from the selected direct worker (personal assistant) to conduct the criminal history record checks during the application process. The following information is obtained to assist with conducting the required checks: full legal name, date of birth, social security number, street address, city, state, driver's license information, gender, previous names used, length of stay in the NC, and city and state of residence within the last five years. The selected direct worker may not render HCBS until the background check is completed and there is no indication of crimes that fall into the hiring ban.
In-Home Aide service providers must include in their personnel files the date the background check was completed for each hired in-home aide. A listing of findings shall be documented in the record if a criminal record exists and how those findings are within the requirements of this waiver program.

To mitigate risk of abuse, neglect, exploitation to a waiver participant, the State Medicaid Agency has implemented a hiring ban for selected direct workers (personal assistant). If any one of the following convicted criminal acts is listed on a background check, the direct worker will not be able to provide hands-on care. The ban provides exclusions when the criminal act is over a ten (10) year period with no same or similar criminal act. The hiring ban include the following:
- Felony or misdemeanor related to manufacture, distribution, prescription or dispensing of a controlled substance;
- Felony or misdemeanor health care fraud;
- More than one felony conviction;
- Felony or misdemeanor for assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud, or theft against a minor or vulnerable adult;
- Felony or misdemeanor patient abuse;
- Felony or misdemeanor involving cruelty or torture;
- Felony or misdemeanor for abuse, neglect, or exploitation of a minor or vulnerable adult;
- Substantiated allegation of abuse, neglect, or exploitation listed with the NC Health Care Registry or Office of Inspector General (OIG) U.S. Department of Health and Human Services Exclusion Database; or
- Any substantiated allegation listed with the NC Health Care Registry or OIG U.S. Department of Health and Human Services Exclusion Database that would prohibit an individual from working in the health care field.

A direct worker (personal assistant) with offenses that are not outside of Medicaid guidelines nor related to abuse, neglect or exploitation may qualify for an exemption and be eligible for employment under the direction of the participant or designated representative if the offense occurred 10 years or more prior. The Financial management entity shall inform the waiver participant or designated representative when an offense is within the 10-year exemption rule. A direct worker (personal assistant) who has findings from the health care registry checks that prevents him or her from working in the health care field are permanently banned from providing services to a waiver participant.

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services

through a state-maintained abuse registry (select one):

○ **No. The state does not conduct abuse registry screening.**

◉ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

The Division of Health Services Regulation (DHSR) is responsible for maintaining the nurse aide registry. DHSR requires direct care staff to be screened through the Nurse Aide Registry at hire and at least annually thereafter.
All direct care staff are not nurse's aides, the DHSR conducts a criminal background check on entities monitored by that division. The licensed entities monitored by DHRS are mandated to conduct criminal backgrounds and registry checks on all hired employees to assure health, safety and well-being of all individuals to mitigate risk.
A waiver participant using the consumer-direction model of care selected worker (personal assistant) is required to undergo a health care registry check prior to providing supplement and supportive services. The health care registry check is completed by the financial management entity during the employment screening process. Health care registry checks are obtained by the NC Health Care Registry and the Office of Inspector General (OIG) U.S. Department of Health and Human Services Exclusion Database. Any findings related to a substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry and or OIG U.S. Department of Health and Human Services Exclusion Database or a finding that restricts the selected worker (personal assistant) from working in the health care field. This procedure is a mandatory responsibility if the financial management entity.
To mitigate risk of abuse, neglect, exploitation to a waiver participant, the State Medicaid Agency has implemented a mandatory requirement of a health care registry check prior to the approval of authorization to the financial management entity to submit Medicaid waiver service claim for reimbursement. The selected worker (personal assistant) must receive clearance to provide HCBS through the HCBS IT system, e-CAP from the financial management entity checking a mandatory field. Once the mandatory field is checked, it validates this requirement was met. Random samples are performed quarterly to monitor the performance of the financial management entity.

Appendix C: Participant Services

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

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

◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**

○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar**

services.

◉ **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

CAP In-home Aide, Respite, In-home, and Personal Assistant Services may be provided by a relative and/or legally responsible person who is an employee of an In-Home Care Agency. The only exception is the Personal Care Assistant under consumer-direction cannot provide Non-Institutional Respite Services, and may NOT also be the legally responsible person or the legal guardian. The CME plays a major role, along with the participant and/or representative in assessing and determining need for personal care. The CME also assists in monitoring the service plan, tasks and time records to assure appropriate provision and utilization of waiver services. Additional safeguards include post-payment reviews conducted by the State Medicaid Agency.

The employment of a spouse, parent, child or sibling of the waiver participant is eligible to provide personal care services only if the person:
a. Is at least 18 years of age;
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.110; and
c. Does not have other employment that interferes with the needs waiver participants regarding time and days.
A legal guardian, Power of Attorney, Health Power of Attorney cannot be hired to provide CAP In-Home Aide to a waiver participant. Exclusions apply when (a) there is a staffing shortage in remote areas of the state; or (b) the lack of a qualified provider who can furnish services at usual times during the day because of the complexity of the waiver participant's care needs.
Also refer to C-2 for extraordinary circumstances for a legal guardian to provide this service.

This restriction also applies to other relatives and hired personnel.

☒ **Self-directed**

☒ **Agency-operated**

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

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

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

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

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

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

When it is determined to be in the best interest of the waiver participant to have a legally responsible individual to provide personal care services, a physician's recommendation shall be provided to the case manager outlining the specific care needs of the waiver participant and how those needs can only be provided by the legally responsible individual. In conjunction with the physician's recommendation, an analysis of the case record is performed to evaluate the legally responsible individual's compliance with treatment and service plans and to ensure critical incident reports did not implicate the legally responsible individual to be negligent. In addition, the physical health of the legally responsible individual is heavily considered.
Payment to a legal guardian to provide in-home aide services to a waiver participant may be made when any one of the following extraordinary circumstances is met:

1. There are no available C NAs in the waiver participant's county or adjunct counties through a Home Health Agency/In-Home Aide Agency due to a lack of qualified providers, and the waiver participant needs extensive to maximal assistance with bathing, dressing, toileting and eating daily to prevent an out-of-home placement.
2. The waiver participant requires short-term isolation, 90-days or less, due to experiencing an acute medical condition/health care issue requiring extensive to maximal assistance with bathing, dressing, toileting and eating, and the waiver participant chooses to receive care in their home instead of an institution.
3. The waiver participant requires physician-ordered 24-hour direct observation and/or supervision specifically related to the primary medical condition(s) to assure the health and welfare of the participant and avoid institutionalization, and the legal guardian is not able to maintain full or part-time employment due to multiple absences from work to monitor and/or supervise the waiver participant; regular interruption at work to assist with the management of the waiver participant's monitoring/supervision needs; or an employment termination.
4. The waiver participant has specialized health care needs that can be only provided by the legal guardian, as indicated by medical documentation, and these health care needs require extensive to maximal assistance with bathing, dressing, toileting and eating to assure the health and welfare of the participant and avoid institutionalization.
5. Other documented extraordinary circumstances not previously mentioned that places the waiver participant's health, safety and well-being is in jeopardy resulting in an institutional placement.

This waiver allows a spouse or legally responsible individual of a waiver participant to perform personal care services and receive payment when any one of the following extraordinary circumstances occur: 1. The waiver participant is experiencing a cognitive limitation such as dementia or Alzheimer's Disease or a related disorder and the present of an unfamiliar individual is more disruptive than productive and the waiver participant requires additional assistance with ADLs than ordinary as identified in a service plan.
2. The waiver participant is in an area with limited access to service providers and the assessment of needs identifies that the waiver participant requires five or more hours per day of uninterrupted personal care.
3. The waiver participant has a secondary diagnosis of mental illness and the behavior, because of this illness, poses harm to an unfamiliar person or past behaviors have alienated service providers.

A legally responsible individual can only perform personal care tasks for 40 or less hours per week. The approved hours are based primarily on the assessed needs identified in the assessment.

The legal guardian will not receive payment for instrumental activities of daily living such as meal preparation, laundry, money management, home maintenance, shopping, and medication management.

When the legal guardian is authorized to receive payment for providing personal assistance services, the waiver participant will be enrolled in the coordinated caregiving waiver service. The enrollment in this service will provide quality assurance of the health, safety and well-being of the waiver participant and provides the controls to ensure that payments are made only for the services authorized to provide.

The assigned case management entity will perform bi-monthly in-person monitoring visit to ensure the services are provided in accordance with the service plan and the waiver participation business requirements.

A legal guardian will not be approved to provide personal care services and receive payment because of unwarranted biases to a Home Health Agencies/In-Home Aide Agencies without first attempting to work with those agencies. A legal guardian will not be approved to provide personal care services and receive payment if there are other providers available to render personal care services when the waiver participant has been discharged from a Home

Health Agency/In-Home Aide Agency due to non-complaint or violent behavior exhibited by the waiver participant or the legal guardian.

A comprehensive multidisciplinary assessment is conducted to identify medical, functional, social and family support needs. The severity of these needs is identified in the assessment and carried over to the service plan. The CME coordinates with the waiver participant and other care professionals to create a plan of care to meet the needs identified in the assessment. Each month, the CME corresponds with the beneficiary and service providers to assure that the services authorized on the POC are adequate in the amount, frequency and duration. Every three months, the CME is required to conduct a home visit to observe hands-on assistance to assure services approved for the amount, frequency and duration are sufficient for current needs. Adjustments are made upon discovery. Also, the CME is required to review supporting documentations to determine the need for a reassessment when the beneficiary is hospitalized or endures a significant change in status. Another monitoring task the CME performs to assure services are in the best interest of the individual is a quarterly multidisciplinary monitoring team meeting with all services providers.

The CME is required to closely monitor the provision of services through monthly contact with the beneficiary and quarterly observation of hands-on tasks.

○ **Other policy.**

Specify:

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

Enrollment is available to an interested provider at any time. Providers must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once Medicaid enrollment application is approved, and the provider has completed a managed change request to provide waiver services, the provider is authorized to provide services in the approved catchment area. Each approved provider is required to be listed on the freedom of choice provide form in each catchment area to be eligible to render services to waiver participants.
The CME and IAE will provide each waiver participant a freedom of choice policy in which the waiver participant must sign to acknowledge his or her rights to choose any qualified provider eligible to provide a waiver services.

Case management entities will be assigned to service a particular county when all qualification requirements are met and when there is a service need in that county.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

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

i. Sub-Assurances:

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

Performance Measures

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

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

Performance Measure:
QP-A1 PM: Number and percent of waiver service providers who met the Medicaid requirements to render wavier services for each waiver participation year N: Number of waiver service providers who met the Medicaid requirements to render wavier services D: Total number of wavier service providers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: GDIT/NCTracks	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: GDIT/NCTracks	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-A2 PM: Number and percent of waiver service providers who met the Medicaid requirements initially and during recertification to render waiver services for each waiver participation year. N: waiver service providers who met the Medicaid requirements initially and during recertification to render waiver services for each waiver participation year D: waiver service providers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5$ margin of error
☒ **Other** Specify: MMIS CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System MMIS	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

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

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

Performance Measure:
QP-B1 PM: Number and percent of hired staff under CD who had a background check prior to rendering waiver services N: Number of hired staff under CD who had a background check prior to rendering waiver services D: Total number of hired staff

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: FMS CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: FMS CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-B2 PM: Number and percent of CD wavier participants who had a competency validation form on file for each hired staff prior to rendering wavier service for each waiver participation year N: Number of CD wavier participants who had a competency validation form on file for each hired staff prior to rendering wavier service D: Total number of CD wavier participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data	**Frequency of data collection/generation**	**Sampling Approach** *(check each that applies):*

collection/generation *(check each that applies):*	*(check each that applies):*	
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-B3 PM:Number and percent of CD non-licensed/non-certified providers who adhered to waiver requirement as evidence of a quarterly assessment. N: Number of CD non-licensed/non-certified providers who adhered to waiver requirement as evidence of a quarterly assessment D: Total number of CD non-licensed/non-certified providers

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-B4 PM: Number and percent of CD hired staff who submitted time/task sheets to the FMS within the required guidelines and timeframe for each waiver participation year N: Number of CD hired staff who submitted time/task sheets to the FMS within the required guidelines and timeframe D: Total number of hired staff

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other**	☐ **Annually**	☐ **Stratified**

Specify: FMS CSRA/NCTracks		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: FMS CSRA/NCTracks	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-B5 PM: Number and percent of non-licensed/non-certified providers through provider-led services who adhered to waiver requirement as evidence of a quarterly assessment. N: non-licensed/non-certified providers through provider-led services who adhered to waiver requirement as evidence of a quarterly assessment D: Total number of non-licensed/non-certified providers through provider-led services

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions

If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95$ 5$ margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
CAP IT system	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

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

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

Performance Measure:
QP-C1 PM: Number and percent of case management entities whose case managers participated in and completed all required mandatory trainings for each waiver participation year Numerator: Number of case management entities whose case managers participated in and completed all required mandatory trainings Denominator: Total Number of case management entities

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: CAP IT System CME	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System CME	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-C2 PM: Number and percent of CD hired staff who had HCBS and CD orientation training prior to rendering waiver services N: Number of CD hired staff who had HCBS and CD orientation training prior to rendering waiver services D:

Total number of CD hired staff

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: FMS CME	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: FMS CME	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-C3 PM: Number and percent of HCBS providers who completed the HCBS training initially prior to rendering waiver services N: Number of HCBS providers who completed the HCBS training initially prior to rendering waiver services D: Total number of HCBS providers

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:

	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
QP-C4 PM: Number and percent of HCBS providers who completed an annual HCBS refresher overview within 12 months of the initial training for each waiver participation year N: Number of HCBS providers who completed an annual HCBS refresher overview within 12 months of the initial training D: Total number of HCBS providers

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
CAP IT System	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

The CAP IT system is a business system employed by the State Medicaid Agency to assist in managing qualification of providers in conjunction with the MMIS entity (GDIT/NCTracks). This system assists in the discovery of provider qualifications through aggregating and analyzing National Provider Identifiers, training requirements and assessment of needs.
The CAP IT system performs the following tasks to ensure compliance to qualified provides policies and procedures which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- Service authorizations
- CAP IT system user identification using MMIS NPI information
- Prior approval segments
- Workflow timelines and alerts
- Communication logs
- Supporting documentation queues
- Knowledge and educational materials
- Training modules

b. Methods for Remediation/Fixing Individual Problems

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

Upon the discovery of non-compliant waiver workflow activities in the area of qualified provider, the State Medicaid Agency notifies the non-compliant provider immediately upon discovery. If the non-compliant area can be remediated, a corrective action plan is requested to remediate the concerns and technical assistance and training on policies and procedures are provided. The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant provider to ensure the corrective action plan is being followed through the duration of the action plan. If the non-compliant issue continues for a duration of 3 months of technical assistance and remediation strategies and quality cannot be achieved, the entity will be terminated indefinitely.
If the provider loses Medicaid enrollment status or is placed on an Office of Inspector General list, termination as a waiver provider is initiated immediately.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System, CME, GDIT/NCTracks	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

◉ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.

Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Please see Attachment #2, HCB Setting Waiver Transition Plan for a description of the current settings that do not meet requirements at the time of submission.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Person-Centered Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

☒ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☒ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☐ **Case Manager** (qualifications not specified in Appendix C-1/C-3).
Specify qualifications:

☒ **Social Worker**
Specify qualifications:

4-year Bachelor Social Work Degree with minimum of 2-3 years of direct experience in long-term care or home and community services; or 4-year Bachelor Human Services Degree with minimum of 2-3 years of direct experience in long-term care or home and community services; or registered nurse who holds a current NC license with 1 year of case management experience in long-term care or home and community services.
Must complete the following annual mandatory initial and refresher trainings:
a. Person-centered thinking and planning training;
b. Abuse, neglect, exploitation;
c. Program integrity (PI);
d. Conflict resolution;
e. Mental Health First Aid;
f. Critical incident reporting;
g. Health, Safety and Well-being and Individual Risk Agreement;
h. Fair hearing and EPSDT;
i. Consumer-Direction;
j. Quality Assurance and Performance Outcomes
k. Cultural Awareness;
l. Motivation interviewing or a similar training; and
n. How to use and navigate e-CAP

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

An independent assessment is conducted to initially assess needs and risk indicators to validate the eligibility to receive this level of care and service. Upon the approval of waiver participation, the waiver participant is required to select a case management entity to assist with the development of a person-centered service plan which is based on an individual's assessed needs and is designated to address any risk indicators identified by the IAE. The CME arranges an appointment with the waiver participant and encourages the waiver participant's support system to attend. Prior to the first appointment, the waiver participant is encouraged to identify goals and objectives to address social and health needs. The CME reviews those goals with the waiver participant and relates them to the identified risk indicators to begin the discussion of the person-centered service plan.
The CME is also responsible to provide monthly case management to ensure each waiver participant's health and welfare is maintained. The CME may be an organization that is approved by the SMA to render other Medicaid and waiver services. In those instances, the CME may also be approved by SMA to render other waiver services when conflict of interest protections is documented as expressed in Appendix D-2-b. To prevent conflict of interest and to promote freedom of choice, the SMA has instituted firewalls to safeguard the waiver participant. Two firewalls: Two firewalls: 1. Clearly defined definition for COI that is discussed with the waiver participant and signed by both the case management entity and the waiver participant and approved by the SMA. This HCBS waiver arranges for conflict free case management in that a CME cannot provide a direct service to the waiver participant and case management by the same person or unit within their organization or make decisions that can potentially benefit or incentivized their organization. 2. Initial Independent Assessments performed by an IAE that has no direct or indirect affiliation with the waiver participant. The IAE is responsible to perform a quality validation of annual eligibility decisions to ensure the service plan is conflict free and the waiver participant could fully exercise freedom of choice. As a means of documenting choice was provided to the waiver participant, the case management entity must review and have the waiver participant to acknowledge and sign an agency disclosure form that provides information about conflict of interest, free choice of providers or lack of specific service providers in that service region. Disclosure about freedom of choice and conflict of interest is provided in four written formats-Participant Disclosure Form, Introductory Letter, Welcome Letter and a reassessment anniversary letter. Each of these letters are generated in the CAP IT system and mailed either by the IAE or CME. Yet another safeguard is Rights and Responsibilities form. This form clearly outlines the responsibilities of the waiver participant, the IAE, CME and SMA in their responsibilities of assuring freedom of choice and conflict of interest protections. The form must be signed and dated by the waiver participant and uploaded in the CAP IT system prior to the approval of the service plan. The e-CAP Business system performs a quality check of the service plan to validate COI protections were practiced by the CME with all waiver participants. When CME acts in a dual role, safeguards are in place to assure the CME administratively separates the plan development function from the direct service provider functions. Two safeguards in are placed to manage potential conflict of interest in this area. The first safeguard is for the services and approval authority to be provided by two distinct units or personnel within that organization. The second safeguard is for the CME to have an independent reviewer to perform quality checks on a quarterly basis to assess concerns of conflict and needs of the waiver participant is adequately met.
In instances of agencies in rural eastern, southern and western communities with limited resources, conflict of interest protections is managed through separation of authority within that agency. The CME/provider agency must administratively separate the plan monitoring function from the direct service provider functions. A safeguard is in place for the monitoring and service rendering staff to be provided by two distinct units/personnel within that organization. A second safeguard is for the CME/provider agency to have an independent reviewer to perform quality checks on a quarterly basis to assess concerns of conflict and needs of the waiver participant is adequately met. The case management entity is also required to assess adequacy of provider network on a quarterly basis from https://medicaid.ncdhhs.gov/providers/programs-services/long-term-care/community-alternatives-program-for-disabled-adults. The SMA identifies in advance the potential agencies that will fall in this threshold through a network analysis on a quarterly basis. When an agency is approved to function in this dual role, the SMA monitors these agencies closely by the initial service plan, paid claims, revisions to service plans, monitoring of monthly and quarterly visit summary reports, incident reports and annual surveys.
The CME is also required to assess provider network in the service region routinely for available providers and discuss free choice of provider (disclosure form) with the waiver participant on a quarterly basis. Entities can only provide both case management and services when prior approved by the SMA.The state CAP unit will assist the waiver participant to select another direct service provider when COI is evident. The waiver participant will be offer a dispute resolution process when COI is identified. The waiver participant will be provided a written notice and requested to reply within 10 business days to initiate a dispute.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

The waiver participant is supported in the service plan development process. Prior to the official in-home assessment, the waiver participant is provided an Introductory letter or an anniversary letter that informs the waiver participant on how the service plan will be developed and how to access needed waiver services based on risk indicators. Both letters provide detailed information about each waiver service to allow the waiver participant the opportunity to formulate a plan to meet health care needs. The letters also provide information about fair hearing and grievance and complaints. Additionally, while the assessor is in the home conducting the comprehensive assessment, the waiver participant is provided with information about person-centered planning and the need to select a case management entity to initiate the person-centered plan. The assessor informs of risk indicators identified after completion of the comprehensive assessment and provides the waiver participant a list of waiver services that may assist to mitigate those risks. The waiver participant is encouraged to begin identifying person-centered goals and services to meet health care needs in preparation of the service plan development.
Upon the completion of the comprehensive assessment by the assessor, the selected case management entity is provided access to the completed comprehensive assessment along with a summary of findings and recommended waiver services that may aid in mitigating risks for the waiver participant. The case management entity meets with the waiver participant to complete the person-centered plan that includes cultural influences and holistic overview of assessed needs. The waiver participant leads the service plan development process. The waiver participant is granted the authority to include individuals he or she finds to be pertinent to participate in the development of the service plan.
Information provided to the waiver participant to assist with service plan development:
•Waiver benefit package - the names of each waiver service and its definition and how one qualifies for a particular waiver services, the utilization limits and how the services may prevent institutional placement.
•Person-centered planning – information to describe the definition of person-centered planning and how the participant is entitled to determine who should be involved in decision-making and who may attend planning meetings. The participant is also provided information about how to ensure his or her likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith, physical activity are included in the plan. The participant is also informed about assumed risk when choosing to participate in a home and community-based program.
•Freedom of Choice – information is provided to describe what freedom of choice is and how the participant can exercise his or her freedom of choice when selecting to participate in the waiver, how to select waiver services and providers to provide services which also includes the case management agency for management of the day-to-day oversight during waiver participation. A participant may select a different provider at any time, for any reason.
•Fair hearing- information is provided on how to request an appeal when an adverse decision is made and the timeline granted to file an appeal.
•Complaints and Grievances- information is provided that describes what is a complaint and a grievance and how to voice a complaint and a grievance. The timeline is provided on how the complaint and grievance is to be managed.
•Abuse, Neglect and Exploitation (ANE) - information is provided on what ANE means, ways to identify concerns and how to report suspensions. This information also states the obligation by State Medicaid Agency, case management entities and service provides to report concerns of ANE to the appropriate officials.
•Resources available in the community- a list of resources is provided to the waiver participant that describes Medicaid services and other community resources potentially available to the participant while the participant completes through the eligibility steps.
Fraud, Waste and Abuse - information is provided on what fraud, waste and abuse is and how to report concerns. This information also informs of the obligation of the State Medicaid Agency, case management entity and service providers to report fraud, waste and abuse when it is suspected.

