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NC Division of Medical Assistance
Medicaid and Health Choice
Community Alternatives Program
Clinical Coverage Policy No: 3K-2
For Disabled Adults (CAP / DA)
Amended Date: January 1, 2017

Related Clinical Coverage Policies
Refer to http://dma.ncdhhs.gov/ for the related coverage policies listed below:
2A3, Out-of-State Service
2B-1, Nursing Facilities
3A, Home Health Services
3D, Hospice Services
3G, Private Duty Nursing
3H-1, Home Infusion Therapy
5A, Durable Medical Equipment
8A, Enhanced Mental Health and Substance Abuse Services
8A-1, Assertive Community Treatment (ACT) Program
8C, Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers
8J, Children's Developmental Service Agencies (CDSAs)
8L, Mental Health/Substance Abuse Targeted Case Management
8-O, Services for Individuals with Intellectual and Developmental Disabilities and Mental Health or Substance Abuse Co-Occurring Disorders

1.0 Description of the Procedure, Product, or Service

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

HCBS waivers are approved by Centers of Medicare and Medicaid Services (CMS) for a specified time. The waiver establishes the requirements for program administration and funding. Federal regulations for HCBS waivers are found in 42 CFR Part 441 Subpart G, Home and Community-Based Services: Waiver Requirements. The NC Division of Medical Assistance (DMA) can renew or amend the waiver with the approval of CMS. CMS may exercise its authority to terminate the waiver when it believes the waiver is not operated properly. This waiver serves adults with disabilities 18 years of age and older who are at risk of institutionalization. To enroll and participate in this waiver, the individual shall meet the Medicaid eligibility requirements for long-term care.
DMA is the administrative authority of the waiver and outlines the policies and procedures governing the waiver. DMA appoints local case management entities to provide the day-to-day operation of the waiver to ensure the primary six waiver assurances are met. These assurances are:

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

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

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

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

The two options under the CAP Program are:
1. CAP/DA (Community Alternatives Program for Disabled Adults) is the traditional option; and
2. CAP/Choice is the consumer-directed option.

The CAP waiver services are:
   a. Adult day health
   b. In-home aide personal care
   c. Home accessibility and adaptation
   d. Meal preparation and delivery
   e. Institutional respite services
   f. Non-institutional respite services
   g. Personal Emergency Response Services
   h. Specialized medical equipment and supplies
   i. Participant goods and services
   j. Community transition services
   k. Training, education and consultative services
1. Assistive technology
m. Case management
n. Care advisor (CAP/Choice only)
o. Personal assistant (CAP/Choice only)
p. Financial management services (CAP/Choice only)

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
   2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service and shall meet the criteria in Section 3.0 of this policy.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to his or her eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

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

a. Medicaid

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

a. are determined to require a level of institutional care under the NC State Medicaid Plan;
b. are members of a target group that is included in the waiver;
c. meet applicable Medicaid eligibility criteria;
d. require more than one waiver service including case management in order to function in the community; and
e. exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care.

There are a variety of Medicaid coverage categories; however, only a Medicaid beneficiary who is a disabled adult 18 years of age and older in one of the categories specified below is eligible for CAP/DA Waiver:

a. Medicaid to the Aged (MAA)
b. Medicaid to the Blind (MAB)
c. Medicaid to the Disabled (MAD)
Note: It is not appropriate to consider an individual for CAP who is not at-risk of institutionalization simply to qualify him or her for Medicaid.

b. NCHC
NCHC beneficiaries are not eligible for CAP Waiver services.

2.2 Special Provisions

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

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

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

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

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

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

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.

2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTRacks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTRacks Provider Claims and Billing Assistance Guide:*
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: [http://dma.ncdhhs.gov/](http://dma.ncdhhs.gov/)

### 2.2.2 EPSDT does not apply to NCHC beneficiaries

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

The Division of Medical Assistance (DMA) shall deny the claim for coverage for a NCHC beneficiary who does not meet the criteria within Section 3.0 of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for a NCHC beneficiary.

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

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

#### 3.1 General Criteria Covered

Medicaid shall cover procedures, products, and services related to this policy when they are medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary’s needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

C. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary’s caretaker, or the provider.

#### 3.2 Specific Criteria Covered

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

None Apply.

**3.2.2 Specific criteria covered by Medicaid**

Medicaid shall cover **CAP/DA waiver** services when a beneficiary meets **all** of the following criteria:

a. Requires the approved HCBS nursing facility LOC as determined by DMA;
b. Meets the required level of care when a slot is available, and the completed CAP assessment finds there is a reasonable indication the individual would need services in the appropriate level of care within 30 days of the evaluation. Refer to Appendix E for definition of risk of institutionalization;

c. Chooses CAP services instead of institutional care as evidenced by the written statement of the beneficiary or primary caregiver on standardized forms as approved by DMA;

d. Requires long-term care support at a level typically provided in an institution that is directly related to a documented medical diagnosis and functional care need as assessed quarterly;

e. Requires two waiver services (excluding incontinence supplies, personal emergency response system, and meals preparation and delivery), on a monthly basis, that mitigate institutionalization through coordinated case management and hands-on personal assistance;

f. Able to have his or her health, safety and well-being maintained at his or her primary private residence within the CAP, budgeting methodology;

g. The beneficiary’s health, safety and welfare can be maintained in the home with use of formal and informal supports;

h. Has an emergency back-up plan with adequate formal and informal support to meet the basic needs outlined in the CAP, assessment and plan of care (POC) to maintain his or her health, safety and well-being.

The emergency back-up plan is created by the CAP, beneficiary with the assistance of the case manager or care advisor. This plan specifies who shall provide care when key direct care staff cannot provide services or tasks as indicated in the current POC.

The case manager or care advisor shall ensure that an adequate emergency back-up plan is in place, because both personal and home maintenance tasks are essential to the well-being of the participant. The plan may include family, friends, neighbors, community volunteers and licensed home care agencies when possible in the event of an emergency or an unplanned occurrence. An emergency back-up plan is necessary for times when the formally (In-home aide or personal assistant) arranged support system is unavailable during regularly scheduled work hours and when the unpaid informal support system is unavailable. The emergency back-up plan must address emergency preparedness;

Medicaid shall cover CAP/Choice waiver services when a beneficiary meets all of the above and the following criteria:

a. Understand the rights and responsibilities of directing his or her own care;

b. Be willing and intellectually capable to assume the responsibilities for consumer-directed care, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary’s care; and

c. Complete a self-assessment questionnaire to determine intellectual ability to direct care, ensure health and safety and identify training
opportunities to build competencies to aid in consumer-directed care listed in **Appendix B**.

In addition to the specific criteria listed in **Subsection 3.2.2**, the following requirements apply to all CAP beneficiaries:

a. Care is maintained at his or her primary private residence or approved place of service within the average cost limitations of the CAP Waiver;

b. Amount, duration, frequency, and provider taxonomy of CAP services and non-CAP services are indicated in the beneficiary’s service plan and approved by the lead agency; and

c. Services are provided in accordance with all requirements specified in this policy; all applicable federal and state laws, rules, and regulations; the current standards of practice; and provider agency policies and procedures.

The following steps must be completed prior to the transition to the CAP program:

a. CAP Service Request Form;

b. Determined anticipated start date of service; and

c. Coordinated transition plan between provider agencies from one Medicaid program to the next.

**Level of Care Determination Criteria**

Professional judgment and a thorough evaluation of the beneficiary’s medical condition and psychosocial needs are required to differentiate between the need for nursing facility care and other health care alternatives. The HCBS LOC must address interventions, safeguards (health, safety, and well-being) and the stability of each beneficiary to ensure community integration and prevention of institutionalization as a result of chronic medical and physical disabilities.

A HCBS Service Request Form with clear indication of nursing facility level of care needs must be completed to its entirety and signed by a designated clinician to establish need for CAP services.

A LOC determination must be completed at initial enrollment. An annual LOC will be determined during the annual continued need review assessment. Changes to a beneficiary’s condition that may cause the beneficiary to no longer meet HCBS LOC may result in a disenrollment from waiver participation.

**Note:** A beneficiary being considered for participation in the CAP shall meet Medicaid’s approved HCBS nursing facility level of care criteria, comparable to the N.C. Medicaid State Plan nursing facility criteria.

**HCBS Nursing Facility Level of Care Criteria includes the need for any of the following Qualifying Conditions:**

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

   1. A service required by s physician’s judgment requires:
      A. supervision of a registered nurse or licensed practical nurse; and
      B. other personnel working under the direct supervision of a registered nurse or licensed practical nurse.
2. Observation and assessment of beneficiary needs by a registered nurse or licensed practical nurse. The nursing services must be intensive and directed to an acute episode or a change in the treatment plan that would require such concentrated monitoring.

3. Restorative nursing measures once a beneficiary’s treatment plan becomes stable. Restorative nursing measures are used to maintain or restore maximum function or to prevent advancement of progressive disability as much as possible. Such measures are:
   A. Encouraging and assisting a beneficiary to achieve independence in activities of daily living (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 beneficiary would not necessarily require skilled nursing care.

4. Dialysis (hemodialysis or peritoneal dialysis) as part of a maintenance treatment plan.

5. Treatment for a specialized therapeutic diet (physician prescribed). Documentation must address the specific plan of treatment such as the use of dietary supplements, therapeutic diets, and frequent recording of the beneficiary’s nutritional status.

6. Administration or control of medication as required by state law to be the exclusive responsibility of 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 beneficiary who receives oxygen continuously as a component to a stable treatment plan:
   A. Nebulizer usage;
   B. Nasopharyngeal or tracheal suctioning;
   C. Oral suctioning;
   D. Pulse oximetry.