Service plan development will also include planning for individuals wishing to transition from an institution. The safeguards in place to ensure an appropriate assessment of need is conducted and that a person-centered service plan is developed to adequately address needs in the type, frequency, duration and amount are identified by the following:
A. Coordination of at least two transition planning meetings are arranged to begin the building of relationships as well as obtaining information to plan for community living. This information will assist to complete the service request form that is required for participation in this HCBS program. At this meeting, educational information about the transition process is effectively communicated to the interested individual and family.
B. During the second transition planning meeting, the assessor will initiate a dialogue about peer supports and social supports, substance addition, behavior support needs and tenancy support needs for preparation of service planning.
C. The assessment of need and the service plan development will be contingent upon various factors, one, in particular, is the confirmation of housing. When housing is secured the following steps are followed:
1. An assessment is initiated within 2 business days of the arrangement of housing.
2. A service plan is completed within 15 business day or within 5 business days of the arrangement of housing, when a time limit is placed on acquiring the housing.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Service Plan Development Process is completed in multiple steps. The first step is to establish the level of care. The LOC is the first determinant of waiver eligibility. The next step is the determination of at-risk of institutionalization based on functional needs and psychosocial factors identified in a comprehensive assessment. At-Risk of institutionalization is defined as participants who meet nursing facility level of care (LOC) criteria with assessed complexity of needs ranging from low to high skill levels and who do not have available resources to meet immediate needs- medical, psychosocial and functional. The affirmative results of being at-risk of institutionalization leads to the last step of eligibility, the service plan development. Breakdown of each step:
First step is the health information gathering and consultation with the primary physician to make a determination of level of care (LOC) using a service request form. Upon the approval of the LOC and the assignment of a slot, the IAE initiates the second steps of eligibility which is the comprehensive assessment that assesses the following functional areas:
• Caregiver information.
• Medical diagnoses.
• Medication and precautions.
• Skin.
• Neurological.
• Sensory and communication.
• Pain.
• Musculoskeletal.
• Cardio-Respiratory.
• Nutritional.
• Elimination.
• Mental Health.
• Informal support.
• Housing and finances.
If the individual needs indicate gaps in service provisions or the individual is assessed to be at-risk of community displacement (institutionalized), and there is an indication there are gaps in service provision, the individual is mailed an approval letter titled “Introductory Letter” that provides supportive information about the waiver. The letter also introduces the waiver participant to home and community-based planning; the roles and responsibility of State Medicaid Agency and the case management entity, freedom of choice and services available to him or her while participating in the waiver. The individual or current approved waiver participant is requested to select a case management entity for the assignment of a case manager to assist with the develop of a person-centered service plan. The interested individual or waiver participant may request individuals he or she prefers to participate in the service plan development phase. The case management entity or the State Medicaid Agency does not place restriction of who may participate in the service plan development, unless there is an obvious conflict of interest.

The development of a person-centered service plan is triggered by risk indicators of medical, behavioral, social and functional needs identified by the independent multidisciplinary assessment team. The case manager is assigned to complete the service plan and assists the waiver participant to identified preferences, likes and dislikes to create services needs for both formal and informal support systems. These identified needs will auto-populate to the service plan worksheet, for consideration and planning. The CAP IT system will not allow a service plan to be completed until there is a plan for each identified risk indicators by service need.

The case management entities shall participate in continuing education throughout the calendar year. Continuing education shall be provided to build and ensure capacities in service plan development. The following are the initial and annual refresher mandatory trainings:
a. Person-centered thinking and planning training;
b. Abuse, neglect, exploitation;
c. Program integrity (PI);
d. Conflict resolution;
e. Mental Health First Aide;
f. Critical incident reporting;
g. Health, Safety and Well-being and Individual Risk Agreement;
h. Medicaid Due Process Appeal Rights and EPSDT;
i. Consumer-Direction;
j. Quality Assurance and Performance Outcomes
k. Cultural Awareness; and
l. Motivation interviewing or a similar training

In addition, the case manager shall complete other required trainings sponsored by their organization annually:
a. Bloodborne Pathogens and Infection Control;
b. Health Insurance Portability Accountability Act (HIPAA)
c. End of Life planning;

Once the assessment is completed, the service plan must be initiated within 5 business days by the case manager. The service plan must be completed and approved by the 5th day of the anniversary month for active waiver participant and within 30 calendar days of the home visit to complete the comprehensive assessment for new individuals entering the waiver. The plan is approved for 12 months and can be updated at any time due to a change in status or request for a new or expanded need.

The assessment team meets with the potential waiver participant/primary caregiver and others at his or her request in their primary residence, to initiate the interdisciplinary comprehensive assessment that includes a historical overview of interested individual or waiver participant's life. The assessment team collects and enters the data in the CAP IT system to initiate the analysis of health care needs. During this process, the assessment team collaborates with current providers and the primary physician to confirm assessed needs to further validate functional level. Upon the completion of the comprehensive assessment as described above, the CAP IT system provides the assigned case manager an overview of assessed needs and areas that are critical to consider during the service plan development phase. The assigned case manager meets with the potential waiver participant/primary caregiver and others at his or her request, to review the findings of the assessment, to begin the discussion of a person-centered plan, the potential waiver participant/primary caregiver uses this information to begin the construction of a person-centered service plan. The case manager collaborates with the waiver participant to develop the
plan of care that will consist of both waiver and non-waiver services. The assessment must be completed and approved within 14 business days for initial and 7 business days for an annual when assigned to an independent assessor. This timeline is tracked by the CAP IT system. Once all needs are identified and the data analysis is received, the file is transferred to a selected case management entity to initiate the service plan.

The service plan development consists of:
a. An interdisciplinary comprehensive assessment that identifies LOC, the waiver participant's preferences, strengths, needs, and ability to live safely in the community; and
b. an approved person-centered service plan that includes cultural influences, likes, dislikes, preferences, goals, objectives community engagement, work and educational goals, church/faith,
physical activity and services in the amount and duration of complexity of need. The services documented on the service plan must address the needs identified in the assessment.

An annual, every 12 months, reassessment is required during the month of the original waiver entry date. The annual re-assessment is called a Continued Need Review (CNR) assessment. The CAP IT system tracks all Continued Need Review and reassessments. The CAP IT system provides monthly alerts to CME or IAE, when applicable, of when annual reassessments are due.
The annual service plan must be approved by the fifth day of the month following the waiver participant's anniversary month. The CNR service plan is effective for the first day of the month following the anniversary month and expires one year later.

Changes and revisions to the Service plan are initiated by the assigned case manager as the waiver participant's needs change. Changes to the service plan are submitted in the CAP IT system within 30-days of identified needs and approved within five (5) business days. The assigned case manager determines whether to revise the service plan when there is a change in the waiver participant's needs. A service plan revision is required when a waiver or Medicaid State Plan service is added, reduced, increased, deleted or when there are changes in amount, duration or frequency of a waiver service. A service plan update is required for a change in provider agency, but the change is not considered a revision. The case manager will obtain a signed agreement from the waiver participant or the responsible party consenting to the change in providers.

Service plan revisions are approved by an approval authority of the Case management entity. Revisions may be approved retroactively for up to 30 calendar days for specific services prior to the date that the plan is revised. The waiver participant or the primary caregiver shall agree to and sign service plan. The CAP IT system places prior approval limits on all authorized waiver services to ensure accurate reimbursement. The assigned case manager monitors the services

monthly with the waiver participant and authorized waiver providers to identify deviations of services and review provision of care. If there are consistent deviations and the service is authorized on the service plan, the case manager must review this with the waiver participant and discuss a possible change in providers. If the waiver participant's needs may be maintained at the deviated service level, a service plan revision must be completed.

The Case management entity shall send a written adverse notice in accordance with State Medicaid Agency Due Process policy to the waiver participant or responsible party if a service is denied, reduced, terminated, or if the waiver participant is disenrolled from the program. The service plan will be active on the date of the effective date and all approved services will be rendered regardless if a requested service on the original POC was denied.

When CAP participation is approved, the case management entity will notify the participant in writing of the approval through a Welcome Letter. The Welcome letter outlines the following:
All approved waiver services along with its definition; contact information, information of freedom of choice, conflict of interest, abuse, neglect and exploitation and fraud waste and abuse. Additional information is provided about resources available in the community- a list of resources is provided to the participant that describes Medicaid services and other community resources. The local department of social services is provided an official letter of notification of waiver approval. The notice informs of the CAP effective date and the special coverage code to enter into the eligibility system to ensure the adjudication of all CAP claims that are submitted.
Each service provider is provided an official notice called a service authorization to authorize the waiver service that is listed on the service plan. In addition, Medicaid provider of other Medicaid services are provided a participation letter to acknowledge approval of receipt of other Medicaid services.
The CAP IT system forwards electronic files to the MMIS to validate the prior approval of LOC as well the prior approval of waiver services in the amount, duration and frequency.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The State has procedures in place to comprehensively assess the waiver participant's needs to identify adverse health, safety and well-being indicators that potentially pose risks and strategies to mitigate those risks. Risk Assessment and Mitigation begins during the multidisciplinary comprehensive assessment. Each waiver participant, will be carefully assessed for health and well-being to plan for safe living in the community. An initial assessment is performed on all new enrollees and an annual assessment is performed on all active waiver participants. Upon the completion of the assessment, the CAP IT system analyzes the data fields to identify areas that could be a potential risk for the waiver participant. Data from the assessment generated by CAP IT system informs the potential waiver participant/primary caregivers and the assessment team of risk factors to consider during the service plan development to keep the waiver participant safely in the community. The results of the assessment are combined into a composite score. This score identifies the acuity level through a calculation that yields an acuity level of low to moderate needs or high to skilled needs. The composite score consists of:

1. ADL cumulative score;
2. Use of skilled services;
3. Current diagnoses; and
4. Beneficiary/caregiver risk indicators.

Each domain of the composite score is an indicator of fragility or complexity of need. The composite score uses a 100-point scale. A waiver participant with a score between 0-36 is represented to have low acuity needs, while a score between 37-64 is represented as intermediate acuity and a score between 65-100 is represented to have high acuity needs. The results of the assessment are used as a driver to develop a person-centered service plan to mitigate risk, upon initial and annual planning. During the development of the service plan the assigned case manager meets with the potential waiver participant/primary caregiver and other of his or her choice to review assessed risks to develop a plan of action to address each risk factor. Waiver and non-waiver services, assistance from the informal supports system are included in the service plan to aid in mitigating risk factors.

On a quarterly basis, a multidisciplinary team is held to perform a mini-assessment to ensure the person-centered service plan continues to meet the assessed needs of the waiver participant. During the multidisciplinary meeting or at any other monitoring interval, if a determination is made that the current service plan is not meeting the waiver participant's needs, one of two steps is followed: 1. The service plan is revised to add services to meet current needs; or 2. A change of status assessment is performed to conduct a full- comprehensive assessment to reevaluate the composite score and risk indicators. Upon the completion of a change in status assessment, a new person-centered service plan is developed to mitigate risk.

Another safeguard the SMA uses to mitigate risk when indicators are present that may potentially jeopardize the health, safety and well-being of the waiver participant or caregivers is an Individual Risk Agreement (IRA). This is an agreement that permits a waiver participant to assume responsibility for his or her personal choices through surrogate decision making or through planning team consensus. This agreement outlines the risks and course of action. The IRA is primarily used to manage behavioral concerns, non-compliance of the service plan and other well-being concerns that can't be mitigate by a formal service. The individual risk agreement is in conjunction with the service plan and does not replace the service plan. The individual risk agreement is instrumental in creating a think-tank for the case manager and the waiver participant to process risks and identify ways to minimize them and to assume responsibility and accountability of decisions.

During the development of the service plan the assigned case manager meets with the potential waiver participant/primary caregiver and other of his or her choice to review assessed risks to develop a plan of action to address each risk factor. Waiver and non-waiver services, assistance from the informal supports system are included in the service plan to aid in mitigating risk factors. If waiver services, the informal supports system, and regular Medicaid Services are not able to fully address the risk factors, a waiver participant has the discretion to enter into an Individual Risk Agreement (IRA) to assume responsibility and accountability of decisions. A risk agreement permits waiver participant to assume responsibility for his or her personal choices through surrogate decision making or through planning team consensus. This agreement in conjunction with the person-centered service plan outlines the risks and course of action. Enrollment and continuous participation in the waiver may be denied based upon a determination that the waiver participant may be unable to participate in the HCBS program despite the implementation of an individual risk agreement. Based on the evaluation of the risk agreement and the assessment of the waiver participant's medical, mental, psychosocial, physical condition and functional capabilities may indicate inability to participate in the waiver when the following conditions cannot be mitigated:

a. Waiver participant cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a Personal Emergency Response System;

b. Waiver participant, lacks the emotional, physical and protective support of a willing and capable caregiver, who must provide adequate care to oversee 24-hour hands-on support or supervision, to ensure the health, safety, and well-being of the

individual with debilitating medical and functional needs; or
c. Waiver participant's needs cannot be maintained by the system of services that is currently available to ensure the health, safety, and well-being despite an individualized risk agreement.
d. Waiver participant's primary private residence, is not reasonably considered safe to meet the health, safety and well-being in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the waiver participant's safety, and these issues cannot be resolved through waiver services or other means;
e. The waiver participant's residential environment would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager/care advisor due to: a) the presence of a physical or health threat due to the proven evidence of unlawful activity conducted in the primary private residence; b) threatening or physically or verbally abusive behavior, by the waiver participant, family member or regular visitor or household member in that home; c) more than two incidences of physically and verbally abusive behavior or threatening language; or d) the presence of a health hazard due to pest infestation.
f. Waiver participant's, legally responsible person or caregiver's safety of self and others is impeded by the participant's, legally responsible person's, or caregivers': a) continuous intrusive and oppositional behavior; b) attempts of suicide; c) behavior that is injurious to self or others; d) verbally abusive or aggressive behavior; e) destruction of physical environment; or f) repeated noncompliance of service plan and written or verbal directives; or
g. Waiver participant or primary caregiver or responsible party, continuously impedes the health, safety and well-being of the waiver participant, by refusing to comply with the terms of the service plan, refusal to sign a plan, and other required documents; when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal), refuses to keep the care manager or care advisor informed of changes in the status of the waiver participant, or the participant's, caregiver's, or other resident's behavior makes it impossible to staff aides to provide the required assistance
h. Waiver participant chooses to remain in a living situation, where there is a high risk, or an existing condition of abuse, neglect, or exploitation as evidenced by an Adult Protective Services assessment or care plan or the parent or responsible party refused to comply with Adult Protective Services where there is a high-risk factor of existing conditions of abuse, neglect, or exploitation.
For new individuals with any of the listed conditions addressed above, an acknowledgement agreement for a 90-day conditional waiver participation period may be implemented. During this 90-day period, an evaluation can be made to determine waiver participation is option for that individual and risks can reasonably be mitigated to ensure health and welfare. If not, disenrollment may be initiated.
For an active waiver participant, three (3) failed individual risk agreements for any one of the listed reasons may result in a disenrollment when a waiver participant willingly chooses to not follow care plan or IRA.
When a serious risk of harm is imposed upon a hired worker (in-home aide, respite worker, case manager or other professional), this serious threat may result in an immediate recommendation for disenrollment from the waiver if a plan cannot be created to assure the safety of the hired worker.
In addition to Risk Assessment and Mitigation Plan, each waiver participant will be required to have an emergency back-up plan. The emergency and disaster plan is created by the waiver participant with the assistance of the case manager. This plan specifies who will provide care when key direct care staff cannot provide services or tasks as indicated in the current service
plan. Because both personal and home maintenance tasks are essential to the well-being of the participant, the case manager is responsible for ensuring that an adequate emergency and disaster plan is in place. In the event of an emergency or an unplanned occurrence, the plan can include family, friends, neighbors, community volunteers and licensed home care agencies when possible. An emergency and disaster plan is necessary for times when the personal care aide or personal assistant is unavailable during regularly scheduled work hours or when the unpaid informal support is unavailable for the balance of the remaining 24-hour coverage period. The emergency and disaster plan is also necessary to document and outline what the care needs are required to be maintained during a disaster.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Each waiver participant is supported in selecting their providers through information and education during each step of waiver entry process (referral, LOC, assessment and service plan development). The CAP IT system generates letters at each step to inform the waiver participant about freedom of choice. This information informs of the right to choose any provider to render waiver and non-waiver services listed on the plan of care. When the waiver participant meets the criteria for waiver participation and is at the point to be assessed, a freedom of choice form is signed by the waiver participant to identify available providers of choice including choice of a case management entity. Each waiver participant is provided notices about informed choice of providers through a Participant disclosure letter, Waiver Introductory letter, Welcome Letter and a Waiver Anniversary Letter. Each letter clearly identifies what informed choice of providers is and how to make a complaint if choice is restricted or when there appears to be a conflict of interest.
The waiver participant is supported through this process by making available to him or her listings of available qualified providers and information about the providers. A resource /customer service line is available for the waiver participant to call and seek guidance. The case manager also supports the waiver participant to select a provider of his or her choice by linking the waiver participant to a qualified provider to engage in an interview or request additional information.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

On an ongoing basis, the State Medicaid Agency selects a representative sample of service plans completed by case management entities and assessments completed by the independent assessment entity for review and auditing to assess compliance. This sampling is performed on a quarterly basis. The representative sample consists of .95 confidence interval with a margin of error of 5%.

A quality assurance (QA) review will be conducted quarterly. Each case management entity is required to maintain a 90% compliance rate in service plan development. When a case management agency is performing less than 90% of compliance, the State Medicaid agency will provide technical assistance for 30- calendars days. Technical assistance will include a retraining, review of non-compliant areas, questions and answers sessions and monitoring. After the 30-day technical assistance time, an assessment of performance is measured. If the performance continues to be less than 90%, a corrective action plan is implemented that includes corrective steps negotiated by the case management entity and approved by the State Medicaid Agency. The corrective action plan will have a duration period for six (6) months that includes monthly over-the-shoulder monitoring by the State Medicaid Agency. Adjustment to the corrective action plan will be made as needed. If after the six (6) month's corrective action period, the case management entity compliance rate remains 89% or less in service plan development, the State Medicaid Agency will implement a transition plan to remove this responsibility from the case management entity.

The person-centered plan must included the following:

1. Have the required signatures on or before services begin;
2. Plan effective date;
3. Identification of services by name and in the amount, frequency and duration;
4. Have person-centered goals to meet care needs;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems;
7. Include a schedule of coverage over a 24 hour period;
8. Have a completed emergency and disaster plan

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☒ **Medicaid agency**
- ☐ **Operating agency**
- ☐ **Case manager**
- ☐ **Other**

Specify:

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The service plan implementation and monitoring are performed at the local case management entity's level. The appointed case management entity initiates a person-centered service plan with the waiver participant and monitors the plan. The State Medicaid agency ensures conflict-free case management through checks and balances managed by State staff. The checks and balances in place include assignment of an independent assessment entity to complete the initial eligibility phases of waiver consideration and validation of the developed service plan to ensure conflict of interest protections and appropriateness of care needs. Upon the approval of waiver participation, the day-to-day ongoing case management needs are provided by a case management entity the waiver participant/primary caregiver selects through freedom of choice. Upon an approved service plan, the case management entity authorizes or acknowledges the waiver and non-waiver services within 5 business days to qualified Medicaid providers in the amount, duration and frequency listed in the service plan. Prior to authorizing or acknowledging waiver services to a Medicaid provider, the assigned case manager confirms that the provider can provide the services within a reasonable timeframe (within five days to initiate the care plan). Each waiver participant is contacted monthly by the case management entity to undergo an assessment of his or her care needs and changes to medical condition, functioning level and social support system. Quarterly multidisciplinary team meetings are held with the waiver participant and all care providers to review the service plan, person-centered goals and desired outcomes to ensure the health and well-being of the participant. If during these scheduled times, a need is identified to revise the service plan or to conduct a new assessment of needs, the case management entity will initiate that process. The waiver participant also has the autonomy to reach out to the assigned case management entity, State staff or a representative from a provider to inform of concern(s) or a change in status to assure health and safety. The State Medicaid Agency has access to data that informs of hospitalizations, ER visits and APS referrals which is monitored regularly to allow for quick intervention to avert health and well-being issues. Monitoring tasks include assessing, planning, referring, linkage and follow-up. Upon the implementation of waiver services, the assigned case manager monitors the delivery, effectiveness and efficiency of all waiver services monthly with the waiver participant /responsible party. On a quarterly basis and as needed, the assigned case manager conducts home visits and on-site agency visits to monitor and observe the provision of waiver services. During these monitoring visits, the assigned case manager assesses medical, social, behavioral and functional areas to identify a change in status which may warrant a services plan revision.
The CAP IT system provides the quality assurance for service plan implementation and monitoring. Monthly reports and alerts are provided to the case manager to ensure appropriate implementation of the service plan as per policy. Real time reports and data are made available to the State Medicaid Agency to monitor the compliance rate and performance of all case management entities to ensure services are implemented within 5 business days of a services plan approval. The QIS is monitored monthly to ensure the safety and well-being of each waiver participant. The data analytic of service utilization, risks factors, incident reports
and complaints and grievances for the CAP QIS framework also allows for quick remediation.
A home visit must be conducted at least quarterly. However, an adult with moderate to high risk indicator scores as identified in a completed assessment must have a face-to-face visit as indicated per risk and monthly multidisciplinary team meeting. This visit is conducted in waiver participant's primary residence to ensure health and well-being.
The CME will observe the home environment for the provision of services by paid caregiver(s). Annually, a home visit must be conducted to perform the annual service plan or more frequently when needed.
•Make a monthly or as needed visit, based on risk indicators with the beneficiary/responsible party to review the health and care needs, satisfaction with services, and assess the provision of all services/supplies to confirm their continued appropriateness.
•Hold a quarterly multidisciplinary treatment team meeting with providers receiving a service authorization/participation notice to review the provision of and continued appropriateness of service plan.
•Document changes in medical, functional and psychosocial status.
•Review quality assurances reports monthly to remedy any identified issues.
•Contact the waiver beneficiary/responsible party following the construction/installation of home modifications to confirm that the modifications safely meet the waiver beneficiary's needs.
•Contact the waiver beneficiary/responsible party within 2 business days of learned discharge from a hospital/rehabilitation facility to assess health status and changes in needs.
•Ensure that services offered to a waiver beneficiary do not duplicate other services.
•Locate and coordinate sources of assistance from informal sources, such as the family and community, so that the burden of care is not exclusively the responsibility of formal supports.

Case Manager should complete monthly contact via telephone or other secured means of contact with the participant. Case Managers shall make sufficient (more than quarterly) face to face contact contingent to the risk factors and other factors that may jeopardize their health safety and wellbeing.
Face to face contact can be completed by Facetime, Skype, Video chat, Remote Patient Monitoring system. These types

of monitoring tools must be secured and permission to use such devices granted by the waiver participant. If these methods are used the participant will show the aide is present, and a virtual walk through will be completed either by the participant /aide/caregiver directing the device/camera throughout the home environment. The type of monitoring may only occur twice in the quarterly monitoring regiment which begins after the completion of the initial or annual assessment. Take for example, the first quarterly visit after the execution of the service plan that incorporates the risk mitigation plan must be face-to-face. The second and third quarterly visits may be conducted through technology when there is no evidence of a critical incident between the two monitoring periods. The fourth quarterly visit must be performed by a face-to-face visit.

The case manager must perform a monthly monitoring activity with the waiver participant and other service providers. During this monthly visit, the case manager can identify concerns with the service plan or other indicators that may jeopardize the waiver participant's well-being. If by routine monitoring, the case manager determines the service plan is not meeting the current and newly identified needs of the waiver participant, an ad-hoc multidisciplinary meeting must be scheduled within 15-day of awareness to discuss the concerns and to create a plan to mitigate risk and monitor care needs. These types of monitoring tools must be secured and permission to use such devices granted by the waiver participant.

Additional monitoring requirements includes completion of critical incident reports, completion of monthly and quarterly monitoring templates, upload of information in a communication log and technical assistance support from SMA. Each case manager is required to complete a critical incident reports for both Level I and II incidents within the specified timeframe. Completed reports are automatically transmitted to the SMA for monitoring of health, safety and well-being. The monthly and quarterly monitoring tools are programmed with risk indicators algorithms that provides a summary of risk factors based on the responses to the questions being asked. The summary report is transmitted to SMA for monitoring as well as to the CM. The summary report also provides next steps for the CM to perform to ensure a plan is executed to mitigate the identified risk factors.

b. Monitoring Safeguards. *Select one:*

○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**

◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

As a quality assurance to manage the monitoring of the service plan and to reduce conflict of interest for a case management entity that may be considered a dual agency, provider of case management and other Medicaid and waiver services,a clearly defined definition for COI is in place and is a requirement of the CME to follow and adhere and specific restrictive assurances are carefully monitored by State Medicaid Agency. These restrictive assurances include an analysis of network adequacy in that service region and a phone or mail questionnaire by representatives from the State Medicaid Agency to the waiver participant regarding access to his or her freedom of choice and engagement with the case management entity. As a means of documenting monitoring requirements and ensuring the waiver participant's needs are adequately met, the case management entity must review with the waiver participant information about disclosure of potential conflict of interest. The waiver participant must voice an agreement or provide written information that the person-centered plan continues to meet current health and social status. The CAP IT system has a function called a Local Authority Review which prompts an unbiased reviewer to ensure the monitoring of the service plan is conducted monthly and quarterly. This agreement is approved by the SMA.
When a CME is granted authority to act in a dual role, safeguards are in place to assure the CME administratively separates the plan monitoring function from the direct service provider functions. Two safeguards in are placed to manage potential conflict of interest in this area. The first safeguard is for the monitoring staff and the service rendering staff to be provided by two distinct units or personnel within that organization. The second safeguard is for the CME to have an independent reviewer to perform quality checks on a quarterly basis to assess concerns of conflict and needs of the waiver participant is adequately met. The case management entity is also required to assess provider network in the service region routinely for available providers and discuss free choice of provider (disclosure form) with the waiver participant on a quarterly basis. The SMA shall provide a quality review of all service plans to ensure the appearance of conflict is not indicated.
The SMA identifies in advance the potential agencies that will fall in this threshold through a network analysis on a quarterly basis. When an agency is approved to function in this dual role, the SMA monitors these agencies closely by the initial service plan, paid claims, revisions to service plans, monitoring of monthly and quarterly visit summary reports, incident reports and annual surveys.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

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

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

Performance Measure:
SP-A1 PM: #/% of waiver participants who had an initial comprehensive assessment completed prior to the development of the SP to identify needs and risk factors for

each waiver participation year N: # of waiver participants who had an initial comprehensive assessment completed prior to the development of the SP to identify needs and risk factors D: Total # waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*

(check each that applies):		
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**

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

Performance Measure:
SP-A2 PM: #/% of waiver participants who had a signed/approved SP that identified PC goals/strategies to meet identified needs through the provision of waiver services/other resources N: # Waiver participants who had a signed/approved SP that identified PC goals/strategies to meet identified needs through the provision of waiver services/other resources D: # Waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system CME	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

Performance Measures

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

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

Performance Measure:
SP-C1 PM: Number/percent of waiver participants who had a re-assessment of need and an updated SP to meet needs within 12 months of the previous assessment/service

plan for each waiver participant year N: Number of waiver participants who had a re-assessment of need and an updated SP to meet needs within 12 months of the previous assessment/service plan D: Waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-C2 PM: Number and percent of waiver participants who had a prior approval segment for all services listed in the updated service plan for each waiver participation year N: Number of waiver participants who had a prior approval segment for all services listed in the updated service plan D: Total number of waiver participants

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

CAP IT system Data Warehouse		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system Data Warehouse	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-C3 PM: Number and percent of waiver participants whose updated/revised service plans were initiated and processed within the established timeframe for each waiver participation year N: Number of waiver participants whose updated/revised service plans were initiated and processed within the established timeframe D: Total number of waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
CAP TT System	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-C4 PM: #/% of waiver participants who had a revised/updated SP when a change of status assessment of need was initiated during each waiver participation year N: # waiver participants who had a revised/updated SP when a change of status assessment of need was initiated D: # waiver participants who had a change in need who were reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

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

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

Performance Measure:
SP-D1 PM: Number and percent of waiver participants who had a PA segment in the type, scope, amount, frequency, and duration as authorized on the currently approved SP for each waiver participation year N: Number of waiver participants

who had a PA segment in the type, scope, amount, frequency, and duration as authorized on the currently approved SP D: Total number of waiver participants

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CSRA/NCTracks CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CSRA/NCTracks CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-D2 PM: Number/percent of waiver participants who had a current SA on file for each service provider to render services in the type, scope, amount, frequency, and duration authorized on the SP N: Number of waiver participants who had a current SA on file for each service provider to render services in the type, scope, amount, frequency, and duration authorized on the SP D: Waiver participants

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

CAP IT system GDIT/NCTracks		
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-D3 PM: Number and percent of waiver participants who had a monthly monitoring consultation with the CME to evaluate if services were delivered in accordance with the SP for each waiver participation year N: Number of waiver participants who had a monthly monitoring consultation with the CME to evaluate if services were delivered in accordance with the SP D: Waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CME CAP IT System	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-D4 PM: Number and percent of waiver participants who had a PA segment for each authorized service provider listed in the SP for the type, scope, amount, frequency, and duration for each waiver participation year N: Number of waiver participants who had a PA segment for each authorized service provider listed on the SP for the type, scope, amount, frequency, and duration D: Waiver participants

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System CSRA/NCTracks	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

e. ***Sub-assurance: Participants are afforded choice: Between/among waiver services and providers.***

Performance Measures

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

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

Performance Measure:
SP-E1 PM: #/% of waiver participants who received notification letters, for each waiver participation year, that included information about freedom of choice between/among waiver services and providers N: # waiver participants who received notification letters that included information about freedom of choice between /among waiver services and providers D: # Waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**

☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
SP-E2 PM: #/% of waiver participants who had on file an initial signed freedom of choice form electing to participate in this waiver N: # waiver participants who had on file an initial signed freedom of choice form electing to participate in this waiver D: # Waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system CME IAE	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system IAE CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT systme	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-E3 PM: #/% of waiver participants who had a signed freedom of choice of provider form on file for each waiver provider authorized to render waiver services for each waiver participation year N: # waiver participants who had a signed freedom of choice of provider form on file for each waiver provider authorized to render waiver services D: # waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other**	☐ **Annually**	☐ **Stratified**

Specify: CAP IT system CME		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin
☒ **Other** Specify: CME CAP IT system	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
SP-E4 PM: #/% of waiver participants who had updated and signed their freedom of choice forms annually to choose between/among waiver services and providers N: # waiver participants who had updated and signed their freedom of choice forms annually to choose between/among waiver services and providers D: # waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT System CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

The CAP IT system is a business system employed by the State Medicaid Agency to manage the service plan development and to ensure assessed needs are adequately planned in the type, scope, duration and frequency, initially, annually and as needed. This system assists in the discovery of non-compliant service plan development practices through aggregating and analyzing waiver activities workflow.
The CAP IT system performs the following tasks to ensure compliance to service plan development policies and procedures which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- Completion of a comprehensive assessment, initially and annually
- Risk indicators based on assessed needs
- RN exception reviews to reassess health care information, when applicable
- Person-centered service plan
- Notification letters to providers and waiver participants
- Individual risks agreements
- Service authorization
- Prior approval segments
- Workflow timelines and alerts

b. Methods for Remediation/Fixing Individual Problems

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

Upon the discovery of non-compliant waiver workflow activities in the area of service plan development, the State Medicaid Agency notifies the non-compliant entity within 30-days of the discovery; requests a corrective action plan and a root cause analysis to remediate the concerns. The State Medicaid Agency provides technical assistance and training on policies and procedures. The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant entity to ensure the corrective action plan is being followed throughout the duration of the action plan. If the non-compliant issue continues, a freeze on performing service plan development activities for waiver participants is imposed on that entity until continuous quality is achieved. If, after 3 months of assistance and remediation strategies are not productive and quality cannot be achieved, the entity assigned to complete service plan development responsibilities will be placed on a probationary status for 3 months (removed from the freedom of choice list until compliance is achieved during the probationary period). If after 6 months of probationary technical guidance and quality in the area of service plan is not achieved, the entity will be terminated indefinitely.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system CME	☐ **Annually**
	☒ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

◉ **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.

○ **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

◉ **Yes. The state requests that this waiver be considered for Independence Plus designation.**

○ **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The participant direction opportunities afforded to waiver participants:
This HCBS program allows a waiver participant to direct his or her care using a consumer-directed model of care using both the employer authority and budget authority. When a request is made to enter this HCBS program, a Participant Disclosure Form is provided to the interested individuals. Within this form information is provided about the service options of this HCBS program and the right to direct care once demonstrated competencies are confirmed to assume the role of employer or designation of a representative who can demonstrate the required competencies. An approved waiver participant may select this option of care at the onset of waiver entry or at any point in time during his or her waiver participation. To initiate enrollment in this model of care, each waiver participant must complete a self- assessment questionnaire and an orientation training before exercising his or her right to select this model of care. The self-assessment questionnaire identifies areas of strengths, weaknesses and opportunities for skill building to assume the role of employer while the orientation training introduces the waiver participant to consumer-direction policies and procedures, State Plan Medicaid terms, Internal Revenue Service requirements, Department of Labor laws and program integrity compromises. Upon the completion of the self-assessment questionnaire and orientation training, a waiver participant is placed on a path to direct his or her care. This path may be direct enrollment into this model of care once all administrative requirements are met or a transitional phase-in upon the completion of identified skill-building techniques as identified through the self-assessment questionnaire.
The process by which participants may access these participant direction opportunities:
During the comprehensive assessment phase of waiver enrollment, quarterly multidisciplinary team meetings or annual reassessment, the HCBS participant is asked if he or she is interested in directing care using the consumer-directed model. If the response is yes, the waiver participant is provided a self-assessment questionnaire to complete to allow the assessment of strengths, weaknesses and opportunities for skill-building in assuming the role of employer. The assessment areas of the self-assessment questionnaire include: Is Consumer-directed care right for me; What are my health care needs; What areas do I need help; Thinking Like an Employer, Findings the right Employee to meet my Care Needs; and Competency Validation of direct care staff. Upon the expressed interest to direct care using the consumer-directed model of care, the assigned case management entity conducts an orientation training and provide consumer-direction educational materials to ensure an informed decision to participate in this model of care is made.
Upon the demonstration of competencies to direct care, the waiver participant signs an enrollment agreement that states his or her willingness and capability to direct their care as evidenced by: their expressed understanding of the rights and responsibilities of directing one's own care; agreement to collaborate with entities that play a role in supporting participants who direct their care; agreement to validate all direct care workers prior to hiring and participation in annual consumer-direction education and training session.
The entities involved in supporting participant direction and types of supports by each entity:
There are three specific entities that support the waiver participant to successfully participate in this model of care. These entities are: State Medicaid Agency, Case Management Entity and Financial Management Services (FMS) providers.
The Medicaid State Agency:
Support is provided by the State Medicaid Agency through:
1. Development of policies and procedures for the administration of this option of care;
2. Administrative oversight to designated entities providing support to waiver participants;
3. Management of a grievance and complaint system to respond to grievances and complaints;
4. Management of a critical incident management system for the management of critical incidents while participating in this model of care; and
5. Quality improvement initiatives to remediate non-compliance discoveries for continuous quality improvement
The Case Management Entity:
Support is provided by the Case Management Entity through:
1. Direct contact with the waiver participant on a monthly, quarterly, and as needed basis to monitor health care needs and progression towards person-centered goals;
2. Regularly scheduled multidisciplinary team meeting to assess benchmarks, achievements, access to care concerns and other topics as identified;
3. Approval of the service plan to assist with authorizing providers of services as listed in the plan of care;
4. Arranging alternative care in the event natural support network is unavailable;
5. Assisting the waiver participant with grievances or complaints or filing an appeal, when applicable; or
6. Troubleshooting payment issues when there is a system error or payment failure.
The Financial Management Entity:
Support is provided by the Financial Management Entity through the completion of:
1. A consumer-direction orientation comprising of employer rules and labor laws;
2. IRS forms for employer and employee;
3. Background and registry checks and age verification on all interested employees;

4. Budget analysis based on negotiated hiring rates;
5. Expenditure reports to manage budget; and
6. Payroll to include tax withholding.
This entity provides customer service support to the waiver participant.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

The waiver participant is provided information about the consumer-directed model of care through an orientation and an Anniversary Notice. The orientation notice is provided to all new individuals who have an approved Service Request Form identifying clinical eligibility of level of care. This orientation notice provides information about the rights and responsibilities of participating in this type of HCBS program to include choice of waiver participation, provider, program selection, waiver services, abuse, neglect and exploitation, grievance and complaints and fair hearings. A resource guide is provided on consumer-direction to provide a high-level overview of this model of care. The anniversary notice is provided to all actively participating waiver participants to inform of the required annual reassessment and the need for the Independent Assessment Entity to schedule an appointment within 60 days of his or her original waiver entry date to maintain waiver participation. The anniversary notice provides information about which health care areas will be assessed, alternative care planning models such as consumer-direction and what happens when changes in care needs may jeopardize continuous participation in this HSBS program and the waiver participant rights to a fair hearing if waiver services are discontinued.
During each comprehensive assessment engagement and quarterly multidisciplinary monitoring engagement, if the waiver participant is not currently enrolled in the model of care, a question is asked if the participant wants to select consumer direction as his or her care model. If the response is yes, the Independent Assessment Entity (IAE) will provide the participant with a self-assessment questionnaire and additional information about consumer-direction. The IAE will inform the participant to complete the form in anticipation of the engagement with the selected case management entity to complete the service plan.
During the service plan development phase, the case management entity conducts an orientation to furnish information to the waiver participant or the participant's representative to allow informed decision-making and understanding of the consumer-directed model of care. Information provided orally and in writing to the waiver participant or the authorized representative includes the following:
• An overview of the consumer-directed model of care;
• Benefits of the consumer-directed model of care;
• An overview of the components included in the self-assessment questionnaire and instruction on how to complete the form and assess demonstrated competencies;
• Explanation of responsibilities of the participant or the designated representative;
• Explanation of assumed liability of participating in the consumer-direction waiver option;
• Overview of entities available to support the participant in consumer-directed services and the responsibilities of each entity;
• Explanation of employee/employer relationships that prohibit employment under the consumer-directed services option;
• Explanation of required minimum qualifications for employees in the consumer-directed services option;
• Overview of Medicaid fraud, waste, and abuse and the State Agency's Program Integrity unit;
• Department of Labor resource information regarding Final Rule requirements including but not limited to overtime and minimum wage payments; and
• Criteria for disenrollment from the consumer-directed waiver option.
The case management entity also links the waiver participant with a financial manager (FM) at initial onset of demonstrated ability to direct care to expose the waiver participant to training, education and outreach in the areas of IRS and DOL laws that govern consumer-direction. The FM conducts an in-person enrollment session. The information furnished to the waiver participant include:
• Explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual or designated representative to modify individual budget;
• Information in completing and filing IRS tax and agency required forms;
• Roles and responsibilities of FMS provider;
• Roles and responsibilities of the employer of record;
• Explanation of employee/employer relationships that prohibit employment under the consumer-directed services option;
• Explanation of required minimum qualifications for employees in the consumer-directed services option
• Information on criminal history record checks and explaining the criminal history identified during the check;
• Procedure of processing referral applications;
• An explanation of Bill of Rights;
• How to access customer services for guidance in technical problems or concerns
• How contact is maintained with the case management entity
• Department of Labor requirements
• Overview of Medicaid fraud, waste, and abuse

An annual overview of these areas is provided to each waiver participant during his or her annual recertification period. The waiver participant is granted sufficient time to make an informed decision to select this model of care. If the waiver

participant expresses non-readiness to direct care but feels this care model is a good fit for his or her lifestyle, the waiver participant may receive services through the direct-led model of care until readiness is demonstrated or the competencies are acquired. The assigned case management entity and the FM work with and provide the waiver participant the necessary tools and resources to acquire the skills to participant in this model care when he or she is ready.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one)*:

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.** Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

This HCBS program permits the appointment of a legal representative to direct care on behalf of the waiver participant. A legal representative is appointed when the waiver participant or the participant's responsible party requests assistance or has demonstrated a need for assistance. The case management entity assists the waiver participant in identifying a legal representative and assure the representative meets the specified criteria. The legal representative must:
• be at least 18 years of age;
• be approved by the waiver participant to act in this capacity;
• agree to a predetermined level of contact with the participant;
• demonstrate knowledge and understanding of the participant's needs and preferences;
• use sound judgment to follow the participant's needs and preferences; and
• comply with all program requirements.

The representative is not reimbursed for providing representative tasks. The case management entity is responsible to monitor activities to ensure the appointed representative acts in the best interest of the waiver participant. If a representative is identified, the representative will be asked to sign the "Representative Agreement" provided by the case management entity. The agreement outlines the requirements and expectations of the representative, and explains that the representative may be removed for not complying with the agreement. The assigned case management entity monitors the delivery of services monthly and reports any concerns to the FM and the State Medicaid Agency.

The representative may not be the personal assistant for the participant or provide any other paid waiver services.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Individual Goods and Services	☒	☒

Waiver Service	Employer Authority	Budget Authority
Financial Management Services	☒	☒
Participant Goods and Services	☒	☒
Respite Services	☒	☒
Training/Education and Consultative Services	☒	☒
Personal Assistance Services	☒	☒
Coordination of care - case management and care advisement	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Public or private entities that meet the required credentials may enroll as a Medicaid provider of financial management services. The entity must have the following credentials:
• A minimum of three years of financial management services experience with other departments or divisions of state government, county government, municipal governments, or large corporation employers;
• Experience and knowledge of the following: automated standard application of payment, check claims, electronic fund transfer, electronic fund account, invoice processing platform, judgement fund, payment application modernization, prompt payment, automated clearing house, Cash management Improvement Act, Governmentwide Financial Report System (GFRS), governmentwide accounting, intergovernmental reconciliation, standard general ledger, and tax payer identification number processes;
• Have the capacity to provide financial management services through the Budget and Employer Authority models of consumer-directed care; and
• Authorized to transact business in North Carolina.