9. Isolation: when medically necessary as a limited measure because of contagious or infectious disease.

10. Wound care of decubitus ulcers or open areas.

11. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan.
b. Conditions That Must be Present in Combination to Justify HCBS Nursing Level of Care

The following, when in combination (two or more), may justify HCBS nursing facility level of care placement:

1. Need for teaching and counseling related to a disease process, disability, diet, or medication.
2. Adaptive programs: training the beneficiary to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must report the purpose of the beneficiary’s participation in the program and the beneficiary’s progress.
3. Ancillary therapies: supervision of beneficiary’s performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of plaster casts.
4. Injections: requiring administration or professional judgment by an RN or LPN or a trained personal assistance.
5. Diabetes: when daily observation of dietary intake or medication administration is required for proper physiological control:
   A. Vision, dexterity and cognitive deficiencies; or
   B. Frequent hypoglycemic and diabetic ketoacidosis (DKA) (high blood sugar) episodes with documentation requiring intravenous or intramuscular (IV or IM) or oral intervention.
6. Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction.
7. Psychosocial considerations: psychosocial condition of each beneficiary must be evaluated in relation to his or her medical condition when determining the need for nursing facility level of care. Factors to consider along with the beneficiary’s medical needs are:
   A. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician’s orders or progress notes or by nursing or therapy notes);
   B. Age;
   C. Length of stay in current placement;
   D. Location and condition of spouse;
   E. Proximity of social support; or
   F. Effect of transfer on resident, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning helps alleviate the fear and worry of transfer).
8. Blindness.
9. Behavioral problems, such as:
   A. Wandering;
   B. Verbal disruptiveness;
   C. Combativeness;
   D. Verbal or physical abusiveness; or
   E. Inappropriate behavior (when it can be properly managed at the nursing facility level of care);
10. Frequent falls; or
Note: When a waiver beneficiary is participating in the consumer-directed option (CAP/Choice), supervision of a registered nurse or licensed practical nurse; and other personnel working under the direct supervision of a registered nurse or licensed practical nurse is not a requirement. Consumer-directed care allows choice of service providers.

3.2.3 Expedited Criteria (Prioritization)

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

a. Age 18-20 21 transitioning from the CAP/C program.

b. Individuals with an active Auto Immune Deficiency Syndrome (Aids) diagnosis with a T-Count of below 200.

c. Individuals transitioning from a nursing facility with Money Follows the Person (MFP) designation.

d. Individuals transitioning from a nursing facility utilizing service of community transition.

e. Eligible CAP beneficiaries who are transferring to another county or lead agency.

f. Previously eligible CAP/DA or CAP/Choice beneficiaries who are transitioning from a short-term rehabilitation placement within 90 days of the placement.

g. Individuals identified at risk by his or her local Department of Social Services (DSS) who has an order of protection by Adult Protective Services (APS) for abuse, neglect and exploitation and the CAP waiver is able to mitigate risk.

h. Medicaid beneficiary with active Medicaid who are temporarily out of the State due to a military assignment of his or her primary caregiver.

i. Individual transferring to North Carolina from another State due to a military assignment who was actively participating in a disabled and aged 1915(c) HCBS waiver.

j. Individual with a diagnosis of Alzheimer’s disease. Three-hundred and twenty (320) are reserved for this priority group.

3.2.4 Case Management

Case management is assessing, care planning, referral or linkage and monitoring and follow-up. Case management services are necessary to identify needed medical, social, environmental, financial, and emotional needs. These services are provided to maintain the beneficiary’s health, safety, and well-being in the community. A case management review is performed at least monthly with the waiver beneficiary.

Waiver case management services are defined as services furnished to assist individuals in gaining access to needed medical, social, educational and other services.
3.2.5 Medicaid Additional Criteria

In addition to the specific criteria covered in Subsection 3.2.2 of this policy, Medicaid shall cover the following CAP waiver services within the beneficiary’s average budget limitation:

**Adult Day Health Services**

This service is for adults who are aged, have disabilities or handicaps that need a structured day program of activities and services with nursing supervision. It is an organized program of service provided for four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting according to NC General Statute 131-D-6. The service encompasses both health and social services needed to ensure the optimal functioning of the beneficiary.

**Assistive Technology**

Assistive technology consists of items, product systems, supplies, and equipment necessary to the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used for the purposes of improving or maximizing the functional capabilities of the beneficiary, improve the accessibility and use of the beneficiary's environment, or address 24 hours-a-day, 7 days-a-week beneficiary coverage issues.

In some cases, the use of assistive technology may reduce the number of hours of personal care that the beneficiary needs. This service may be used for adaptive or therapeutic equipment designed to enable a beneficiary to increase, maintain, or improve functional capacity in performing daily life tasks that would not be possible otherwise; specialized monitoring systems; and specialized accessibility and safety adaptations or additions. This service provides technical assistance in device selection and training in device used by a qualified assistive technology professional, assessment and evaluation, purchases, shipping costs, and as necessary, the repair of such devices.

The beneficiary's POC must clearly indicate a plan for training the beneficiary, family, primary caregiver, personal aides or assistants who are to assist in the application or use of the device(s). Professional consultation must be accessed to ensure that the equipment or supply meet the needs of the beneficiary.

**Community Transition**

Community transition services are available to cover one-time expenses, not to exceed $2,500 per beneficiary. These expenditures are for initial set-up expenses for beneficiaries who make the transition from an institution to his or her own primary private residence in the community. The funds are used to pay the necessary expenses for a beneficiary to establish a basic living arrangement. Such items include:

a. Equipment, essential furnishings, and household products;

b. Moving expenses;

c. Security deposits or other such payments (e.g., first month's rent) required to obtain a lease on an apartment or primary private residence;
d. Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating);

e. Environmental health and safety assurances, such as pest eradication, allergen control, one-time cleaning prior to occupancy;

f. Personal hygiene supplies;

g. First week supply of groceries; and

h. Up to a one month supply of medication in instances when the beneficiary is not provided with medication upon discharge from the nursing facility.

**Home Accessibility and Adaptation**

Home accessibility and adaptation include equipment and physical adaptations or minor renovations to the beneficiary's primary private residence that are required to meet his or her needs and are documented in the approved plan of care. Home accessibility and adaptation aids are provided to enhance the beneficiary's mobility, safety, and independence in the primary private residence. This service often plays a key role in preventing institutionalization.

**Institutional Respite Care**

Institutional respite is computed on a daily rate and in-home respite is computed on 15-minute unit interval. The combined use of both institutional respite care and non-institutional respite care must not exceed 30 calendar-days or 720 hours in one fiscal year.

**Non-Institutional Respite Services**

These services are provided in the CAP/ beneficiary’s primary private residence and are provided by an in-home aide working through a homecare agency licensed by the State of North Carolina and authorized by the case manager to provide this temporary care. This service may be used to meet a wide range of needs, including family emergencies; planned special circumstances (such as vacations, hospitalizations, or business trips); relief from the daily responsibility and stress of caring for a beneficiary with a disability; or the provision of time for the caregiver(s) to complete essential personal tasks. Non-Institutional respite is computed on a daily rate and in-home respite is computed on 15-minute unit interval.

**Participant Goods and Services**

Participant goods and services include services, equipment, or supplies not otherwise provided through this waiver or through the Medicaid State Plan that meet the following requirements:

a. The item or service would increase the individual’s ability to perform ADLs or IADLs;

b. The item or service would decrease dependence on personal assistant services or other Medicaid-funded services; and

c. The beneficiary does not have the funds to purchase the item or service. CAP/Choice beneficiaries may direct the financial manager (through the approved plan of care) to save a portion of his or her monthly beneficiary-directed budget for these items and services.
In-Home Aide Service
In-Home Aide Service provides assistance with personal care and basic home management tasks to beneficiaries who are unable to perform these tasks independently due to physical or mental disabilities. In-Home Aide Service Services may be provided in the community, home, workplace, or educational settings at the discretion of the Home Care Provider. Under the Medicaid Infrastructure Grant (MIG) with Vocational Rehabilitation, DMA agreed to provide community based services in the workplace for those beneficiaries who qualify.

Personal Emergency Response Services (PERS)
This service pays for the monthly service charges or monthly rental charges for a system used to alert a central monitoring facility of medical emergencies that threaten the beneficiary's health, safety and well-being.

Specialized Medical Equipment and Supplies
Waiver supplies include specialized supplies approved through the CAP waiver which are not covered under the State Medicaid Plan. These supplies are provided to the waiver beneficiary to promote the health and well-being of the beneficiary. The service is necessary to avoid institutionalization.

The following are waiver items:
  a. nutritional supplements taken by mouth when ordered by a physician;
  b. medication dispensing boxes;
  c. reusable incontinence undergarments;
  d. disposable liners for reusable incontinence undergarments; and
  e. incontinence pads for personal undergarments.

Training, Education and Consultative Services
Training and education includes training for the beneficiary, a family member who is the primary caregiver, or the personal assistant for CAP/Choice beneficiaries.

The purpose of this training is to enhance the decision-making ability of the beneficiary, enhance the ability of the beneficiary to independently care for themselves, or enhance the ability of the family member or personal assistant in caring for the beneficiary. Training and education include information and techniques for the use of specialized equipment and supplies. All training and education services must be documented in the beneficiary's POC as a goal with the expected outcomes. This service provides conference registration and enrollment fees for classes.

3.2.6 CAP/Choice (only)

Care Advisor
The care advisor is a specialized case manager from a CAP local lead agency with an understanding of consumer-directed care. The care advisor focuses on empowering consumers to define and direct his or her own personal assistance needs and services. The care advisor guides and supports the beneficiary, rather
than directing and managing the beneficiary, throughout the service planning and delivery process. The care advisor provides the four basic functions of case management (assessing, care planning, referral/linkage, and monitoring/follow-up) however these functions are performed under the guidance and direction of the Choice beneficiary.

**Personal Assistant Services**

Personal assistant services are available only for those beneficiaries who have elected CAP/Choice under the CAP Waiver. The personal assistant is hired by the beneficiary to provide help with personal and home maintenance tasks for beneficiaries who are unable to meet these needs independently due to physical or mental impairments. Personal maintenance tasks are basic activities of daily living that must be performed to assure or support the beneficiary’s physical well-being.