Because these entities are private entities, 45 CFR § 92.42 are adhered. The procure process is a request for information (RFI) to render FMS. The receipt of the information is reviewed to determine ability to render this type of service. Multiple entities may be selected to furnish FMS.
The provider must meet all the qualifying conditions listed in Appendix C-1/C-3 and all other Medicaid enrollment requirements. A managed change request is submitted to MMIS for provider enrollment to request consideration to render FMS and approved by the member of the waiver unit.

A managed change request is submitted to MMIS for provider enrollment to request consideration and approval to render FMS.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The FMS provider is enrolled as a Medicaid provider approved to render financial management service which is an approved home and community-based services of this HCBS program. This service is called financial management and is reimbursed in 15-minute increments. The maximum utilization per month is one (1) hours. The FMS provider is compensated a one-time fee for the enrollment activities completed and a monthly fee for ongoing FMS provided to the participant. This service utilization is included in the service plan in the amount, frequency and duration. Claims are made to the MMIS for reimbursement of start-up and monthly management fees.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☒ **Assist participant in verifying support worker citizenship status**

☒ **Collect and process timesheets of support workers**

☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**

☒ **Other**

Specify:

The FMS provider completes criminal history record and health care registry checks on the personal assistant(s) and assist the waiver participant or designated representative in understanding the findings of the reports. The FMS provider educates the waiver participant on protocol in the event a report returns with results that are not in compliance with the State Agency's criteria for personal assistant in the consumer-directed model of care.
The FMS provider provides education to the waiver participant on responsibilities of being an employer and information on appropriate employee/employer relationships.

Ongoing customer service support is provided to assist the waiver participant or designated representative with any questions or concerns related to services provided by the FMS provider.

Supports furnished when the participant exercises budget authority:

- [x] **Maintain a separate account for each participant's participant-directed budget**
- [x] **Track and report participant funds, disbursements and the balance of participant funds**
- [x] **Process and pay invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other services and supports**

Specify:

The FMS provider issues guidance to the waiver participant or designated representative on appropriate spending practices to ensure spending is within budgetary limitations (i.e. discussion of overtime payment to employees, factors that may affect pay rates, such as tax factor changes).

Additional functions/activities:

- [ ] **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

As a Medicaid provider, the FMS provider must complete recertification every five years. The State's Medicaid fiscal agent oversees provider enrollment and recertification to ensure the FM continues to meet the requirements for a Medicaid provider.

The State Medicaid and the case management entity monitor the execution of the FMS to ensure compliance with waiver policies and procedures. Expenditure reports are reviewed regularly to ensure consumer-directed services are managed appropriately by the FMS provider.

The CAP IT system in conjunction with the case management entity generate prior approval notices to the FMS provider and the State's Medicaid fiscal agent that identify the type, amount, frequency, and duration of approved services to provide. The State's Medicaid fiscal agent monitors the prior approval notices monthly to ensure financial transactions are within the established allowable limits.

The State Medicaid agency conducts monthly monitoring reviews with the FMS provider to address performance, incidents, and provisions of financial management services.

The FMS provider shall provide quarterly reports to the State Medicaid Agency to include detailed payroll budget utilization reports (per waiver participant) that includes:
• Vendor name
• Vendor number
• Case management entity name
• Care advisor name
• Participant name
• Participant identification #
• Authorization date: From___ To____ for participant
• Service code(s) for authorized services
• Annual authorization $ amount for participant
• Amount of FUTA, SUTA, and FICA taxes withheld within current quarter
• Payroll period(s): From ___ To ___ within current quarter
• Participant's total expenditure for pay period(s) within current quarter
• Name, number of hours worked and rate of pay for each participant's personal assistant designated personal assistant hours per week within current quarter
• Total number of hours worked, gross wages, net wages, FICA taxes, and other deductions for each personal assistant within current quarter
• Authorization budget balance carried forward for waiver participant
• Amount remaining on annual authorization for waiver participant
• Annual authorized amount for participant for other consumer-directed services
• Budget balance carried forward for participant for other consumer-directed services
• Expenditure amount for pay period for participant for other consumer-directed services
• Workers Compensation policy date: From_____ To_____ for participant
• Workers Compensation annual policy premium rate for participant
• Workers Compensation bi-weekly amount for participant

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Information and assistance is provided to support the waiver participant or designated representative in the consumer-direction model of care through a selected case management entity using case management services. The case management service for this model of care is called care advisement. Case managers transition into the role of care advisors when assisting a consumer-direction waiver participant. The care advisor provides information and assistance to the waiver participant or designated representative during initial entry into the waiver, reassessment, monthly monitoring and on an as needed basis. The care advisor's role is to empower the waiver participant to define and direct his or her personal assistance needs and services. The Information and assistance provided by the care advisor to the waiver participant include:
• How to make informed decisions about what will work best for waiver participant's lifestyle;
• Assistance with identification of the services that are consistent with waiver participant's needs,
• Assistance with identification of available services and supports that reflect the waiver participant's circumstances, and
• Assistance with incorporating person-centered goals into a service plan.
The information and assistance provided by the care adviser equips the waiver participant with sufficient information to voice understanding of the responsibilities involved with directing care using the consumer-direction model of care.
Information and resources provided to the waiver participant also include:
• Expenditure reports to ensure the identified budget does not exceed the monthly budgetary limits;
• Identification of risk indicators to manage health and welfare concerns;
• Tools to identify appropriateness of a network system and informal supports;
• Identification of limitations that may create the need for a representative for the waiver participant;
• Department of Labor Laws;
• Program Integrity hotline
• Adult Protective Services hotline to report ANE
• Time and task sheets

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Equipment, Modification and Technology	☒
Individual Goods and Services	☐
Community Integration Services	☐
Community Transition	☒
Financial Management Services	☒
Participant Goods and Services	☒
Personal Emergency Response Services	☒
Respite Services	☒
Training/Education and Consultative Services	☒
CAP In-Home Aide	☒
Specialized Medical Supplies	☒
Meal Preparation and Delivery	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Personal Assistance Services	☒
Coordination of care - case management and care advisement	☒
Nutritional Services	☐
Coordinated Caregiving	☒
Pest Eradication	☐
Adult Day Health	☒

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Waiver participants are provided with information on opportunities to access independent advocacy. This information is provided by the case management entity and the financial managers during initial enrollment, anniversary and upon a request. Independent advocacy may be obtained through by the following agencies: Community Resource Connection program sponsored by the Division of Aging and Adult Services (DAAS), NC 211, the Department of Health and Human Services (DHHS) Call Center, and Legal Aid of North Carolina.
The DAAS provides counseling, training, and technical assistance in how to live independently and how to arrange and access resources in the community. North Carolina has various DAAS offices located throughout the state and accessible Monday-Friday from 8am-5pm for in person, in writing, or telephone assistance.
The NC 211 and DHHS Call Center provides information, referrals, education and outreach to individuals requesting assistance. The NC 211 and DHHS Customer Service Center is available 24-hours, 7-days per week and includes interpretive services for non-English speaking callers.
Legal Aid of North Carolina offers free legal services in civil matters to low-income individuals. Legal Aide offices are located throughout the state and accessible Monday-Friday from 8am-5pm.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily

terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A waiver participant enrolled in consumer-direction may elect to withdraw from this option of care at any time. A transition plan is created immediately upon the expressed desire to transition to direct-led model of care. The transition date is planned for the last day of the transition month to allow the alternative service delivery method to occur the first day of the month following the transition month. The following steps are followed to complete a waiver participant requested to transition from the consumer-directed model of care:
1. The waiver participant or designated representative informs the assigned case management entity of his or her desire to transition from the consumer-directed model of care.
2. The case management entity provides the waiver participant or designated representative with a freedom of choice form to select a service provider agency to provide personal care services.
3. The case management entity collaborates with the waiver participant or designated representative to update the person-centered service plan to reflect the transition from consumer-directed model of care. The waiver participant or designated representative confirms his or her agreement to transition by signing the service plan.
4. The case management entity submits the updated person-centered plan of care into the CAP IT system.
5. The CAP IT system analyzes the person-centered plan of care to ensure accuracy of performance measures to allow for approval and sign off by the local approval.
6. The CAP IT system generates the new program participation letter and the case management entity sends a letter to the waiver participant. Newly selected providers are provided service authorization letters.
7. The waiver participant or the designated representative and the FMS provider notify the personal assistant(s) of the transition to direct-led model of care.

The waiver participant service provision is uninterpreted as well as the preservation of health, safety, and well-being for the duration of the transition. The case management entity increases the oversight and monitoring of the beneficiary to a weekly basis to mitigate any unplanned or unforeseen risks.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

The State Medicaid Agency will involuntarily remove a waiver participant from the consumer-directed model of care and require the participant to receive provider-managed services when the following concerns cannot be managed despite agreements and support
• Immediate health, safety, and well-being concerns
• Utilization of funds exceeding planned expenditure levels for consumer-directed care when the overage cannot be managed through corrective actions and measures
• Substantiated fraud, waste, and abuse from the waiver participant or designated representative
• Substantiated abuse, neglect, or exploitation from a personal assistant and the inability to select a new personal assistance
• Demonstrates inability to consumer-direct as evidenced by consistent non-adherence to program rules despite corrective actions and measures
• Confirmed misuse of waiver funds and services
• Repeated use of unapproved expenditures that cause the budget to be over maximum limits
• Conflict of interest by the waiver participant's responsible party which ultimately places the waiver participant at greater risk
• Inability or unwillingness to select an approved representative when the need for a representative has been identified by the State Medicaid Agency, Financial Management entity or case management entity
• Refusal to accept training or arrange training for hired workers
• Refusal to allow case management entity to monitor services
• Refusal to participate in mandatory monthly and quarterly monitoring requirements
• Non-compliance with supportive entities to include the State Medicaid agency, case management entity, or FMS provider
• Non-compliance with an established corrective action or quality assurance plan issued to the participant or designated representative
• Inability to implement the approved plan of care or comply with waiver requirements

The State Medicaid Agency will remove a waiver participant from the consumer-directed model of care if any of the above items occur three times or more in a 12-month period as documented by a completed participant corrective action plan. Immediate termination from consumer-directed model of care may occur if there is blatant misuse of waiver funds or the participant's health, safety, and well-being is in jeopardy. Prior to considering initiating a termination from consumer-direction, the case management entity will report the concern or allegation to the State Medicaid Agency. The State Medicaid Agency will investigate the concern or allegation. The State Medicaid Agency will review all available documentation related to the concern or allegation. Upon review of all information; the State Medicaid Agency will make a determination of immediate removal from the consumer-directed model of care. The State Medicaid Agency will coordinate with the case management entity to complete processes for the removal.

The participant will receive written notification on the involuntary termination and the timeline of the transition. All supportive entities; State Medicaid Agency, case management entity, and FMS provider will coordinate to establish a timeline and effective date of the termination. The participant will be allowed the opportunity to select provider-managed providers to receive services. The FMS provider and participant will inform the personal assistant(s) of the transition and the impact the transition will have on their employment.
To ensure continuity of care and the waiver participant's health, safety, and well-being, the waiver participant will continue to receive services as listed on the current person-centered plan of care until consumer-directed model of care is terminated. If this termination required immediate removal from this model of care, the State Medicaid Agency will arrange for the waiver participant to select a provider who is able to submit claims for consumer-directed services until the program changes are made.

The participant has the option to file an appeal regarding the concerns resulting in the termination from this model of care. Upon the change to the new model of care, the waiver participant will be provided a change of program notice at which time he or she may request an appeal. If an appeal is requested and the waiver participant is not in immediate jeopardy, consumer-directed service will continue through the duration of the appeal through maintenance of service.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction

opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		2170
Year 2		2384
Year 3		2622
Year 4		2888
Year 5		3176

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☒ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Associated costs for staff recruitment, hiring, and verification of qualifications may be compensated by the participant's participant goods and services budget.

Staff criminal history and background verification is reimbursed to the FMS agency by Medicaid through the waiver service, Financial Management Services.

☒ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

None

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Each waiver participant will have a maximum budget limit to negotiate a pay rate for hired employees. The approved negotiated rate is included in the service plan which is developed based on the methodology currently in place as listed in Appendix C-4. The process involves the completion of an assessment to identify needs; development of goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. A completed assessment identifies the composite score for complexity of need of the waiver participant to ensure appropriate planning of care needs and resources. All formal services are listed in the plan of care to identify an estimated monthly cost of care for all waiver service to ensure the cost does not exceed the estimated monthly cost of an individual in an institution. During the enrollment into consumer-directed care, the FMS provider provides information to the waiver participant regarding how to set a rate of pay including flexibility for pay increases, unexpected changes, maximum utilization of waiver services, Department of Labor overtime and minimum wage requirements. Information shared include how the pay rate must budget for wages for the personal assistant(s), applicable taxes, insurances overtime payment and Workman's Comp. To provide the waiver participant with an overview of monthly expenditures under the consumer-directed model of care, the FMS provider creates a consumer-directed budget. The FMS provides information to the waiver participant or designated representative to ensure understanding and agreement about how to establish and manage a personal assistance budget. An example of a completed budget is shared with waiver participant to build competencies. The negotiated pay rate is added to the plan of care to ensure the rate does not exceed the State Medicaid Agency approved reimbursement limits including applicable taxes, insurances overtime payment and Workman's Comp. An assessment of the service plan is reviewed with the waiver participant monthly to determine any changes in the participant's status that may warrant a modification of the budget.

The SMA posts publicly a Fee Schedule that lists the maximum reimbursement for waiver services that can be directed by the waiver participant. One other training document is used that is publicly available to the waiver participant and other stakeholder is a budgeting resource tool. This tool provides information about the budget and how to create a budget. The waiver participant is informed of the maximum limit. Through training and education by the SMA and the FMS, the waiver participant is taught how to create a range of pay within the maximum limit and DOL guidelines that is consistent with their budget

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The waiver participant is informed of the amount of the consumer-directed budget during initial enrollment, quarterly monitoring periods and during the annual reassessment and as requested by the waiver participant. The FM provides the waiver participant or designated representative with a monthly report to show his or her current budget and utilization trends. The waiver participant may request and view information about his or her utilization trends upon request from the FM.

To request an adjustment in the budget amount; the waiver participant must request a change of status assessment through the case management entity to initiate this process. The case management entity will complete an assessment and the information is entered into the CAP IT system to determine the complexity of need and budgetary limit.

To request an adjustment in the budget related to negotiated pay rates; the waiver participant must request the change from the FM; in coordination with the assigned case management entity. Any requested changes must correspond with established budgetary limits. The FM will review the requested changes with the waiver participant and correspond with the case management entity to determine if the budget amount can accommodate the pay rate changes based on the State Medicaid Agency maximum reimbursement limits.

A waiver participant whose request is denied for a budget adjustment or when a budget is reduced, is granted the opportunity for a Fair Hearing as outlined in Appendix F, when a service request is denied, reduced or terminated.

Prior the denial of the request or the reduction of the budget, information is provided to the waiver participant by the case manager or financial manager about why the request approved or why the budget must be reduced. The CM and FM work closely with the waiver participant to determine strategies to adjust the budget or prevent a reduction in the services. When no other alternatives are available, the waiver participant is provided an adverse notice with appeal rights.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- ○ **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ◉ **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

The waiver participant may request modifications to the budget amount at any time to the case management entity. A request to the waiver participant-directed budget requires the completion of a change of status assessment. The change of status assessment is initiated in CAP IT system and completed by the case management entity. The CAP IT system will determine the updated budgetary limits based upon the participant's composite score for complexity of need. Modifications to the participant-directed budget are documented in the service plan by the case management entity. The updated participant-directed budget information is forwarded to the FMS to ensure utilization is consistent with budget modifications.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The FMS provider tracks the usage of the participant-directed budget monthly. The FMS provider generates expenditure reports that illustrates utilization of the waiver participant's budget. The waiver participant, Medicaid State Agency, and case management entity have access to review the budget reports. The FMS shall report any identified "red flag" cases to the State Medicaid agency. Red flag cases are cases that illustrate over utilization of the consumer-directed budget or cases that have the potential to exceed the consumer-directed budget. The Case management entity conducts monthly and quarterly monitoring the waiver participant which include a review of the participant's budget report. Reports that indicate budget concerns (over-utilization or under-utilization) are reviewed and discussed in detail with the waiver participant to develop an action plan to ensure utilization aligns with the established budgetary limits. Continued instances of over-utilization or under-utilization must be reported to the State Medicaid agency. The State Medicaid Agency will conduct a review to determine if consumer-directed care remains appropriate or if a transition to provider-managed waiver option is necessary.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Each individual or currently enrolled waiver participant is granted a Fair Hearing when an adverse decision is made for initial waiver entry, ongoing waiver participation, denial of a provider or program choice or when a requested waiver service is reduced, denied, terminated or suspended or not honored. A Participant Disclosure form is a method used to inform interested individuals and active participants about the fair hearing process when accessing services through this HCBS program. This form is provided after the analysis of a submitted service request form that determines clinical eligibility for HCBS participation as well as during the annual reassessment for HCBS participation. The form clearly outlines the steps for eligibility for waiver entry and access to waiver services, rights to request a fair hearing when an adverse decision is made and how to request a fair hearing. Contact information such as telephone numbers and addresses are provided on the Participant Disclosure Form. In addition to the Participant Disclosure Form, when an adverse decision is made, each waiver participant is granted a letter of notice that clearly describes the original request and the reason(s) the request was denied, reduced or terminated. The notice letter also includes instructions on how to appeal this adverse decision. Included in the adverse letter notification is an appeal form with pre-populated identifying information to allow ease of filing. The waiver participant is instructed to mail in the letter within the prescribed time frame to continue to receive services through maintenance while the request goes through the fair hearing process.
The State Medicaid Agency manages all adverse hearing to ensure timelines were met, clear supporting information is provided for the adverse decision and service entitlements are maintained during the appeals process.
The Fair Hearing timelines are listed below and can be access through this link:
https://files.nc.gov/ncdma/documents/files/DueProcessRights050311.pdf

Appealing a Medicaid Adverse decision 30 days of the date the notice was mailed
Hearing resolution 90 days of the (Office of Administrative Hearing) OAH's receipt of the completed Recipient Hearing Request Form
Maintenance of Service (MOS) Appeal request submitted 10-30 days for the date the notice was mailed

How notice is made, the entity or entities responsible for issuing the notice and where notices of adverse actions and the opportunity to request a Fair Hearing are kept:

The notice about the fair hearing is provided to the waiver participant by the entity performing the specific task of determining eligibility of a request. The Independent Assessors will provide the Participant Disclosure Form when an initial request to participate in this HCBS program is made. This notice provides the interested individual basic information about entry eligibility and steps to take if an adverse decision is made or when a request is not honored. This form is mailed to the individual in regular US Mail along with a consent form to gather pertinent health information. The IAE also makes direct contact with the interested individual by telephone or in person to discuss this process and reasons adverse decision may be made.
The Independent Assessment Entity is responsible for providing an adverse notice to a newly interested individual or an active HCBS participant if the assessment of need is denied for HCBS participation. This adverse notice is mailed. The IAE also makes direct contact with the interested individual by telephone or in person to discuss this process and reasons an adverse decision were made. The IAE sends the notice by trackable mail to the individual using the State Medicaid address on file or the most recent address if the individual is not eligible for Medicaid. The mailing is tracked to ensure it was retrieved by or delivered to the individual within the established time line. An electronic copy of the letter is maintained in the IT system for reference as well as access for the assigned case manager to reference.

The case management entity (CME) will provide an adverse notice if a service plan or item(s) on a plan of care is denied, reduced, terminated or suspended. The case management entity is responsible for providing an adverse notice to an individual if service plan or plan of care is denied, reduced, suspended or terminated. The waiver participant may request a fair hearing if he/she feels a service request was not honored/acknowledged. This adverse notice is mailed. The CME also makes direct contact with the individual by telephone or in person to discuss this process and reasons adverse decision was made. The CME sends the notice by trackable mail to the individual using the State Medicaid address on file or the most resent address if the individual is not eligible for Medicaid. The mailing is tracked to ensure the notice is was retrieved by or delivered to the individual within the prescribed time line. An electronic copy of the letter is maintained in the IT system for reference.

Assistance (if any) that is provided to individuals in pursuing a Fair Hearing
The Participant Disclosure Form provides interested and active participant's contact information to the State Medicaid Agency, the case management entities in the catchment area, the IT contracted vendors and the customer support center/call center to request assistance when needed. The adverse notice and the appeal form also includes similar information. The interested or active participant may request assistance from anyone to assist to pursue a fair hearing. The CME also aid an active HCBS participant in pursuing a fair hearing.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The state operates an additional dispute resolution process**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ( ) **No. This Appendix does not apply**
- (●) **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

DHHS – State Medicaid Agency

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Types of grievances/complaints that participants may register
A HCBS participant may register a grievance or complaint regarding any subject matter pertaining to waiver participation or dissatisfaction with services or providers. Common grievances/complains may consist of the following:
• Program integrity concerns such as perceived exploitation of funds beneficiary/caregiver fraud, provider fraud
• Rights and responsibilities concerns such as perceived violation of privacy/rights unethical behavior
• Qualified provider concerns such as perceived unqualified personnel, unauthorized services, disregard for the plan of care, inadequate or inappropriate care or service delivery, no supervision, staff unreliable – late or doesn't keep schedule, customer service issue, constant staff turnover, staff not courteous or respectful of the beneficiary and or family
• Service provisions concerns such as delayed services, service limitations, non-covered service, placement on a wait list, and billing and reimbursement errors
Complaints can be reported by:
• Waiver participant or Representative
• Direct Service Provider
• Case Management Entity
• CAP IT System
• Independent Assessment Entity
• Stakeholders
Complaints may be submitted both verbally and in writing. Persons submitting verbal complaints will be encouraged to put the complaints in writing. Complaints can be received through mail, email or fax.
Anonymous complaints will be reviewed in situations that allege issues that are critical to the health and safety of an individual served. Complaints alleging abuse, neglect or exploitation will not be handled through this complaint protocol. A critical incident report will be completed by the case manager; and a referral made to Adult Protective Services.