**Financial Management Services**

Financial management services are provided to ensure that beneficiary-directed funds outlined in individual plans of care are managed and distributed as intended. The Financial Intermediary (FI) files claims through NCTracks and reimburses the personal assistant(s) and individual providers. The FI deducts all required federal, state taxes, including insurance and FI fees, prior to issuing reimbursement or paychecks. The FI entity is responsible for maintaining separate accounts on each beneficiary’s services, and producing expenditure reports as required by the state Medicaid agency. The FI also provides payroll statements on at least a monthly basis to the personal assistant(s) and the lead agency. The FI conducts necessary background checks and age verification on personal assistants.

### 3.2.7 NCHC Additional Criteria Covered

None Apply.

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

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

#### 4.1 General Criteria Not Covered

Medicaid shall not cover procedures, products, and services related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;

b. the beneficiary does not meet the criteria listed in **Section 3.0**;

c. the procedure, product, or service duplicates another provider’s procedure, product, or service; or

d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.
4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Specific Criteria Not Covered by Medicaid

Medicaid shall not cover CAP participation and services for any one of the following:

a. The Community Alternatives Program (CAP) evidence code has not been entered or has been removed from the eligibility information system (NC FAST);

b. The HCBS Service Request Form is incomplete or has been denied;

c. The required annual assessment recertification was not approved or completed within 60 calendar-days of the annual assessment date;

1. An assessment of medical and functional needs has not been completed by an RN or social worker to determine risk of institutionalization, defined in Appendix E;

2. The beneficiary enters a nursing facility for a short-term rehabilitation stay or long-term nursing home stay. When a beneficiary enters a skilled nursing facility or rehabilitation center for a short-term rehabilitative stay, CAP services are temporarily suspended until discharged from the facility. The beneficiary is eligible to be reinstated onto the program upon discharge. A beneficiary is eligible to be reinstated upon discharge if the short-term rehabilitation does not exceed 90-calendar-days of placement;

3. The beneficiary does not require and use two waiver services monthly (excludes incontinence products, personal emergency response system and meal preparation and delivery) despite case management coordination;

4. The beneficiary’s health and well-being cannot be met through an individualized person-centered service plan or risk agreement when the beneficiary resides in an unsafe home environment placing the eligible beneficiary at risk, listed in Subsection 7.4; such as during the planned and unplanned absences of the paid provider, if applicable;

5. The beneficiary or responsible party refuses to sign or cooperate with the established POC and any other required documents, placing the eligible beneficiary’s health, safety and well-being at risk, listed in Subsection 7.4;

6. The lead agency has been unable to establish contact with the beneficiary or his or her responsible party for more than 90 calendar-days, for the provision of care, despite more than two (2) verbal and (2) written attempts;

7. The beneficiary Medicaid eligibility is terminated;

8. The beneficiary is in a Medicaid sanction period;

9. The beneficiary or responsible party demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP Waiver as outlined in the “Beneficiary Rights and Responsibilities,” form signed by the CAP beneficiary; or
10. The beneficiary does not reside in an approved primary private residence listed in Appendix E;

Medicaid shall not cover CAP/Choice participation and services for any one of the above items or following:

a. The beneficiary or responsible party is not willing or intellectually capable to assume the responsibilities of consumer-directed care based on a self-assessment questionnaire when electing to participate in consumer-directed care, and does not have an approved representative who is willing and intellectually capable to assume the responsibilities to direct the beneficiary’s care;

b. The beneficiary does not have an emergency back-up or disaster plan with adequate social support to meet the basic needs outlined in the interdisciplinary comprehensive assessment to maintain his or her health, safety and well-being; or

c. The beneficiary or responsible party demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP Waiver as outlined in the “Beneficiary Rights and Responsibilities,” form signed by the CAP beneficiary and signed during the admission process.

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

4.2.3 Medicaid additional Criteria Not Covered

In addition to the specific criteria not covered in Subsection 4.2.2 of this policy, Medicaid shall not cover CAP participation and services for any one of the following:

a. Items not covered by assistive technology service are:
   1. computer desks and other furniture;
   2. heating, ventilation, air conditioning;
   3. plumbing, swimming pools, spas, hot tubs, saunas; and
   4. service and maintenance contracts, and extended warranties.

b. Community transition services do not provide ongoing payment for rent.

c. DME convenience items or features are not covered, e.g. shampoo trays, gait belts. CAP lead agency case managers shall work with DME suppliers to ensure good beneficiary care and to be knowledgeable of DME being supplied to CAP beneficiaries.

d. Case management service does not consist of:
   1. outreach;
   2. travel time;
   3. activities after the beneficiary’s discharge, termination, or death;
   4. activities such as taking the referral and obtaining the Service Request Form, that occur prior to the CAP effective date;
   5. attending training;
   6. completing time sheets;
   7. recruiting, training, scheduling, and supervising staff;
8. billing Medicaid;
9. documenting case management activities; and
10. gathering information to respond to quality assurance requests.

4.2.4 NCHC Additional Criteria Not Covered
a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval
Medicaid shall require prior approval for:
   a. HCBS nursing facility LOC for CAP/DA participation; and
   b. all waiver service authorization limits.

5.2 Prior Approval Requirements

5.2.1 General
The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:
   a. the prior approval request; Refer to Subsection 5.2.2.a;
   b. all health records and any other records that support the beneficiary has met the specific criteria in Subsection 3.2 of this policy; and

5.2.2 Specific
The provider(s) shall submit to DHHS fiscal agent the following:
   a. HCBS Service Request Form (SRF) along with the Physician Attestation in Appendix A, to determine clinical eligibility for participation in the CAP Waiver. The SRF establishes the level of care and is the first indicator of whether a beneficiary is appropriate for CAP services. The SRF must be completed within 45 calendar-days from the initiation date. An SRF that is incomplete after 45 calendar-days of initiation will be voided. A slot is not reserved for an SRF pending over 45 calendar-days.

All sections and required fields on SRF must be completed in its entirety to establish eligibility determination for level of care. The sections and fields on the form include:
   1. Service request.
2. Beneficiary demographics.
3. Beneficiary conditions and related support needs.
4. Informal caregiver availability.
5. Attestation by Physician.
6. Date of LOC request and determination.

b. The interdisciplinary comprehensive assessment identifying assessed needs and level of acuity (refer to Subsection 5.4); and

c. The completed and signed person-centered service plan that identifies the CAP and regular State Plan services in the amount, frequency, duration and scope.

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

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

5.3 CAP Participation

5.3.1 Approval Process

Inquiries and Referrals:
When inquiry is made about CAP services, the lead agency shall provide information about the eligibility for, requirements of, and services of the CAP Waiver. This is an opportunity to discuss the benefits and limitations of the CAP Waiver. The lead agency, or designated entity, assists with the completion of the SRF. When an SRF is approved, a Welcome Letter is mailed to the prospective CAP beneficiary to inform of the LOC approval.

Assessment Approval:
When a CAP slot is available, the CAP beneficiary is placed in assessment and assignment which notifies the lead agency to initiate the assessment. The assessment should be initiated within 10 business days.

Coordinate with Medicaid Eligibility Staff:
The lead agency alerts the county DSS case worker of the in-process CAP assessment to begin the long-term care Medicaid application. The lead agency also follows up with DSS to ensure that the application is being processed.

Person-Centered Service Plan:
Upon the completion of the analysis of the comprehensive assessment, if the individual is determined at-risk of institutionalization, the person-centered service plan is initiated to plan for services in the amount, frequency and duration of needs.
Coordinate with Community Care of North Carolina (CCNC):
The lead agency contacts the local CCNC network to obtain data available in his or her Provider Portal within five (5) days of assessment and assignment. This information helps guide the assessment and the Plan of Care Development.

5.3.2 Minimum required documents for CAP participation approval:

a. **Initial:** Contact information for the CAP beneficiary and primary caregiver; an approved SRF: Signed consent to release information; Signed Participants’ Rights and Responsibilities; Signed Freedom of Choice form with selected providers; Service plan that outlines service needs and cost summary; Completed comprehensive interdisciplinary needs assessment that contains the acuity level; emergency back-up plan; job or school verification statement; physician’s order, individual risk agreement, and self-assessment questionnaire, if applicable.

b. **Annual:** Contact information for the CAP beneficiary and primary caregiver; Signed consent to release information; Signed Participants’ Rights and Responsibilities; Signed Freedom of Choice form with selected providers; Service plan that outlines service needs and cost summary; Completed comprehensive interdisciplinary needs assessment that contains the annual LOC assessment and acuity level; emergency back-up plan; job or school verification statement; physician’s order, individual risk agreement and self-assessment questionnaire, if applicable.

c. **Change in Status:** Contact information for the CAP beneficiary and primary caregiver; Signed consent to release information; physician’s order; Service plan that outlines service needs and cost summary; Completed comprehensive interdisciplinary needs assessment that contains the acuity level; emergency back-up plan; job or school verification statement; signed Freedom of Choice form with selected providers, individual risk agreement and self-assessment questionnaire, if applicable.

5.4 CAP Comprehensive Interdisciplinary Needs Assessment

The lead agency social worker and registered nurse shall complete an initial and annual interdisciplinary comprehensive needs assessment on each beneficiary to determine medical, functional and social acuity level to plan for all the beneficiary’s assessed needs. The interdisciplinary comprehensive assessment must include:

a. Personal health information;
b. Caregiver information;
c. Medical diagnoses;
d. Medication and precautions;
e. Skin;
f. Neurological;
g. Sensory and communication;
h. Pain;
i. Musculoskeletal;
j. Cardio-Respiratory;
k. Nutritional;
l. Elimination;
m. Mental Health;
n. Informal support; and
o. Housing and finances.
Initial Interdisciplinary Comprehensive Assessment

The initial interdisciplinary comprehensive assessment is conducted after the determination of level of care derived from the Service Request Form. Each field in the assessment must be completed prior to the initiation of the plan of care. The interdisciplinary comprehensive assessment must be completed within 45 calendar-days of the referral to the CAP/DA Lead Agency.