(b) The process and timelines for addressing grievance/complaints
Complaints/Grievances/Inquiries come directly to State Medicaid Agency staff via telephone, email, mail or the IT Case management system called e-CAP. Complaints/Grievances/Inquiries may also come in as Constituent Request through the DHHS Director's Office, NC Governor's Office, DHHS Secretary's office of Government Affairs, NC General Assembly Members/Division Staff, US Congress Members. The grievance/complaint is assigned to a subject matter expert for research and analysis to formulate a response and identify the root cause.
Constituent Requests require that State Medicaid Agency staff to take appropriate action to resolve the request and compose a comprehensive response to the constituent or referral source in a business letter format referencing the Requestor name, referral source, Date of Inquiry, issue, State Medicaid Agency staff actions in chronological order to include dates and names of State Medicaid Agency staff and the external parties contacted. State Medicaid Agency staff must also indicate the resolution date and the outcome. Constituent Request responses must be approved by the Division prior to forwarding finale response to the constituent. Responses to Constituent Requests are due within 3 business days, but may require an extension due to data report generation or external collaboration. When Constituent Requests are assigned with an "Urgent" status they require same-day completion.
If it is determined that a Complaint/Grievance/Inquiry does not require a formal response to NC Governor's Office, DHHS Secretary's office of Government Affairs, NC General Assembly Members/Division Staff, US Congress Members, State Medicaid Agency staff will take appropriate action to resolve the Complaint/Grievance/Inquiry and will provide a resolution within 3 business days when possible. Depending on the need for external collaboration, a more extended resolution time may be required.
The following actions may be taken:
o No action needed
o Technical Assistance required
o Recoupment/Overpayment
o Recommendation for Termination
o Referral to Program Integrity
o Referral to Division of Health Service Regulation
o Referred/reported complaint to DHHS Division
o Development of a Quality Improvement Plan
o Recommend care giving training/teaching
o Recommend staff training/teaching
o Recommend change in treatment regimen
o Implementation of a Risk Agreement
o Implementation of a Corrective Action Plan

All Complaints/Grievances/Inquiries and Constituent Request are documented in e-CAP or in a shared drive and archived for trending.

The complainant is informed that filing a grievance or complaint does not substitute for a fair hearing.

(c) The mechanisms that are used to resolve grievance/complaints
Complaint investigations may include but is not limited to interviews with the beneficiary, formal and informal supports or other appropriate individuals, record reviews, staff interviews, site visits, documentation for billing and e-CAP monitoring system.

An official written response is provided to the complainant to address the grievance/complaint. A description of the concern is restated to ensure understanding and information is provided about the steps taken to research or invest the concerns and lately information is provided about the steps the Division will make or the complainant could take to resolve the identified issues. If there is discovery of non-complaint areas during the research or root cause analysis steps, the State Medicaid Agency identify areas for remediation and opportunities for continuous improvement. Changes are immediately made to workflow and training is provided.
Data collected will be aggregated and used to identify system-wide issues, for risk prevention and to improve the quality of services. The Quality Unit will direct an analysis of the compiled data. This will include trends in type and provider and effectiveness of district response. This analysis will be part of the quality management team activities and will be reviewed monthly.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

To safeguard the health and welfare of each approved waiver participant, the State Medicaid Agency, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation (ANE) and other critical incidence. To assure the health, safety and well-being of each waiver participant, the case management entities (CMEs) shall engage in a multidisciplinary treatment team (MDT) meeting quarterly and, on an ad-hoc basis when needed. To mitigate the waiver participant's health and welfare when a critical incident occurs, it is mandatory for all case management entities to complete a critical incident report and investigate the incident each time a waiver participant has been involved in a critical incident that jeopardizes his or her health, safety and well-being. Upon knowledge of the critical incident, a report must be completed within 3 business days. Each case management entity is provided access to the critical incident report (CIR) developed by the State Medicaid Agency (SMA).

The Critical Incident Form has automatic fill-in responses through drop-down box options. The form is accessible through the CAP IT system. The CAP IT system will track receipt of all critical incident reports to assure timeline is adhered. State Medicaid Agency staff will also follow-up to assure the identified waiver participant is receiving the necessary services as identified through the recommendation of the incident report.

Level of reporting is managed by two incident levels: Level I and Level II.
Incident reports, including follow-up action requirements, are defined as one of two levels.
Level I incidences must be reported within 3 business days in the CAP IT system. These incidences include: hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered.
Level II incidences must be reported within 3 business days to State Medicaid Agency. These incidences include, APS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, falls requiring hospitalization or results in death, traumatic injury, medication administration that results in injury or hospitalization, wandering away from home, homicide/suicide and media related events.

Incidences of abuse, neglect and exploitation must be reported to the appropriate authority and carefully followed to assure services are adequately met to keep the waiver participant safe in the community.
Level I Critical Incidents
Accident or Injury (LEVEL I)
Accident or Injury is defined as an incident resulting in the need for medical services beyond first aid (e.g. fractures, some falls, burns, lacerations/wounds, etc.) and/or patterns of injuries that may potentially indicate an immediate or serious risk of participant safety. This could include a pattern of repeated falls.
Deaths by Natural Causes – Explained Death (LEVEL l)
Death caused by a long-term illness, a diagnosed chronic medical condition, serious acute illness or other natural/expected conditions resulting in death.
Emergency Room Visit (LEVEL I)
Emergency Room visit means an emergency room visit for an assessment or for the management of an unstable health condition or high-risk behavior that does not result in a hospital admission.
Hospitalization (LEVEL I)
Hospitalization means an overnight admission, whether scheduled or unscheduled, but not expressly for psychiatric issues.
Inpatient Psychiatric Hospitalization (LEVEL I)
Inpatient psychiatric hospitalization means an emergency, overnight admission for assessment or management of an unstable psychological condition or high-risk behavior that require management by a physician.
Level II Critical Incidents
Abandonment (LEVEL II)
Abandonment is defined as the desertion of a participant by an individual who has the responsibility for providing care for that participant, or by a person with physical custody of that participant. This may include desertion of a participant at a hospital, nursing home or other location.
Abandonment may need to be reported as neglect.
Abuse (LEVEL II)
Abuse can be physical, sexual, emotional or verbal.
1. Physical Abuse is defined as the use of physical force that may result in bodily injury, physical pain, or impairment. Physical abuse may include, but is not limited to such acts of violence as: striking (with or without an object), hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, or burning. Additionally, use of physical restraints, force-feeding, and physical punishment of any kind are examples of physical abuse.
2. Sexual Abuse is defined as non-consensual sexual conduct of any kind with a participant. It includes, but is not limited to, exposure to unwanted sexually explicit material or verbal harassment of a sexual nature, unwanted touching, all types

of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.
3. Emotional or Psychological Abuse is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Emotional/psychological abuse may include, but is not limited to verbal assaults, threats, intimidation, insults, humiliation, and harassment. In addition, treating a participant in a matter not appropriate for their age, isolating participant from his/her family, friends, or regular activities, giving a participant the "silent treatment," and enforcing social isolation are examples of emotional/psychological abuse.
4. Verbal abuse is defined as the use of any oral or gestured language that includes disparaging or derogatory terms to participants, or within their hearing distance, regardless of the participant's age, ability to comprehend, or disability.
Death – Unexplained Deaths (LEVEL II)
Death means the end of life. ALL DEATHS MUST BE REPORTED in as much detail as possible. The reportable event must describe the circumstances surrounding a participant's death. Unexplained deaths need to be differentiated from deaths that are explained deaths (meaning they were expected or considered a result of natural causes). An Unexplained Death is defined as a death suspected to have resulted from other than natural causes, potentially due to abuse or neglect or such as an occurrence of medical error by others. The circumstances surrounding an unexplained death must document fully all available information about the death including contributory events and a clear explanation of why the death is considered unexplained (resulting from other than natural causes). If autopsy, protective services or police reports are available, they should be uploaded into the Critical Incident form.
Exploitation – Financial/Theft (Immediate Jeopardy) (LEVEL II)
Exploitation means taking advantage of a waiver participant for personal gain by manipulation, intimidation, threats, or coercion. It involves the misuse of a vulnerable participant's funds, property, or person. Examples may include, but are not limited to:
• alleged fraud,
• use of participant funds for purchases without providing and maintaining itemized receipts
• cashing an individual's checks without authorization or permission,
• forging a participant's signature,
• misusing or stealing a participant's money or possessions,
• destruction of a participant's personal property,
• withholding a participant's funds,
• coercing or deceiving a participant into signing any document, or
• improper use of conservatorship, guardianship, or power of attorney.

Injuries of unknown source (Level II)
An injury should be classified as an "injury of unknown source" when both of the following criteria are met:
• The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and
• The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

Missing Person (LEVEL II)
Missing Person / Elopement is defined as a participant whose whereabouts are unknown and he/she is considered missing. A missing person does not include a participant who is able to leave the facility to pursue activities, shop or visit with friends or relatives, unless the participant cannot be located after a reasonable time has elapsed without contact. A missing person report is not needed for a participant who lives with unpaid caregivers or housemates (such as natural family) unless the families have requested assistance locating the missing person or while the participant was receiving a waiver service. Even if the participant has been located, a completed Reportable Event form is required.
Neglect (Immediate Jeopardy) (LEVEL II)
Neglect is defined as the refusal or failure to provide a participant with such life necessities as food, water, clothing, shelter, personal hygiene, medicine, medical care, personal care, comfort, personal safety, supervision, and other essentials included in an implied or agreed-upon responsibility to a participant.
Self-neglect is characterized as the behavior of a participant that threatens his or her own health or safety including substance abuse and dangerous behavior. Self-neglect generally manifests itself as a refusal or failure to provide himself or herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.
Restraints / Seclusions (LEVEL II)
Restraints / Seclusions are defined as physical, chemical or involuntary seclusion. Physical restraint means any manual method, physical device, material, or equipment, attached or adjacent to a participant's body, that:

• a participant cannot remove easily,
• restricts freedom of movement or access to the participant's own body, or
• is used for discipline or convenience.
Physical restraint may include, but are not limited to a device or garment that interferes with freedom of movement or withholding assistance or mobility device to a dependent participant for the purpose of interfering with the participant's free movement.
Chemical restraint means the administration of drugs with the intent of significantly curtailing the normal mobility or normal physical activity of a participant.
Involuntary seclusion means the separation of a participant from others such as in a locked room, or from the participant's room or against the participant's will or the will of the participant's guardian/representative. Involuntary seclusion does not mean separating the participant from other individuals on a temporary and monitored basis.
Suicide (combine with death) (LEVEL II)
Suicide is the act of taking one's own life voluntarily and intentionally.
Suicide Attempt (LEVEL II)
Suicide attempt is the act of deliberately harming one's self with the intention of causing death.
Treatment and Medication Errors (LEVEL II)
A treatment error involving medication is defined as any medication management event that results in participant requiring medical services beyond first aid. This would include any preventable event that may cause or lead to inappropriate medication use or omission or harm while the medication is in the control of the health care professional, family member, or participant. This may also include mistakes by prescribers or pharmacists regarding type of medication, labeling, dosage or packaging.
Other treatment errors may include, but are not limited to the improper delegation of a task or the inadequate or poorly performed actions of a delegating nurse or personal assistance aide.
Other Incident Types (Level II)
Other incident type may include, but are not limited to:
• Infectious diseases,
• Insect infestations,
• Any unusual incident, which may involve law enforcement or may attract media attention, emergency closure of a participant's home or program facility for one or more days, or
• Bankruptcy or loss of lease by program

The critical incident report has fields that identify the participant demographic information, description of the incident, participant's response, action taken/prevention/disposition, notification/reported to other authority, recommendation by the case manager or care advisor of how to mitigate future incidences and the recommendation by the State Medicaid Agency against the data report and action taken.

Each case management entity is provided annual training in critical incident reporting approved by the state Medicaid agency. The case management entity is responsible to educate and inform waiver participants/responsible parties and service providers on 1) types of critical incidences, 2) how to make a report, and 3) the timeframe to make a report. The case management entity must provide training and education initially, quarterly, annually and as needed to all waiver participants.

For incidences of abuse, neglect and exploitation, the state has prescribed guidelines to react to a report and create an action plan.

To assure the health, safety and well-being of waiver beneficiaries, the goal is to report a critical incident immediately when it happens. However, for incidences that the case management entities are not immediately aware, upon of the knowledge of the incident the case management entity is expected to file a report and follow through to assure the health, safety and well-being of the waiver participant. The report must be submitted through CAP IT system within 72 hours. When the case management entity is notified of an incident, notification or report to other providers or entities must occur within 72 hours of the reported incident.

The types of events that warrant notification to state Medicaid agency are reports of abuse, neglect and exploitation that are referred to the local DSS Adult Protective Services.
Article 6, Chapter 108A of the North Carolina General Statutes requires that county departments of social services

perform certain activities for disabled adults alleged to be abused, neglected, or exploited and in need of protective services. In accordance with its authority under N.C.G.S. 143B-153, the North Carolina Social Services Commission has established rules and regulations for the provision of Protective Services for Adults.
The County Departments of Social Services must accept all reports alleging abuse, neglect, or exploitation of a disabled adult who needs protective services. This includes anonymous reports.

North Carolina has a mandatory reporting law. Any incidents containing allegations of abuse, neglect or exploitations must be immediately reported to the local Department of Social Services responsible for investigation of abuse, neglect or exploitation allegations. Any person having reasonable cause to believe that a disabled adult needs protective services shall report such information to the director of the county Department of Social Services, or his representatives, where the disabled adult resides or is present. Other reports may be required by law, such as reports to law enforcement.

The report may be made orally or in writing. The report shall include the name and address of the disabled adult; the name and address of the disabled adult's caretaker; the age of the disabled adult; the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect; and other pertinent information. (G.S. 108A-102)
North Carolina conducts a comprehensive functional assessment (evaluation) to determine whether there is a need for protective services in situations where it is alleged that a disabled adult has been abused, neglected, or exploited.
Protective Services are those services provided by the State or other government or private organizations or individuals that are necessary to protect the disabled adult from abuse, neglect, or exploitation. (G.S. 108A-101)
North Carolina General Statutes require that any director receiving a report that a disabled adult needs protective services shall make a prompt and thorough evaluation to determine whether the disabled adult needs protective services and what services are needed. The evaluation shall include a visit to the disabled adult and consultation with others having knowledge of the facts of the particular situation. A thorough evaluation of a protective service report shall include identifying indicators of abuse, neglect, or exploitation and the disabled adult's strengths and limitations by assessing physical health, mental health, social support, activities of daily living, and instrumental activities of daily living, financial support, and physical environment. Other reports

The State Medicaid Agency is provided "need to know information:" to assure the appropriate planning of all waiver participants from the DHHS-Division of Aging and Adult Services. The case management entities and the DSS-APS workers consult with one another about the facts of a particular situation for appropriate care planning and referrals.

Natural disasters such as hurricanes are considered critical events. Every locality/county must have a disaster plan in place and shelters available that can provide care for individuals and families, including those with special needs, who must evacuate their homes. Each waiver participant is required to have an emergency plan that covers disaster planning.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Initially an annually each waiver participant is provided information about abuse, neglect and exploitation and how to make a report when concerns arise. The interdisciplinary assessment captures information about informal support systems and their burden of care that identifies potential risk factors for abuse, neglect and exploitation. Additional information is provided when requested or when the case management entity is concerned about abuse, neglect and exploitation. During the waiver enrollment process, the individual is given information about the waiver through a participant disclosure letter, an Introductory letter and a Welcome letter that includes information about ANE. This information describes signs of ANE, contact information and mandatory reporting requirements. The following statement is included in the letter "If you think that you are not safe or have any concerns about abuse, neglect or exploitation you can call your local Department of Social Services for assistance with Adult Protective Services. You can also call your case manager or care advisor." to provide guidance to the waiver participant if he or she feels abused, neglected or exploited. In addition, During the review of participant rights and responsibilities, case manager and care advisors educate and provide information to participants, families and legal representatives. Participants sign the Participant's Rights and Responsibility form indicating that they have received information about incident reporting.

Each member of the case management entity is required to have annual mandatory training that includes what constitutes abuse, neglect and exploitation; and how to complete, assess, report and mitigate critical incidences of waiver participants. The State Medicaid Agency provides a high-level training in ANE in supporting waiver participants. The DHHS-Division of Aging and Adult Services provides semi-annual training in ANE to the case management entities. In addition, providers are required to provide on-going training to direct service staff in how to recognize abuse, neglect and exploitation, and where to go for help.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

When a waiver participant experiences a critical event or incident, the case management entity is responsible to receive the details of the event or incident to complete a critical incident report using the CAP IT system. The report is designed to document: who the report is from; the type of event or issue; the date and time of the event/issue, if applicable; the location of the incident (participant's home, etc.); details of the event; involved parties; the source of the information; individuals who have first-hand knowledge of the event; whether the attending physician was notified; and the name, address and phone number of the physician and any other agencies or individuals that were also notified. The specific nature of an event or issue will determine if notification to others is warranted, e.g., APS, DHHS and law enforcement. The Critical Incident Form has automatic fill-in responses through drop-down box options. The form is accessible through the CAP IT system. The CAP IT system will track receipt of all critical incident reports to assure adherence to timelines. State Medicaid Agency staff will also follow-up to assure waiver participant with a level II critical incident report is receiving the necessary services as identified through the recommendation of the incident report.
The State Medicaid Agency has trained each case management entity on how to detect and accept critical incident reports (CIR). Upon the knowledge of an incident, each case management entity is required to submit a CIR via CAP IT within 72 hours. The CAP IT system will compile all critical incident reports to assure accuracy of policy compliance and that the incident was clearly followed-up. Each incident is placed in a data query to track the frequency of each incident to identify trends.

Level of reporting is managed by two incident levels: Level I and Level II.
Level I incidences must be reported within 3 business days the CAP IT system. These incidences include: hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered.
Level II incidences must be reported within 3 business days to State Medicaid Agency. These incidences include, APS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, falls requiring hospitalization or results in death, traumatic injury, medication administration that results in injury or hospitalization, wandering away from home, homicide/suicide and media related events.

Incidences of abuse, neglect and exploitation must be reported to the appropriate authority and carefully followed to assure services are adequately met to keep the waiver participant safe in the community.

To assure the health, safety and well-being of each waiver participant, the case management entities shall address remediation efforts that mitigate the waiver participant's health and welfare when a critical incident occurs. It is mandatory for all case management entities to evaluate each report to identify the best course of action for waiver participant. When an event or incident occurs, the case management entity must respond to the following bulleted items that are associated with the event to evaluate the validity and concern listed in the report and to ensure the health, safety and well-being of the waiver participant.

- The waiver participant or family member is considered at risk of health, safety and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a personal emergency response system;
- The waiver participant lacks the emotional, physical and protective support of a willing and capable caregiver who must provide adequate care to oversee 24-hour hands-on support or supervision to ensure the health, safety, and wellbeing of the individual with debilitating medical and functional needs;
- The waiver participant's needs cannot be met and maintained due to unwillingness or uncooperativeness by the system of services that is currently available to ensure the health, safety, and well-being;
- The waiver participant's primary private residence is not reasonably considered safe to meet the health, safety and wellbeing in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the waiver participant's safety, and these issues cannot be resolved;
- The waiver participant's primary private residence presents a physical or health threat due to the credible allegations of unlawful activity conducted; verbal abusive behavior, threatening or physically or verbally abusive behavior, presence of a health hazard due to pest infestation, hoarding of animals, or animal excretion and evidence of ANE; or
- The waiver participant's continuous intrusive behavior impedes the safety of self and others by attempts of suicide, physical abuse or injury to self or others, verbal intimidation, destruction of physical environment, or repeated noncompliance of service plan and written or verbal directives;
- The waiver participant's primary caregiver or responsible party continuously impedes the health, safety and well-being of the waiver participant by refusing to comply with the terms of the plan of care, refusal to sign a rights and responsibility form and other required documents, refusal to keep service providers informed of changes and status

changes, refusal to implement or follow-through with an individual risk agreement to remove or lessen the risk or refusal to necessary waiver services approved in the service plan; or

- The waiver participant chooses to remain in a living situation where there is confirmed, abuse, neglect, or exploitation as evidenced by an APS assessment or care plan.

When an event/issue is identified by, or reported to the case management entity, a Critical Incidents Report form is completed and the case management entity arranges an investigation for a Level II critical incident within 5 calendars days.

The case management takes the following steps to investigate the report information:

- Contact with reporter, if provided to discuss the event/incident or concern;
- Contact with involved service providers listed on the POC to discuss waiver participant 's care needs and any concerns related to the incident report
- Home visit with the waiver participant to conduct a risk assessment of needs against the incident report
- Review of past incident reports, hospital visits and ER visits and other data elements to identity trends
- Contact with pertinent individuals or formal agency to identify concerns.

The case management entity also evaluates the following areas during the investigation:

- Human factor (staffing levels, knowledge, training and competency)
- Prior addressed risk factors
- Equipment-related factors (maintenance)
- Environmental factors (lighting, noise, clutter)
- Communication factors (training and adequate tools)

A plan of protection or assurance of health, safety and well-being is put in place when the case management entity conducts the investigation of the event/ incident. The case management entity collects all this information to complete a root cause analysis report to assist with closing out the investigation to decide about the best course of action for the waiver participant. The following questions are asked:

- Was the incident preventable?
- If staff was involved, did they respond to the incident appropriately?
- If family was involved, did they respond to the incident appropriately?
- Were resources utilized in an appropriate and cost-effective way?
- Did the Case Manager/Care Advisor handle the incident appropriately?

The answers to the questions lead to the remediation plan for the waiver participant such as a risk of dignify declaration form, a revision to the service plan, additional support from formal and informal support systems or disenrollment from the HCBS program when health, and safety cannot be met or mitigated regardless of tried attempts. The state Medicaid agency will make the final remediation plan based on the nature of the incident and the findings in the investigative report. The data query generated by the CAP IT system is reviewed by the State Medicaid Agency on a quarterly basis and compared against the data query generated by DAAS. These two reports are used to identify trends and strategies to mitigate future occurrences.

The case management entity shall initiate an investigation within 5 business days of a Level II incident report to ensure health, safety and well-being of waiver participant. The waiver participant must be notified of the recommendation of the investigations within 15 business days of the incident.

The Department of Social Service, APS section is responsible for evaluating all cases of abuse, neglect and exploitation. The Adult Protective Services unit has a prescribed timeframe of 24, 48 and 72 hours to investigate a report of ANE. The reporter is provided a disposition of the results of the initial home visit to investigate the allegations of ANE within 30-45 days, depending on the allegation type. APS have specific guidelines of evaluating a case to determine if a waiver participant is at risk and needs protection. The assigned Adult Protective Service Worker evaluates the waiver participant cognitive skills to determine capacity to make decision and the need for supportive care. If waiver participant is deemed

not to be able to make appropriate cognitive decision, APS will provide an order of protection.

The state has an agreement with the state aging and adult agency (Division of Aging and Adults Services-DAAS) to provide quarterly data query of waiver participants reported to be abused, neglected or exploited. The data query provides the date of the report, the alleged perpetrator, and the disposition of the case, confirmed or substantiated. The report is compiled by county, the waiver program, type of report, disposition decision, and the number of reports received on a given waiver participant. The local DSS trains the APS workers on how to capture and complete the needed information on the report. A planning meeting is scheduled quarterly with the DMA staff and the DAAS staff to review and analyze the data query to identify trends and implement strategies to mitigate future occurrences.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The State Medicaid Agency is responsible for overseeing the operation of the incident management system for this waiver population.
Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each waiver participant are identified as part of the intake and assessment process. The CAP IT system generates reports of risk indicators identified in the comprehensive assessment for use by the case management entity for continuous care planning of health, safety and well-being. These data elements of risk indicators assist the case management entity to proactively identify services and supports to mitigate potential risk(s) that may lead to an unfavorable event or incident for the waiver participant.

When a waiver participant encounters an event or incident, a Critical Incident Report is filed through the CAP IT system. This system aggregates the data on the critical incident report and sends alerts regarding needs and recommendations to the case management entity and the State Medicaid Agency. The reports provide information about the incidents, who were involved in the incident and recommendations made regarding the incident. The State Medicaid Agency reviews these reports quarterly to identify trends and strategies to reduce similar occurrences in the future. Questions that are posed when reviewing the data consist of the following:

- How can the State Medicaid Agency prevent this from happening again with this individual/family?
- How can State Medicaid Agency prevent some of these incidents from happening again on a statewide program level?
- Are waiver resources utilized in an appropriate and cost-effective way?
- Were there signs or indications that may have prevented this event/incident?
- Are the staff and family members adequately trained on how to manage health condition?
- Is the waiver participant fully aware of health care needs and how to follow care plan requirements?

An Critical Incident committee meets quarterly to track and trend Level II incidences. The committee reviews summary of care history, age and gender of the participant, date of enrollment in the program, the significant diagnosis, participant's extent on formal and informal supports, summary of events, contributing factors, participants enrollment/action surrounding the event, immediate action taken, participant status, identification of risk points and their potential contribution to the event.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. **Use of Restraints.** *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

◉ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

This HCBS program prohibits the use of restraints and restrictive interventions for all settings approved in this waiver. The care provided to these individuals must be non-invasive and free from restraints and seclusion, including personal restraints, drugs used as restraints or mechanical restraints.

Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to detect unauthorized use of restraints.

The case management entity is primarily responsible for detecting the unauthorized use of restraints through two required face-to-face visits and two other required visits that may be conducted using technology. However, if a concerned is voiced or identified, the case management entity is required to make an unannounced visit to evaluate the concern and when necessary call an ad-hoc multidisciplinary meeting to assess the unauthorized use of restraints. A critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery. The case management entity will initiate referrals and investigatory steps within 2 business days of notification.

For this HCBS program, restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to a waiver participant's body that the waiver participant cannot remove easily, which restricts freedom of movement or normal access to one's body.
For this HCBS program, seclusion involves placing a waiver participant alone in a room or other area from which exit is prevented. This may or may not include use of locking mechanism.

If a waiver participant is determined to be restrained or secluded, the case management entity or the service provider (if the service provider is not the offender) is required to contact law enforcement, adult protective services or the Department of Health Services Regulation (DHSR) to report the event.
Any known or observed use of restraints is referred to APS and Division of Health Services Regulation (DHSR), to investigate and report on their findings. The case management entity is responsible for monitoring the investigation and findings to assure the health, safety and well-being of the waiver participant. The State Medicaid Agency will also monitor the status of the report to ensure the critical reporting system is working as designed.
The use of restraints or seclusion with a waiver participant indicates an immediate need to reassess the waiver participant and his or her plan of care to determine if there are unmet medical or functional needs; whether the waiver participant's caregiver can appropriately deliver the required services while managing stress; and whether the HCBS program remains an appropriate choice for the waiver participant.
If a case management entity observes or learns that restraints, seclusion, or restrictive interventions are being used, a critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery. The case management entity will initiate referrals and investigatory steps within 2 business days of notification.

○ **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints.** Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

The HCBS waiver does not permit, for all settings approved in this waiver, the use of interventions that restrict waiver participant movement; restrict a waiver participant's access to other individuals, locations, or activities; restrict a participant's basic freedoms or that employ aversive methods to modify behavior.
Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to detect unauthorized use of restrictive interventions.

The case management entity is primarily responsible for detecting the unauthorized use of restrictive interventions through two required face-to-face visits and two other required visits that may be conducted using technology. However, when a concerned is voiced or identified, the case management entity is required to make an unannounced visit to evaluate the concern and when necessary call an ad-hoc multidisciplinary meeting to assess the unauthorized use of restrictive interventions. A critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery. The case management entity will initiate referrals and investigatory steps within 2 business days of notification.

•Waiver participant's basic freedom include sleep, shelter, food, drink, physical movement for prolonged periods of time, medical care or treatment, and use of bathroom facilities.
• Aversive methods or techniques are intended to cause pain or other unpleasant sensation such as contingent noxious stimulation, visual or facial screening (i.e., placing a cloth or other material over the face or eyes).
If SMA determines the use of the restrictive interventions is not in compliance with the requirements outlined above, the appropriate law enforcement and/or adult protective services will be contacted on the day of discovery to report the event. The SMA is responsible for monitoring investigations and findings to assure the health, safety and well-being of the waiver participant is being met.
The use of restrictive interventions with a waiver participant indicates an immediate need to reassess the waiver participant and their plan of care to determine if there are unmet medical or functional needs; whether the waiver participant's caregiver can appropriately deliver the required services while managing stress; and whether this HCBS program remains appropriate.
If a waiver provider or HCBS program consultant observes or learns restrictive interventions are being used, a critical incident report must be completed and submitted to SMA on the date of discovery. SMA will initiate referrals and investigatory steps within 2 business days of notification.

○ **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

◉ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

The State of North Carolina dose not permit the use of seclusion including personal restraints and drugs for any waiver beneficiary for all settings approved in this waiver. Observation by the case manager during monthly or quarterly visits, complaint information from care providers and critical incident reports are used to detect unauthorized use of seclusion.

The case management entity is primarily responsible for detecting the unauthorized use of seclusion through two required face-to-face visits and two other required visits that may be conducted using technology. However, when a concerned is voiced or identified, the case management entity is required to make an unannounced visit to evaluate the concern and when necessary call an ad-hoc multidisciplinary meeting to assess the unauthorized use of seclusion. A critical incident report must be completed and submitted to the State Medicaid Agency on the date of discovery. The case management entity will initiate referrals and investigatory steps within 2 business days of notification.

All waiver services and regular State Plan services must be provided in accordance with all requirements specified in this waiver and the State's governing clinical coverage policy; all applicable federal and state laws, rules, and regulations; the current standards of practice; and provider agency policies and procedures. Each case management entity must have a policy on seclusion that complies with the definition of seclusion as stated in the June 22, 2007 memo to State Survey Agency Directors, Ref S&C-07-22, and re: Clarification of Terms Used in the Definition of Physical Restraints as Applied to the Requirements for Long Term Care Facilities. Refer to: http://www.cms.gov/surveycertificationgeninfo/downloads/SCletter07-22.pdf

When evidence is received that unauthorized use of seclusion occurs, a critical incident report must be completed by the case management entity on the date of discovery. The case management entity must notify the appropriate law enforcement and child protective services to report the occurrence. The State Medicaid Agency will follow-up within 2 business days of notification to ensure incident is correctly mitigated.

○ **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

- (●) **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ( ) **Yes. This Appendix applies** *(complete the remaining items)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

Answers provided in G-3-a indicate you do not need to complete this section

i. Provider Administration of Medications. *Select one:*

- ( ) **Not applicable.** *(do not complete the remaining items)*
- ( ) **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. Medication Error Reporting. *Select one of the following:*

○ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

(b) Specify the types of medication errors that providers are required to *record:*

(c) Specify the types of medication errors that providers must *report* to the state:

○ **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.**

Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

Performance Measures

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

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

Performance Measure:
HW-A1 PM: Number and percent of CMEs that participated in ANE and CIR training for each waiver participation year N: Number of CMEs that participated in ANE and CIR training for each waiver participation year D: Total number of CMEs

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-A2 PM: #/% of waiver participants who had a CIR and updated service plan to mitigate risk factors after an ANE screening was conducted N: # waiver participants who had a CIR and updated service plan to mitigate risk factors after an ANE screening was conducted D: # waiver participants who had an ANE screening

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**

☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system CME	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-A3 PM: Number and percent of waiver participants who, initially and annually, received notification letters that included information about ANE and how to report a concern of ANE N: Number of waiver participants who, initially and annually, received notification letters that included information about ANE and how to report a concern of ANE D: Total number waiver participants

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin error
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-A4 PM: #/% of waiver participants who had a quarterly monitoring visit by CME to assess HSW in attempt to identify, address, and seek to prevent instances of ANE N: # waiver participants who had a quarterly monitoring visit by CME to assess HSW in attempt to identify, address, and seek to prevent instances of ANE D: # waiver participants reviewed

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other**	☐ **Annually**	☐ **Stratified**

Specify: CAP IT System CME		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-A5 PM: #/% of waiver participants who had an investigative analysis conducted to identify a root cause when CIR was completed for an unexplained death N: # waiver participants who had an investigative analysis conducted to identify a root cause when CIR was completed for an unexplained death D: Total # unexplained deaths

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT System CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
CAP IT system	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

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

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

Performance Measure:
HW-B1 PM: Number and percent of CMEs that participated in mandatory CIR training each waiver participation year N: Number of CMEs that participated in mandatory CIR training each waiver participation year D: Total number of CMEs

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =

☒ **Other** Specify: CAP IT system CMe	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-B2 PM: #/% of Level II CIRs that were processed in accordance with policy and guidelines within the established timeframe N: # Level II CIRs that were processed in accordance with policy and guidelines within the established timeframe D: # participants who had a Level II incident reported

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-B3 PM:#/% of waiver participants who had an updated SP or individual risk agreement in place to mitigate future risk of similar incident when a Level II CIR was processed N: # waiver participants who had an updated SP or individual risk agreement in place to mitigate future risk of similar incident when a Level II CIR was processed D:# of waiver participants who had a Level II incident reported

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and**	☐ **Other**

	Ongoing	Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-B4 PM: Number and percent of waiver participants with an emergency/disaster plan on file for each waiver participation year N: Number of waiver participants with an emergency/disaster plan on file for each waiver participation year D: Total number of waiver participants

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence

		Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT System	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-B5 PM: #/% of waiver participants with documentation of an updated/reviewed

emergency/disaster plan for each recorded Level II CIR N: # waiver participants with documentation of an updated/reviewed emergency/disaster plan for each recorded Level II CIR D: Total # waiver participants who had a Level II incident reported

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

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

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

Performance Measure:
HW-C1 PM: Number and percent of CMEs and HCBS providers that had policies and procedures for prohibition of restrictive intervention (restraints, seclusions) for waiver participants N: Number of CMEs that had a policies and procedures for prohibition of restrictive intervention (restraints, seclusions) for waiver participants D: Total number of CMEs and HCBS providers

Data Source (Select one):
Presentation of policies or procedures
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100%**

		Review
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin
☒ **Other** Specify: CAP IT system CME/HCBS providers	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

Performance Measure:
HW-C2 #/% waiver participants with a Level II CIR for restraints/seclusion/restrictions that were addressed in accordance w/policy. N: # waiver participants with a Level II CIR for restraints/seclusion/restrictions that were addressed in accordance w/policy. D: # waiver participants who had a Level II incident for restraints/seclusion/restrictions reported were addressed in accordance w/policy

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

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

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

Performance Measure:
HW-D1 PM: #/% of waiver participants who were enrolled with a primary care physician to manage all health care needs during each waiver participation year N: # waiver participants who were enrolled with a primary care physician to manage all health care needs D: Total # waiver participants reviewed

Data Source (Select one):
Reports to State Medicaid Agency on delegated Administrative functions
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: GDIT/NCTracks	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify:	☐ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
GDIT/NCTracks	
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
HW-D2 PM:#/% of participants who had a quarterly MDT meeting with care providers to address overall health care needs to ensure needs were adequately met/administered by the service provider N:Participants who had a quarterly MDT meeting with care providers to address overall health care needs to ensure needs were adequately met/administered by the service provider D:# waiver participants reviewed

Data Source (Select one):
Meeting minutes
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☒ **Representative Sample** Confidence Interval = 95% 5% margin of error
☒ **Other** Specify: CAP IT system CME	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

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

The CAP IT system is a business system employed by the State Medicaid Agency to manage the health and welfare for all waiver participants to ensure safety communication living and integration. This system assists in the discovery of non-compliant areas in health, safety and well-being workflows through aggregating and analyzing data.
The CAP IT system performs the following tasks to ensure compliance to health and welfare policies and procedures which allows the State Medicaid Agency to quickly discover areas of noncompliance:

- Completion of a comprehensive assessment, initially and annually
- Risk indicators based on assessed needs
- Person-centered service plan
- Notification letters to providers and waiver participants
- Individual risks agreements
- Training
- Prior approval segments
- Workflow timelines and alerts
- Critical incident management
- Grievance and complaint management

b. Methods for Remediation/Fixing Individual Problems

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

Upon the discovery of non-compliant waiver workflow activities in the area of health and welfare, the State Medicaid Agency notifies the non-compliant entity immediately upon discovery. If the non-compliant area can be remediated, a corrective action plan and a root cause analysis are requested to assist to remediate the concerns. The State Medicaid Agency provides technical assistance and training on policies and procedures within 5 days of discovery. The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant provider to ensure the corrective action plan is being followed throughout the duration of the action plan. If the non-compliant issue continues ongoing after 3 months of assistance, the entity will be terminated indefinitely.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☒ **Sub-State Entity**	☐ **Quarterly**
☒ **Other** Specify: CAP IT system	☐ **Annually**
	☒ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the state must be able

to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The State Medicaid Agency has developed a quality management plan that integrates, analyzes measures and processes data and responds to information from multiple sources across functions within the waiver operation systems (CAP IT, MMIS and CME) to ensure waiver assurances are met. The primary system used to monitor the compliance to the waiver assurances and measures the quality of the waiver's performance is the CAP IT system. The CAP IT system is the hub for all waiver activities. Information pertaining to all the waiver assurances is entered in the CAP IT system by the State Medicaid Agency (SMA), Case management entities (CMEs), Independent assessment entity (IAE) and HCBS providers. The CAP IT system correlates this information to align with the waiver business workflow to allow the SMA the ability to aggregate and analyze trends and areas that may need remediation. The data elements in the system is real-time which promote immediate discovery and quick implementation of remediation steps. The CAP IT system generates data on all six waiver assurances which allows the SMA to perform daily and ad-hoc analysis of waiver's performance.

To assist in managing the waiver's performance, the CAP IT system is programmed to manage the workflow for this waiver based on the requirements and deliverables for each assurance drawing from several data sources, including:
1. The web-based case management and business process tool
2. On-site audits and reviews;
3. Desktop audits and reviews
4. The Medicaid Fiscal Contractor
5. NC Division of Health Services Regulation for licensure/certification records;
6. DMA Program Integrity Unit for audits, reviews, and investigations;
7. Experience Surveys; and
8. Stakeholder's input

The system tracks compliance using mandatory fields, time limits and workflow interruptions when the correct steps are not followed. The users are provided alert notifications and messages to promote compliance to the programmed workflow.

On a quarterly basis, the State Medicaid Agency conducts a comprehensive analysis of data reports to review trends, compliance to timelines and utilization in the areas of LOC, service plan, administrative authority responsibilities, financial accountability and health and welfare, qualified providers to measure the effectiveness of the CAP IT system in assuring each waiver assurance is met. This analysis identifies strengths and opportunities for improvement as well as identification of areas to prioritize. During this comprehensive analysis, discovery methods are used to ensure that staff, processes, data systems, and reporting mechanisms are working as intended to meet minimum standards and desired outcomes of the waiver quality improvement system. As a first step, identified areas of weak performance are brought up to minimum standards through an understanding of the problem. Remedial action is taken to correct the root causes of the problem to improve performance in the weak area to prevent similar problems in the future. During analysis review, if a trend is identified that requires more focus or remediation, the case management entities, independent assessment entity or HCBS provider is informed of the quality improvement focus within 15 business days of discovery. Depending on the focus of the trend, training/technical assistance is performed and a remediation plan is put in plan to either enhance what is working well or re-train to enhance efficiency and compliance. If the identified trend requires remediation, a 3-month QIS period is implemented which includes re-training and direct technical guidance. The State Medicaid Agency may impose suspension of specific activities until the issue is remediated to quality improvement. This QIS quarter is provided to all CMEs and IAEs, however, the entities that are directly out of compliance must complete a corrective action plan for review and approval to initiate steps to align to waiver assurances. If compliance is not achieved, a "non-eligible provider transition plan" is developed.

Prioritization of noncompliance areas is made when access to care barriers or gaps in services provision are presented. These gaps may include HCBS providers not receiving authorization timely to render approved services, prior approval records that prohibit reimbursement of services and workflow that restricts ability to the documents the receipt of a request a fair hearing.

A dashboard is updated daily in the CAP IT systems that displays performance of the waiver. An announcement queue is used to communicate quality improvement information.

To validate the efficiency and capacity of each responsible entity, the CAP IT system measures their performance

monthly. Each entity must maintain a 90% quality compliance rate.

The CAP IT system is assessed daily to measure ability to manage this HCBS QIS and waiver compliance. The assessment of the system is monitored through:
1. Audits and reviews;
2. MMIS;
3. Experience Surveys;
4. Stakeholder's input
5. Scope of the work; and
6. Weekly discussion and tracking meetings.

When areas of non-compliance are identified, the CAP IT system is informed of the concerns and required to complete a root cause analysis. A corrective action plan is implemented that includes timeframes and any identified system change requests. Refer to H-1bi. This system is in the process of being certified.