Note: Upon the completion and approval of the Service Request Form, a referral for long-term care Medicaid for waiver participation must be made to the local Department of Social Services.

5.4.1 CAP Person-Centered Service Plan Requirements

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

a. Summarize the evaluation and assessment information to highlight the beneficiary’s strengths and needs;

b. Outline person-centered goals and objectives based on the assessment and identified needs;

c. Develop a comprehensive list of CAP waiver services and non-waiver services, medical supplies and durable medical equipment (DME), and document the authorized provider name, amount, frequency and duration of each service;

d. Calculate the monthly beneficiary cost of care for including all CAP waiver services and non-waiver services to ensure the waiver services costs and limits do not exceed the plan of care limit associated with the beneficiary’s acuity level determined through the most recent beneficiary assessment;

e. Ensure the beneficiary’s right to choose among providers as evidence a signed provider freedom of choice form;

f. Ensure the beneficiary’s right to choose between CAP/DA or CAP/Choice and institutionalization and from among Medicaid-enrolled providers as evidenced by a signed provider Freedom of Choice form; Develop a service plan annually and update when warranted due to status changes in the waiver participant condition; and

g. Identify health and welfare monitoring priorities during the service plan period.

Note: The POC is initiated after the completion of the interdisciplinary comprehensive assessment and must be approved within five (5) business days of the completed assessment.

5.4.2 Continued Need Review (CNR) Assessment Requirements

A CNR assessment must be completed every 12 consecutive months to determine the continued medical, functional, and psychosocial care needs of the beneficiary for safe community living. The CNR assessment must be completed by week three (3) of the CAP effective month. The service plan must not be initiated prior to the completion of the interdisciplinary comprehensive assessment.
The CNR assessment consists of the following:

a. completed interdisciplinary comprehensive assessment that identifies LOC, the beneficiary’s preferences, strengths, needs, and ability to live safely in the community; and

b. developed and approved person-centered service plan as evidence of completed assessment.

### 5.4.3 Continued Need Review Person-Centered Service Plan Requirements

The annual service plan is called CNR service plan. To complete the annual service plan, refer to Subsections 5.4.1 and 5.4.3. The CNR service plan must be approved by the first day of the month following the beneficiary’s identified CAP effective date. The annual service plan must be completed during the month of the CAP effective date. The CNR service plan is effective the first day of the month following the CAP effective date and expires one calendar year later. The CNR person-centered service plan achieves the following:

The CNR person-centered POC achieves the following:

a. Summarizes the evaluation and assessment information to highlight the beneficiary’s strengths and needs;

b. Outlines goals and objectives based on the assessment and identified needs; and

c. Ensures the beneficiary’s right to choose between CAP/DA program and institutionalization and from among Medicaid-enrolled providers. Obtain the signature of the beneficiary or responsible party on the Freedom of Choice form.

### 5.4.4 Changes and Revision to the Service Plan

The CAP case manager or CAP/Choice care advisor determines whether to revise the POC when there is a change in the beneficiary’s needs. A POC 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.

Service plan revisions are approved by an approval authority of the lead agency. Revisions may be approved retroactively for up to 30 calendar-days prior to the date that the plan is revised. The beneficiary or the primary caregiver shall agree to and sign and date the service plan acknowledging changes for CAP provisions.

**Documenting a change in services:** The CAP case manager or CAP/Choice care advisor shall revise the POC as the beneficiary’s needs change. Changes to the POC are submitted in the web-based case management tool within 30 calendar-days of identified needs for Lead Agency approval within five (5) business days.

**Documenting a change of provider agency:** A POC update is required for a change in provider agency, but the change is not considered a revision. The case manager or care advisor will obtain a signed agreement from the beneficiary or the responsible party consenting to the change in providers.

### 5.5 CAP Effective Date

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

a. the date of the Medicaid application;

b. the date the case was approved for an assessment and placed in assessment and assignment in e-CAP; or
c. the date of deinstitutionalization.

5.6 Authorization of Services

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

**Note:** The lead agency shall use DMA-approved forms containing the same information for service authorizations and participation agreements.

Regular Medicaid State Plan providers approved to provide a Medicaid service to a CAP beneficiary receive a participation notice acknowledging medical necessity has been met to receive the service as outlined in the provider’s plan of care.

5.7 Person-Centered Service Plan Denial

If the lead agency or DMA does not approve the person-centered service plan, the lead agency or DMA notifies the CAP beneficiary or legal representative through an electronically generated notice that is mailed to the CAP beneficiary. The lead agency notifies the DSS’s eligibility unit of the notice mailed to the CAP beneficiary.