Stakeholders are notified quarterly through planned stakeholder engagement meetings about waiver trends and performances. Stakeholders are given the opportunity to voice concerns or provide recommendation on how the systems may be more efficient or methods to implement and manage waiver assurances and QIS.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☒ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☒ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☒ **Other** Specify: CAP IT system, CME and IAE	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

A quarterly assessment of the functionality of the CAP IT system is conducted to monitor the performance and wavier specification per the approved scope of work. A State Medicaid representative reviews data reports and conducts testing to assess the effectiveness of the waiver functionality and it reliability to design. One hundred percent of the data must be processed and made available to the State Medicaid Agency when requested. However, on a quarterly basis, the State Medicaid Agency gathers and review the data in the aggregate. The data must be able to drill down to the minimal sub-assurances and an individual beneficiary or case managers. Upon the discovery of a less of out of compliance areas, a meeting is held with vendor to address concerns, identify causes and assist with the implementation of a corrective action plan. If the system is functioning as designed, but the waiver functionality is incongruent with processes or workflow, a change request is made to amend the scope of work or contract. The vendor must submit specification for approval to the State Medicaid agency that addresses the new functionality. After the approval of the specification, a user acceptance test is performed to ensure the updated functionality is working as designed. Upon the completion of this process, the State Medicaid agency ensure the system is functioning as designed through observation and review. If the system is not functioning as designed, the vendor will have 5 business days to correct the area(s) of concern or provide a proposal that include timelines.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

A safeguard implemented by the State Medicaid Agency (SMA) to continuously evaluate the Quality Improvement Strategy (QIS) for this HCBS program is through data analysis. The State Medicaid Agency requires the CAP IT system vendor to generate daily reports on all workflows that are directly connected to the six waiver assurances. The CAP IT systems must also maintain history files. On a quarterly basis, and when a concern arises, an analysis of the reports is performed to evaluate system's performances. Data from this system is crossed-referenced, when applicable, to MMIS to validate compliance or issues of concern. This analysis allows a whole system review to identify areas that are working as designed and areas that need improvement. System improvements are implemented when areas of weaknesses are identified or when the system warrants
Another safeguard implemented by the SMA to evaluate the QIS is the recommendations made from the Home and Community Care Quality Management committee. This committee meets quarterly to evaluate the QIS.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- ○ **No**
- ◉ **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ **HCBS CAHPS Survey :**
- ○ **NCI Survey :**
- ○ **NCI AD Survey :**
- ◉ **Other** *(Please provide a description of the survey tool used):*

My Experience Survey to assess experience in ADH settings.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the*

financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The oversight of the waiver financial integrity and accountability (FIA) is performed by the SMA with data reports received from the CAP IT system and the MMIS. The SMA does not require an independent audit of provider agencies specific to this waiver. The FIA oversight consists of the Office of Compliance &Program Integrity (OCPI) and contracted vendor to conduct post/pre-payment reviews of providers that deliver Waiver services, both provider-led and consumer-directed. Post-payment reviews are done by OCPI (on-site) on complaints that enter the Business Intake Center. These complaints come from internal SMA units/outside providers, beneficiaries and agencies. The SMA's IT System receives prior authorizations(PA)from utilization reviews and documented and archived authorizations in MMIS. The MMIS has edits/audits programmed to allow claims to adjudicate before payment. The OCPI uses the Fraud and Abuse Management System (FAMS), Java-Surveillance and Utilization Review System (JSURS), and Advantage Suite to detect over/under-utilization of services, and improper/aberrant billing practices. FAMS and JSURS have the capacity to identify providers billing practices/behaviors outside the norm of peers. On a quarterly basis, a random sample of post-payment reviews, a sampling approach consistent with the waiver's QIS, is sent to the SMA from each of the assigned reviewers that were completed during the previous quarter. For the SMA, the post-payment review process (completion of cases) occurs daily during business days. Data Analysis meetings are conducted bimonthly and a case disposition matrix is followed to determine whether a provider should be recommended for post/pre-payment review. Reasons why a provider would be placed on post/pre-payment include: credible allegations of fraud; Identification of aberrant billing practices because of investigations; Aberrant Data analysis results; Failure of the provider to timely respond to a request for documentation. A Data Analytics Team within the SMA identifies data leads for audit and investigation based on the reasons for post/pre-payment placement, as listed above. Advantage Suite has the capacity to identify over/under utilization of services. When providers are identified through data analytics, a Data Analytics Report is created and assigned to an investigator to conduct further research and make a recommendation to refer a provider for post/pre-payment review. Post-payment reviews are conducted to determine if the provider delivered services in accordance with the policies, rules, and regulations for the claim billed. Post-Payment reviews may include a review of service requests, assessments, service plans, prior authorizations, staff qualifications, and claims paid. Prepayment claims review may include review of service requests, service orders, assessments, staff qualifications, service plans, and claims prior to payment. A provider placed on prepayment claims review must obtain a 70% accuracy rate for three consecutive months to successfully complete the program. Providers may stay on prepayment claims review up to 12 months. The provider is provided the audit tools and instructions in the initial notice letter, and TA/support is given throughout the prepay process. If the provider does not meet this standard within six months of being placed on prepayment review, SMA may implement sanctions, including termination of the provider's Medicaid Application. The provider is notified of appeal rights. Pursuant to § 108C-7(b) and federal regulation, providers are not entitled to payment prior to claims review. To ensure that claims presented by a provider for payment meet the requirements of Federal/State laws, regulations and medical necessity criteria, a provider may be required to undergo prepayment claims review. The accuracy rate is determined by the total number of claims and detail line items (from all service locations operating under the NPI number) and determined as approved/denied within each month in which the claims are submitted for payment. 70% of all claim detail lines submitted must be identified by the designated vendor as containing no error(s). A single claim may contain one or more procedures billed on the same/different DOS. In this prepayment review process, the methodology for calculating a provider's accuracy rate is to take all claim detail lines with no identified errors divided by the total number of claim detail lines submitted for review. All the details of the statute are followed to assure that the provider successfully completes the program including the number of claims per month is no less than 50% of the provider's average monthly submission of Medicaid claims for the three-month period prior to the provider's placement on prepayment review. There are approximately 90,000 NC Medicaid providers and less than 1% have been placed on pre-payment review. Since 2010, 239 providers, of all types, were placed on prepayment claims review, 197 have either completed the process or are in some phase of the process; 117 have been terminated or are in the process of being terminated for failure to achieve at least 70% claims accuracy for 3 consecutive months; and 62 have passed the pre-payment process. There is no time frame for how often a provider would be placed on pre-payment review. However, a determination can be made during the bimonthly Data Analysis Workgroup meetings. Terminations are the only actions that have been taken for providers failing pre-payment review. An access of care analysis is conducted prior to a pre-payment action being initiated.

SMA provides oversight and monitoring of the contracted vendors' performance on a routine basis to ensure contract compliance and quality performance which may include case referrals, special initiatives, provider performance reports, quality assurance reports, and recommendations. All vendors are invited to participate in joint training sponsored by SMA and The Medicaid Fraud Control Unit on an annual basis. Training often covers case studies, recent provider trends, investigative techniques, policy, rules, and regulation updates, and data analytics used to target reviews and investigations. The CAP IT system contains algorithms with logic that can interpret information from the Service Request Form (SRF) and the assessment that results in the development of a service plan. The assessment tool has key indicators to identify risk factors in the areas of sensory and communication, mental and behavioral health, informal supports, housing and finance, safety and well-being, and medical and diagnostic functioning. Upon the completion of the assessment, the CAP IT system, analyzes the data gathered and provides the case manager a report that contains risk indicators and suggestions on the types of services the waiver participant would need to maintain health, safety and well-being in the community. The case

manager reviews those risk indicators along with the wavier participant to develop the service plan. The CAP IT system also monitors services as listed on the service plan through monthly and quarterly documentation the case manager is required to complete in the CAP IT system. The case manager gathers information about waiver participation and health and welfare during contact with the wavier participant and providers as well as from the review of paid claims. Key responses entered by the case manager populate to the service plan, the participant profile and a risk indicator section to aid in assessing if the waiver participant's needs are adequately addressed and met. The case manager is required to respond to probing questions in the monthly and quarterly monitoring assessment that analyze if services are provided as planned and if these services are meeting needs in the amount, frequency and duration as identified. The CAP IT system provides a summary of each waiver participant which is referred to as "participant at a glance". This summary provides an overview of all care needs, services approved, risk indicators, ADLs composite score and caregiver involvement and availability. If the analysis by the CAP IT system reveals that needs do not appear to be met or there are concerns of risk, the case manager is prompted to complete a change in status assessment, a plan of care revision or a risk agreement. The SMA consultant reviews this information and provides guidance to the case manager. Level of care determination is generated by the CAP IT system. When the assessment is approved which determines the participant to be at-risk of institutionalization and appropriate to participate in this HCBS program, the CAP IT system automatically transmits the prior approval (PA) to SMA's MMIS. When the service plan is completed by the case manager that identifies the service types in the amount, duration and frequency, the CAP IT system automatically transmits the service types in the amount, frequency and duration to SMA's MMIS for adjudication of claims. SMA's MMIS will adjudicate claims up to the amount transmitted by the CAP IT system. SMA's contract administrator is responsible to ensure the CAP IT system is transmitting level of care PAs and service limit PAs to SMA's MMIS system timely and correctly. The contractor administrator will review all PAs transmitted to SMA's MMIS and will run data queries each week to assure claims adjudicated per the PA. The CAP IT system reviews 90% cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from consistent failure to comply with service plan. The Office of State Auditor (OSA) is responsible for conducting the periodic independent audit of the waiver program to include consumer-direction under the provisions of the Single Audit Act. Payment Error Rate Measurement (PERM) and recipient eligibility cases are completed every three years to determine whether medical record documentation supports services/products billed and whether the services/products were paid correctly. Post-payment reviews of all Medicaid providers conducted by the SMA look at the complete audit trail including the approval of the service plan; the authorization to the provider that rendered approved services, service provision and service documentation; the authorization for claims submission and actual claims data. The results of monthly monitoring are reviewed by the IT system and the SMA. The findings are shared with the CME. The findings enable the agencies to improve the way financial integrity and accountability are operated. The QA review process is not a negative process, but one that leads to the continuous quality improvement. Additionally, PA limits are placed on services to assure claims data is billed as planned in the SP. The waiver unit reviews claim data monthly to identify outliers/unusual occurrences. Outliners/unusual occurrences are analyzed to assure financial soundness and integrity. Concerns are referred to SMA's PI unit for an official investigation and follow-up. In addition to this process at the state level, the CME reviews paid claims routinely to ensure accuracy of service provision and reports concerns to SMA for follow-up. Program Integrity Section is tasked with multiple responsibilities. These responsibilities include: resolution of provider fraud, abuse and administrative over-payments; determining the accuracy of Medicaid eligibility determinations; performing reviews of claims filed to identify problem areas; assisting in claim payment audits; conducting periodic reviews with providers who bill for payments; and referring cases of possible fraud to the Attorney General's Medicaid Investigations unit.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. Sub-Assurances:

a. Sub-assurance: The State provides evidence that claims are coded and paid for in accordance with the

reimbursement methodology specified in the approved waiver and only for services rendered.
(Performance measures in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

Performance Measures

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

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

Performance Measure:
FA-A1 PM: #/% of waiver claims that adjudicated in accordance with the assigned procedure codes and approved reimbursement rates only for services rendered N: # waiver claims that adjudicated in accordance with the assigned procedure codes and approved reimbursement rates for this waiver program only for services rendered D: # waiver claims reviewed

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95% 5% margin of error*
☒ ***Other*** *Specify:* *CAP IT GDIT/NCTracks*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*

	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *CAP IT system GDIT/NCTracks*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

Performance Measure:
FA-A2 PM: #/% of waiver participants with a service plan prior approval segment that promoted claim adjudication in accordance with the waiver reimbursement methodology N: # waiver participants with a service plan prior approval segment that promoted claim adjudication in accordance with the waiver reimbursement methodology D: Total # participants reviewed

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100%***

		Review
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%* *5% margin of error*
☒ ***Other*** *Specify:* *CAP IT system GDIT/NCTracks*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*
	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *CAP IT system GDIT/NCTracks*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

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

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

Performance Measure:
FA-B1 PM: #/% of waiver claims that adjudicated based on the approved Fee Schedule N: # waiver claims that adjudicated based on the approved Fee Schedule D: Total # waiver claims reviewed

Data Source *(Select one):*
Financial records (including expenditures)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	***Frequency of data collection/generation*** *(check each that applies):*	***Sampling Approach****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***	☐ ***100% Review***
☐ ***Operating Agency***	☐ ***Monthly***	☒ ***Less than 100% Review***
☐ ***Sub-State Entity***	☒ ***Quarterly***	☒ ***Representative Sample*** *Confidence Interval =* *95%* *5% margin of error*
☒ ***Other*** *Specify:* *GDIT/NCTracks*	☐ ***Annually***	☐ ***Stratified*** *Describe Group:*

	☐ ***Continuously and Ongoing***	☐ ***Other*** *Specify:*
	☐ ***Other*** *Specify:*	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	***Frequency of data aggregation and analysis****(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *GDIT/NCTracks*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

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

The CAP IT system is a business system employed by the State Medicaid Agency to manage the financial accountability of the waiver in conjunction with the State's MMIS contracted entity. This system assists in the discovery of non-compliant reimbursement activities through aggregating and analyzing approved waiver services.
The CAP IT system performs the following tasks to ensure compliance to service plan development policies and procedures which allows the State Medicaid Agency to quickly discovery areas of noncompliance:

- *Linkage to approved Fee schedules*
- *Service authorization*
- *Prior approval segments*

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on*

the methods used by the state to document these items.

Upon the discovery of non-compliant waiver workflow activities in the area of financial accountability, the State Medicaid Agency notifies the non-compliant entity within 15-days of the discovery and requests a self-referral to program integrity to remediate the concerns and for technical assistance and training. The State Medicaid Agency approves the corrective action plan and follows-up with the non-compliant service provider/entity to ensure the corrective action plan is being followed through the duration of the action plan. If the non-compliance issue continues, a pre-payment reimbursement plan is imposed on that provider until continuous quality improvement is achieved. If, after 3 months of assistance, and remediation strategies that promotes continuous quality is not achieved, the entity will be terminated as a waiver service provider.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	***Frequency of data aggregation and analysis*** *(check each that applies):*
☒ ***State Medicaid Agency***	☐ ***Weekly***
☐ ***Operating Agency***	☐ ***Monthly***
☐ ***Sub-State Entity***	☐ ***Quarterly***
☒ ***Other*** *Specify:* *CWE, e-CAP* *CSC/NCTracks*	☐ ***Annually***
	☒ ***Continuously and Ongoing***
	☐ ***Other*** *Specify:*

c. Timelines

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

◉ ***No***

○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The SMA collaborates with an actuarial contractor to calculate an appropriate fee schedule based on the services and requirements outlined in Appendix C. The Provider Reimbursement Unit works collaboratively with the actuary to set all provider rates for waiver services. Rates are set based on demand for services, qualification of providers, and estimated provider service cost. The methodology used for rate determination for waiver participants directing their care is the same rate methodology used for provider managed services.

Generally, the State determines rates through a fee-for-service fee schedule methodology using market data and information specific to the State of North Carolina. For fee schedule rates, the State has historically solicited data from providers to inform the rate development process.
In SFY 2017-2018, Provider Reimbursement unit performed a formal review/rebase and the following components were considered as part of the SFY 2017-2018 review/rebase:
• Staffing Assumptions and staff wages
• Employee-related expense (e.g., benefits, employer taxes)
• Non-direct program expenses (e.g., supplies, training and supervision)
• Provider administrative overhead
• Direct staffing hours – this considers the training and other non-billable activities that practitioners are involved in.

Rates are set to reimburse reasonable cost as defined in section 1861(v) of the Social Security Act. Service rates are developed using various information: Medicaid historical fee schedules, Medicare, historical cost to providers, cost modeling and Medicare established fee schedules; and, in some cases, providers are invited to participate in forums related to rate setting.

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

A CAP/DA Waiver Fee Schedule is posted to the SMA website and updated periodically. The Fee Schedule lists all the HCBS services in Appendix C and the utilization limits for reference by waiver participants and HCBS providers. The MMIS portal provides up-to-date information about rate changes and the claim submittal process. Local case management entities, at the direction of the SMA, provides waiver participants an HCBS informational sheet that lists the approved waiver services and the maximum utilization limits.

The rates and reimbursement for all services including consumer-directed services are uniformed for every provider and across geography. The utilization limits were set based on historical claim data and associated expenditures.

Review of rates are performed at the time of annual updates as required by SMA. During each waiver year, stakeholder meetings are held to listen to user and providers experiences. Information about rates are recorded and reviewed closely. Also, at the end of each waiver year, utilization data is analyzed to identify requests or approvals that minimally met or exceeded the maximum limits to assist in informing if the reimbursement rates are sufficient and to make a recommendation to Provider Reimbursement unit for a rate analysis review. A formal rebase will be conducted no later than the next waiver renewal cycle.

Rates changes are triggered by legislative mandates or stakeholder group interaction with economically or fiscally sound supporting information as well as CMS rate change methodology. Changes to the state rate methodology are triggered by the same factors as listed above.

Maximum reimbursement of rates is uniformed for every provider and across geography for the following services is the same instance rate and is reviewed at least annually by SMA:
• Equipment, modification and technology -- $13,000 for the waiver life cycle; billed in varies dollar increments up to the maximum limits.
•Participant Goods and Services - $800 per fiscal year; billed in varies dollar increments up to the maximum limits.
•Community Transition - $2,500.00 per Waiver beneficiary waiver life cycle; billed in varies dollar increments up to the maximum limits.
•Community Integration Services - $2,500.00 per Waiver beneficiary waiver life cycle; billed in varies dollar increments up to the maximum limits.
•Training/Education and Consultative Services- $500.00 per state fiscal year; billed in varies dollar increments up to the maximum limits.
Maximum reimbursement of rates is uniformed for every provider and across geography for the following services is the

same per month rate and is reviewed at least annually by SMA:
•Coordination of care- case management and care advisement –$377/month (80 hours X $56.56/hr.) per calendar year
• Financial Management Services - $93.00 per month
Maximum reimbursement of rates is uniformed for every provider and across geography for the following services is the same per unit rate (one unit = 15 minutes) and is reviewed at least annually by SMA:
• Personal Assistant Services
• CAP In-Home Aide
• Respite Care (in-home)
• Specialized Medical supplies - units vary by item and are consistent with State Plan services
Maximum reimbursement of rates is uniformed for every provider and across geography for the following services is the same per day or per meal rate and is reviewed at least annually by SMA:
•Institutional respite - per day
• Adult Day Health – per day
• Coordinated caregiving – per day
• Personal emergency response services - paid per month
•Meal preparation and delivery – per meal

SMA is in constant communication with providers and their associations through frequent meetings and stakeholder engagements. Consumers may submit complaints by phone, or in writing expressing rates insufficiency. These complaints are closely reviewed, and an analysis is conducted to review trends as related to rates to aid in future recommendations and the rebase of rate during the waiver renewal cycle.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

The billing flow for waivers services from provider-led and consumer-directed services are process and adjudicated by the State's claims payment system.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

◉ ***No. state or local government agencies do not certify expenditures for waiver services.***

○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies

that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

GDIT is the fiscal agent (FA) and monitors the State MMIS for Medicaid claim processing and payment. It is the FA's responsibility to process valid Medicaid claims from enrolled providers in accordance with SMA policies, edits, audits, guidelines, and reimbursement methodologies. The GDIT claim payment system is called NCTracks.
Payments are made through the State MMIS and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers.
A prior approval of a LOC determination and a special waiver coverage code must be in the MMIS system before reimbursement of a waiver claim may occur.
Once the provider is provided the authorization to render a waiver service, the provider then submits that claim to NCTracks for reimbursement.
Validation that services have been provided as billed is a function of quality assurance conducted by the IT system and the case management entities. Audits include verification that the services were provided as billed. Additional validation is through desk and onsite audits and Program Integrity reviews.

Annually the SMA's Accountability Team conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of enrolled providers. This review includes monitoring of requirements that addresses staff qualifications, service authorizations, person centered plans, service documentation, and billing protocol.
For the waiver, a billed event must meet the following requirements to be validate
1. Have the required signatures by or before when services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and
7. Include a 24-hour schedule of coverage, if warranted.
During and prior to waiver participation the State Medicaid Agency validates:
• The IT system reviews 100% of its cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided.
•The reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, different LOC monthly to assure accuracy and 100% compliance of authorized services.
• The IT system conducts quality assurance reviews that include a review of the person-centered plan and service documentation for each waiver participant. The reviewer reviews the current service request form, the assessment and the approved person centered, service documentation, and paid claims to ensure that services were billed appropriately as according to the service plan.
• The IT system places prior approval limits on all service plans to identify deviations from the providers and review provision of services monthly. If there are consistent deviations and the service is authorized on the service plan, the case manager must review these with the waiver participant for further validation.
The State Medicaid Agency/IT system will provide each case management entities with QI reports to validate all authorized services. The case management entities will contact the IT system/State Medicaid Agency when program integrity concerns are present. The State Medicaid Agency will arrange for a program integrity review of the concerns.
In addition to the activities described above, the State Medicaid Agency utilizes desktop reviews and on-site reviews (audits), reports, and special reviews to ensure program accountability for service plan development and implementation. These desktop reviews and on-site reviews occur annually and as needed.
Submitted claims are systematically reviewed by the fiscal agent to ensure that all required information is present.
Completed claims processed through MMIS are run against system edits to verify:
• Services are prior authorized (i.e., level of care);
• Individual is a Medicaid beneficiary and is enrolled in the waiver (i.e. CAP indicator);
• Provider is an enrolled waiver provider;
• Claim is not a duplicate;
• Claim is paid per the published rates; and the participant was not institutionalized during the time covered.
Payments are made through GDIT/NCTracks and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers.
Validation that services have been provided as billed is a function of quality assurance conducted by the IT system and the case management entity. Additional validation that services were provided as billed is performed during case management entity and provider on-site compliance monitoring reviews, conducted by the State Medicaid Agency's Program Integrity Unit. Validation will also be achieved through participant's surveys by mail or by telephone;

education about fraud and abuse and how to report concerns of payment integrity and quality of care. During enrollment and annually thereafter, each waiver participant will be provided
education and information regarding financial accountability. In addition, post payment reviews, review of provider records and claims will also be used for validation.
The SMA will also employ an EVV system to verify and validate personal care services were provided and rendered as approved.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- (●) ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ( ) ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

- [ ] ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☒ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☐ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

◉ ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

- ○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***
- ○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ◉ ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ○ ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ◉ ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ○ ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ◉ ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.***
- ○ ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ◉ ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ○ ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ○ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ○ ***This waiver is a part of a concurrent ?1115/?1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The ?1115 waiver specifies the types of health plans that are used and how payments to these***

plans are made.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☒ ***Appropriation of State Tax Revenues to the State Medicaid agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable****. There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the

mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

  Check each that applies:

  - [ ] ***Health care-related taxes or fees***
  - [ ] ***Provider-related donations***
  - [ ] ***Federal funds***

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

In-home respite service is a service that can be provided in the waiver participant's home, home of a relative or current private-living arrangement. Institutional respite is a service that can be provided in an institutional setting such as a nursing facility or a hospital with designated institutional beds (swing beds).

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR §441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can***

be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- (●) ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ( ) ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- [ ] ***Nominal deductible***
- [ ] ***Coinsurance***
- [ ] ***Co-Payment***
- [ ] ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- (●) ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ( ) ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1		8945.68	8945.68	44062.15	4983.95	49046.10	40100.42
2		9214.05	9214.05	45384.01	5133.47	50517.48	41303.43
3		9490.47	9490.47	46745.33	5287.47	52032.80	42542.33
4		9775.19	9775.19	48147.90	5446.09	53593.99	43818.80
5		10068.44	10068.44	49592.33	5609.48	55201.81	45133.37

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	13588	13588
Year 2	13588	13588
Year 3	13588	13588
Year 4	13588	13588
Year 5	13588	13588

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay was projected based on a review of historical Medicaid waiver enrollee durational patterns for participants in the CAP/DA waiver based on claims/eligibility data provided by the state's fiscal intermediary for state fiscal year 7/1/15-6/30/16 (SFY 2015/2016). Note that when the State began efforts to create the Appendix J projections to include with the renewal, SFY 2016/2017 complete claims data was not yet available. For this reason, the Appendix J projections relied on SFY 2015/2016 claims and enrollment information.

Enrollment and average length of stay were reviewed using state claims and eligibility data to evaluate any potential churn of enrollment based on individuals only being enrolled for a partial year. The results of this approach were then compared to historical CMS 372 reports and found to be comparable with no notable change in ALOS.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Year 1 Factor D Derivations are estimated based on North Carolina's experience for SFY 2015/2016 CAP/DA waiver users and reflect only CAP/DA waiver services. Claims data was run to factor actual utilization (users and units) of current services during SFY 2015/2016. Note that when the State began efforts to create the Appendix J projections to include with the renewal, SFY 2016/2017 complete claims data was not yet available. For this reason, the Appendix J projections relied on SFY 2015/2016 claims and enrollment information.
Medicaid expenditure data was relied on to develop Factor D in order for the State to be able to evaluate potential changes to the fee schedule and service offerings at the procedure code level, rather than HCBS service taxonomy level. Additionally, Medicaid utilization data at the procedure code level was required to inform analysis regarding fee schedule unit definition changes pursued by the State during the waiver period. This expenditure data, and the corresponding enrollment information, were compared to CMS 372 reports for overlapping time periods and found to be reasonable and consistent.

Utilization was then trended forward to the first year of the waiver using historic utilization trends of 3% based on review of trends for the CAP/DA waiver service spending observed in available CMS 372 reports for SFY 2012/2013 through SFY 2014/2015. The service rates utilized in the Appendix J projections reflect the waiver fee schedule effective January 2019.

For Waiver Years 2 – 5, utilization is trended forward at the same 3% annual rate noted above, along with 1% annual growth in service rates. The 1% annual unit cost trend was included as an estimate of potential future fee schedule unit cost growth during the prospective time period. It is included as consideration for cost of living/ inflationary growth to services, including those paid based on cost rather than a standardized preset fee (e.g., assistive technology, home accessibility and adaptation, etc.).

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Year 1 Factor D' Derivation is estimated based on actual Medicaid expenditures for all non-waiver services (i.e., acute medical and behavioral health) for CAP/DA recipients during SFY 2015/2016. The data was trended forward to each waiver year using 3% annual growth in expenditures to align with trends observed for the CAP/DA waiver spending as summarized in the CMS 372 reports for SFY 2012/2013 through SFY 2014/2015. Similar to the Factor D Derivation section above, expenditure data for Factor D' was found to be consistent with CMS 372 information from overlapping time periods.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Year 1 Factor G Derivation is estimated based on actual Medicaid institutional claims expenditure data for Medicaid recipients residing in nursing facilities. The data was run for SFY 2016/2017, and was trended forward to each waiver year using 3% annual growth in expenditures. This trend factor was based on review of institutional claims for the identified Nursing Facility level of care population during the SFY 2014/2015 through SFY 2016/2017 time periods.
Medicaid expenditure data was relied on to develop Factors G and G', specifically expenditures for individuals accessing nursing facility services. Medicaid expenditures were further examined to understand the cost differential between short term and long term (those with stays >90 days) nursing facility users. Ultimately, the State relied on the expenditures and enrollment for long term nursing facility users to better reflect typical costs of nursing facility level of care adult populations within the State and exclude populations who may be relying on nursing facilities for only a short period for rehabilitative purposes. The results of this approach were compared to Factors G and G' information from the CMS 372 reports. The Factor G' information from the CMS 372 was found to be consistent with the long term nursing facility user expenditures. For Factor G, the long term nursing facility expenditure data was found to be somewhat higher on an average annual cost per user than available CMS 372 reports. The State feels that the Factor G levels in this waiver renewal, and underlying long term nursing facility resident expenditure data, are a more appropriate metric and comparison to the populations enrolled in the CAP/DA waiver.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The Year 1 Factor G' Derivation is estimated based on actual Medicaid claims expenditure data for non-institutional services (i.e., acute medical and behavioral health) for long term nursing facility users. These are the costs associated with non-nursing facility expenditures for these recipients. The data was run for SFY 2016/2017, and was trended forward to each waiver year using 3% annual growth in expenditures. This trend factor was based on review of all non-institutional claims for the identified Nursing Facility level of care population during the SFY 2014/2015 through SFY 2016/2017 time periods. This trend factor also aligns with the identified trend for the Factor D' projection.
As outlined in the Factor G Derivation section above, the expenditure data relied on for this analysis was consistent with CMS 372 reports for overlapping time periods.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Adult Day Health	
CAP In-Home Aide	
Coordination of care - case management and care advisement	
Financial Management Services	
Personal Assistance Services	
Community Integration Services	
Community Transition	
Coordinated Caregiving	
Equipment, Modification and Technology	
Individual Goods and Services	
Meal Preparation and Delivery	
Nutritional Services	
Participant Goods and Services	
Personal Emergency Response Services	
Pest Eradication	
Respite Services	
Specialized Medical Supplies	
Training/Education and Consultative Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2097958.50
Adult Day Health	Day	363	150.00	38.53	2097958.50	
CAP In-Home Aide Total:						
CAP In-Home Aide	15 minutes	10783	5724.00	3.90	240715378.80	
CAP In-Home Aide						
CAP In-Home Aide						
Coordination of care - case management and care advisement Total:						
Case Management	Month	10915	5.00	377.00	20574775.00	
Care Advisor	Month	2251	4.00	377.00	3394508.00	
Coordination of care - case management and care advisement						
Coordination of care - case management and care advisement						
Financial Management Services Total:						
Financial Management Services	Month	2235	11.00	93.00	2286405.00	
Financial Management Services						
Financial Management Services						
Personal Assistance Services Total:						
Personal Assistance Services	15 minutes	2212	6652.00	3.90	57385473.60	
Personal Assistance Services						
Community Integration Services Total:						
Community Integration Services	Instance	69	1.00	500.00	34500.00	
Community Integration Services						

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	13588
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Services						
Community Integration Services						
Community Integration Services						
Community Integration Services						
Community Transition Total:						**15000.00**
Community Transition	Instance	30	1.00	500.00	**15000.00**	
Coordinated Caregiving Total:						**2136332.88**
Low Service Level	Day	121	408.00	33.29	**1643460.72**	
Skilled Service Level	Day	22	408.00	54.91	**492872.16**	
Equipment, Modification and Technology Total:						**3910579.26**
Home Accessibility and Adaptation	Instance	1659	1.00	2000.00	**3318000.00**	
Assistive Technology	Instance	351	1.00	1688.26	**592579.26**	
Individual Goods and Services Total:						**95200.00**
Individual Goods and Services	Instance	119	1.00	800.00	**95200.00**	
Meal Preparation and Delivery Total:						
Meal Preparation and Delivery	Meal	701	176.00	4.87	**600841.12**	
Meal Preparation and Delivery						
Nutritional Services Total:						**24000.00**
Nutritional Services	Instance	30	1.00	800.00	**24000.00**	
Participant Goods and Services Total:						**213600.00**
Participant Goods and Services	Instance	267	1.00	800.00	**213600.00**	
Personal Emergency Response Services Total:						**2005641.00**
Personal Emergency	Month				**2005641.00**	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	**13588**
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Response Services		6753	10.00	29.70		
Pest Eradication Total:						56640.00
Pest Eradication	Instance	177	1.00	320.00	56640.00	
Respite Services Total:						775176.84
In-Home	15 minutes	634	312.00	3.90	771451.20	
Institutional	Day	1	18.00	206.98	3725.64	
Specialized Medical Supplies Total:						9290022.68
Nutritional Supplements	Unit	4712	988.00	0.84	3910583.04	
Disposal Liners	Unit	2539	806.00	0.34	695787.56	
Resuable Incontinence supplies	Unit	249	904.00	20.80	4681996.80	
Medication dispensing box	Unit	152	1.00	10.89	1655.28	
Training/Education and Consultative Services Total:						187500.00
Training/Education and Consultative Services	Instance	375	1.00	500.00	187500.00	
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			13588
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2175705.84
Adult Day Health					2175705.84	
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			13588
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	363	154.00	38.92		
CAP In-Home Aide Total:						
CAP In-Home Aide	15 minutes	10783	5896.00	3.94	250491677.92	
CAP In-Home Aide						
CAP In-Home Aide						
Coordination of care - case management and care advisement Total:						
Case Management	Month	10915	5.00	380.77	20780522.75	
Care Advisor	Month	2251	4.00	380.77	3428453.08	
Coordination of care - case management and care advisement						
Coordination of care - case management and care advisement						
Financial Management Services Total:						
Financial Management Services	Month	2235	11.00	93.93	2309269.05	
Financial Management Services						
Financial Management Services						
Personal Assistance Services Total:						
Personal Assistance Services	15 minutes	2212	6851.00	3.94	59708383.28	
Personal Assistance Services						
Community Integration Services Total:						
Community Integration Services	Instance	69	1.00	505.00	34845.00	
Community Integration Services						
Community Integration Services						

GRAND TOTAL:

Total Estimated Unduplicated Participants: 13588

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Integration Services						
Community Integration Services						
Community Integration Services						
Community Transition Total:						**15150.00**
Community Transition	Instance	30	1.00	505.00	**15150.00**	
Coordinated Caregiving Total:						**2221018.80**
Low Service Level	Day	121	420.00	33.62	**1708568.40**	
Skilled Service Level	Day	22	420.00	55.46	**512450.40**	
Equipment, Modification and Technology Total:						**3949684.14**
Home Accessibility and Adaptation	Instance	1659	1.00	2020.00	**3351180.00**	
Assistive Technology	Instance	351	1.00	1705.14	**598504.14**	
Individual Goods and Services Total:						**95200.00**
Individual Goods and Services	Instance	119	1.00	800.00	**95200.00**	
Meal Preparation and Delivery Total:						
Meal Preparation and Delivery	Meal	701	182.00	4.92	**627703.44**	
Meal Preparation and Delivery						
Nutritional Services Total:						**24000.00**
Nutritional Services	Instance	30	1.00	800.00	**24000.00**	
Participant Goods and Services Total:						**213600.00**
Participant Goods and Services	Instance	267	1.00	800.00	**213600.00**	
Personal Emergency Response Services Total:						**2025900.00**
Personal Emergency Response Services	Month	6753	10.00	30.00	**2025900.00**	
Pest Eradication Total:						**56640.00**

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	13588
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Pest Eradication	Instance	177	1.00	320.00	56640.00	
Respite Services Total:						805608.06
In-Home	15 minutes	634	321.00	3.94	801845.16	
Institutional	Day	1	18.00	209.05	3762.90	
Specialized Medical Supplies Total:						9663655.39
Nutritional Supplements	Unit	4712	1017.00	0.85	4073288.40	
Disposal Liners	Unit	2539	830.00	0.34	716505.80	
Resuable Incontinence supplies	Unit	249	931.00	21.01	4870517.19	
Medication dispensing box	Unit	152	2.00	11.00	3344.00	
Training/Education and Consultative Services Total:						187500.00
Training/Education and Consultative Services	Instance	375	1.00	500.00	187500.00	
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			13588
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:		310	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2268278.10
Adult Day Health	Day	363	159.00	39.30	2268278.10	
CAP In-Home Aide Total:						
CAP In-Home Aide					260630932.82	
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			13588
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:		310	

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	15 minutes	10783	6073.00	3.98		
CAP In-Home Aide						
CAP In-Home Aide						
Coordination of care - case management and care advisement Total:						
Case Management	Month	10915	5.00	384.58	20988453.50	
Care Advisor	Month	2251	4.00	384.58	3462758.32	
Coordination of care - case management and care advisement						
Coordination of care - case management and care advisement						
Financial Management Services Total:						
Financial Management Services	Month	2235	11.00	94.87	2332378.95	
Financial Management Services						
Financial Management Services						
Personal Assistance Services Total:						
Personal Assistance Services	15 minutes	2212	7057.00	3.98	62128134.32	
Personal Assistance Services						
Community Integration Services Total:						
Community Integration Services	Instance	69	1.00	510.05	35193.45	
Community Integration Services						
Community Integration Services						
Community Integration Services						
Community						

GRAND TOTAL:

Total Estimated Unduplicated Participants: 13588

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integration Services						
Community Integration Services						
Community Transition Total:						**15301.50**
Community Transition	Instance	30	1.00	510.05	**15301.50**	
Coordinated Caregiving Total:						**2312817.54**
Low Service Level	Day	121	433.00	33.96	**1779266.28**	
Skilled Service Level	Day	22	433.00	56.01	**533551.26**	
Equipment, Modification and Technology Total:						**3989180.49**
Home Accessibility and Adaptation	Instance	1659	1.00	2040.20	**3384691.80**	
Assistive Technology	Instance	351	1.00	1722.19	**604488.69**	
Individual Goods and Services Total:						**95200.00**
Individual Goods and Services	Instance	119	1.00	800.00	**95200.00**	
Meal Preparation and Delivery Total:						
Meal Preparation and Delivery	Meal	701	187.00	4.97	**651502.39**	
Meal Preparation and Delivery						
Nutritional Services Total:						**24000.00**
Nutritional Services	Instance	30	1.00	800.00	**24000.00**	
Participant Goods and Services Total:						**213600.00**
Participant Goods and Services	Instance	267	1.00	800.00	**213600.00**	
Personal Emergency Response Services Total:						**2250774.90**
Personal Emergency Response Services	Month	6753	11.00	30.30	**2250774.90**	
Pest Eradication Total:						**56640.00**
Pest Eradication	Instance	177	1.00	320.00	**56640.00**	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	**13588**
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Respite Services Total:						839230.58
In-Home	15 minutes	634	331.00	3.98	835218.92	
Institutional	Day	1	19.00	211.14	4011.66	
Specialized Medical Supplies Total:						10077149.57
Nutritional Supplements	Unit	4712	1048.00	0.86	4246831.36	
Disposal Liners	Unit	2539	855.00	0.35	759795.75	
Resuable Incontinence supplies	Unit	249	959.00	21.22	5067145.02	
Medication dispensing box	Unit	152	2.00	11.11	3377.44	
Training/Education and Consultative Services Total:						187500.00
Training/Education and Consultative Services	Instance	375	1.00	500.00	187500.00	
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			13588
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2349009.30
Adult Day Health	Day	363	163.00	39.70	2349009.30	
CAP In-Home Aide Total:						
CAP In-Home Aide	15 minutes	10783	6255.00	4.02	271139613.30	
CAP In-Home Aide						
			GRAND TOTAL:			
			Total Estimated Unduplicated Participants:			13588
			Factor D (Divide total by number of participants):			
			Average Length of Stay on the Waiver:			310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CAP In-Home Aide						
Coordination of care - case management and care advisement Total:						
Case Management	Month	10915	5.00	388.42	21198021.50	
Care Advisor	Month	2251	4.00	388.42	3497333.68	
Coordination of care - case management and care advisement						
Coordination of care - case management and care advisement						
Financial Management Services Total:						
Financial Management Services	Momth	2235	12.00	95.82	2569892.40	
Financial Management Services						
Financial Management Services						
Personal Assistance Services Total:						
Personal Assistance Services	15 minutes	2212	7268.00	4.02	64628800.32	
Personal Assistance Services						
Community Integration Services Total:						
Community Integration Services	Instance	69	1.00	515.15	35545.35	
Community Integration Services						
Community Integration Services						
Community Integration Services						
Community Integration Services						
Community						

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	13588
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Integration Services						
Community Transition Total:						**15454.50**
Community Transition	Instance	30	1.00	515.15	**15454.50**	
Coordinated Caregiving Total:						**2406098.64**
Low Service Level	Day	121	446.00	34.30	**1851033.80**	
Skilled Service Level	Day	22	446.00	56.57	**555064.84**	
Equipment, Modification and Technology Total:						**4029071.82**
Home Accessibility and Adaptation	Instance	1659	1.00	2060.60	**3418535.40**	
Assistive Technology	Instance	351	1.00	1739.42	**610536.42**	
Individual Goods and Services Total:						**95200.00**
Individual Goods and Services	Instance	119	1.00	800.00	**95200.00**	
Meal Preparation and Delivery Total:						
Meal Preparation and Delivery	Meal	701	193.00	5.02	**679170.86**	
Meal Preparation and Delivery						
Nutritional Services Total:						**24000.00**
Nutritional Services	Instance	30	1.00	800.00	**24000.00**	
Participant Goods and Services Total:						**213600.00**
Participant Goods and Services	Instance	267	1.00	800.00	**213600.00**	
Personal Emergency Response Services Total:						**2273059.80**
Personal Emergency Response Services	Month	6753	11.00	30.60	**2273059.80**	
Pest Eradication Total:						**56640.00**
Pest Eradication	Instance	177	1.00	320.00	**56640.00**	
Respite Services Total:						**873364.88**
In-Home	15 minutes		341.00	4.02	**869099.88**	

GRAND TOTAL:

Total Estimated Unduplicated Participants: 13588

Factor D (Divide total by number of participants):

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
		634				
Institutional	Day	1	20.00	213.25	4265.00	
Specialized Medical Supplies Total:						10480755.80
Nutritional Supplements	Unit	4712	1079.00	0.87	4423295.76	
Disposal Liners	Unit	2539	880.00	0.35	782012.00	
Resuable Incontinence supplies	Unit	249	988.00	21.43	5272037.16	
Medication dispensing box	Unit	152	2.00	11.22	3410.88	
Training/Education and Consultative Services Total:						187500.00
Training/Education and Consultative Services	Instance	375	1.00	500.00	187500.00	
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		13588
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:		310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2444848.56
Adult Day Health	Day	363	168.00	40.09	2444848.56	
CAP In-Home Aide Total:						
CAP In-Home Aide	15 minutes	10783	6442.00	4.06	282024189.16	
CAP In-Home Aide						
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		13588
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:		310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
CAP In-Home Aide						
Coordination of care - case management and care advisement Total:						
Case Management	Month	10915	5.00	392.31	21410318.25	
Care Advisor	Month	2251	4.00	392.31	3532359.24	
Coordination of care - case management and care advisement						
Coordination of care - case management and care advisement						
Financial Management Services Total:						
Financial Management Services	Month	2235	12.00	96.78	2595639.60	
Financial Management Services						
Financial Management Services						
Personal Assistance Services Total:						
Personal Assistance Services	15 minutes	2212	7486.00	4.06	67229669.92	
Personal Assistance Services						
Community Integration Services Total:						
Community Integration Services	Instance	69	1.00	520.30	35900.70	
Community Integration Services						
Community Integration Services						
Community Integration Services						
Community Integration Services						
Community Integration Services						

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	13588
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition Total:						15609.00
Community Transition	Instance	30	1.00	520.30	15609.00	
Coordinated Caregiving Total:						2500870.68
Low Service Level	Day	121	459.00	34.64	1923870.96	
Skilled Service Level	Day	22	459.00	57.14	576999.72	
Equipment, Modification and Technology Total:						4069367.70
Home Accessibility and Adaptation	Instance	1659	1.00	2081.21	3452727.39	
Assistive Technology	Instance	351	1.00	1756.81	616640.31	
Individual Goods and Services Total:						95200.00
Individual Goods and Services	Instance	119	1.00	800.00	95200.00	
Meal Preparation and Delivery Total:						
Meal Preparation and Delivery	Meal	701	198.00	5.07	703705.86	
Meal Preparation and Delivery						
Nutritional Services Total:						24000.00
Nutritional Services	Instance	30	1.00	800.00	24000.00	
Participant Goods and Services Total:						213600.00
Participant Goods and Services	Instance	267	1.00	800.00	213600.00	
Personal Emergency Response Services Total:						2296087.53
Personal Emergency Response Services	Month	6753	11.00	30.91	2296087.53	
Pest Eradication Total:						56640.00
Pest Eradication	Instance	177	1.00	320.00	56640.00	
Respite Services Total:						907795.64
In-Home	15 minutes	634	351.00	4.06	903488.04	
Institutional					4307.60	

GRAND TOTAL:	
Total Estimated Unduplicated Participants:	13588
Factor D (Divide total by number of participants):	
Average Length of Stay on the Waiver:	310

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
	Day	1	20.00	215.38		
Specialized Medical Supplies Total:						10905775.07
Nutritional Supplements	Unit	4712	1112.00	0.88	4610974.72	
Disposal Liners	Unit	2539	907.00	0.35	806005.55	
Resuable Incontinence supplies	Unit	249	1018.00	21.64	5485350.48	
Medication dispensing box	Unit	152	2.00	11.33	3444.32	
Training/Education and Consultative Services Total:						187500.00
Training/Education and Consultative Services	Instance	375	1.00	500.00	187500.00	
				GRAND TOTAL:		
				Total Estimated Unduplicated Participants:		13588
				Factor D (Divide total by number of participants):		
				Average Length of Stay on the Waiver:		310