If a person-centered service plan is not submitted with an authorized signature (beneficiary or legal representative) by the expiration of the CAP effective date, the CAP beneficiary becomes ineligible for continuation of participation in the CAP Waiver. The DHHS designated contractor or DMA disenrolls the CAP beneficiary from the CAP Waiver. The CAP beneficiary is notified in writing from the DHHS designated contractor or DMA. The DSS is notified of the CAP disenrollment and the CAP beneficiaries may be terminated from Medicaid if Medicaid eligibility is contingent upon CAP participation.

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

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

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

a. Case management entities shall coordinate the transfer to prevent gaps in service provisions. The following steps must be completed prior to the transfer:
   1. determined anticipated start date of service;
   2. coordinated transition plan between provider agencies;
   3. discuss and plan for the health, safety and well-being of the beneficiary;
   4. initiate with the IT contractor the transfer of the electronic health records to the receiving county;
   5. arrange for a home visit by the receiving entity to assess the home environment identifying any health and welfare concerns and planning for mitigation and safety; and
   6. coordinate the provision of services to start on the first date of the transfer.

b. For CAP/C beneficiaries aging out:
   1. The CAP/C case manager or care advisor shall implement a transition, transfer plan 12 months prior to the birth month. These coordination activities include:
      A. Completion of a transition plan during the annual needs review assessment that occurs at age 20;
      B. consultation with the CAP/C beneficiary and primary caregiver to educate about other Medicaid and community resources to meet needs after the age of 21.
   2. Three months (90 days) prior to the birth or identified transfer month, a multidisciplinary team meeting must convene to discuss care needs and to ensure the identified formal and informal resources are able to meet care needs
   3. The month prior to the birth month, the local Department of Social Services shall be notified of the need to change the CAP evidence indicator for CAP participation for the identified CAP/DA start date will be entered in the Eligibility System for services to begin in the birth month.
   4. On the first day of the birth or identified transfer month, CAP services are authorized and provided to the beneficiary are provided to beneficiary.

c. For CAP beneficiaries transferring to a different county:
   1. The case manager or care advisor of the transferring agency shall coordinate the transfer with the case manager or the care advisor of the receiving agency at least 30 calendar-days prior to the anticipated transfer.
   2. The case managers or care advisors of the transferring and receiving agencies shall discuss and plan for the health, safety and well-being of the beneficiary.
   3. The electronic health record is transferred to the receiving county.
   4. The case manager or care advisors of the receiving agency shall arrange for a home visit to assess the home environment to identify any health and welfare concerns to plan for mitigation and safety.
   5. The case manager or care advisor shall coordinate the provision of services to start on the first date of the transfer into the receiving county.

Note: An active beneficiary previously approved to participate in the CAP program can continue to participate in the program when a transfer to another county occurs. A transferring beneficiary is considered in a priority category, is guaranteed a slot in the
receiving county, and can continue under the current Medicaid eligibility until the next Medicaid certification period.

5.9 CAP Waiver Benefit Specific Service Limitations

5.9.1 Home Accessibility and Adaptation

a. Home modifications that add to the total square footage of the home are excluded from this service.
b. Home modifications can be provided only in the following settings:
   1. A dwelling where the waiver beneficiary resides that is owned by the individual or the family; and
   2. In rented residences when the modifications are portable.
c. This service cannot be used to purchase locks.
d. The total cost of home accessibility and adaptation aids cannot exceed $10,000 over the cycle of the waiver (5 years).
e. The case manager or care advisor shall track the cost of home accessibility and adaptation aids billed and paid during the plan year, to avoid exceeding the $10,000 limit over the lifetime of the waiver (five years).

5.9.2 Institutional Respite Care

The combined use of both institutional respite care and non-institutional respite care must not exceed 30 calendar-days or 720 hours in one fiscal year.

5.9.3 Non-Institutional Respite Services

The combined use of both institutional respite care and non-institutional respite care must not exceed 30 calendar-days or 720 hours in one fiscal year.

5.9.4 Personal Emergency Response Services (PERS)

PERS does not cover the purchase and installation of equipment in the beneficiary’s primary private residence.

5.9.5 Participant Goods and Services

The cost of participant goods and services for each beneficiary must not exceed a limit of $800 annually. Any item over $200 must be approved by a DMA consultant.

5.9.6 Community Transition Services

a. Transition services must not exceed $2,500 per beneficiary over the lifetime of the waiver. The lifetime of this waiver is five (5) years.
b. Transition services must be used within 90 calendar-days from the date the beneficiary transitioned from an institution.

5.9.7 Training, Education and Consultative Services

Training and Education Services

This service is limited to $500 per fiscal year. Individuals who are paid service providers, with the exclusion of the personal assistant (Choice), cannot be trained or educated using this service.

5.9.8 Assistive Technology

a. The cost of assistive technology is limited to $3,000 per beneficiary per the cycle of the waiver. The lifetime of this waiver is five (5) years.
b. Repair of assistive technology is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment. The waiver beneficiary shall own the assistive technology. Waiver funding must not be used to replace equipment or devices that have not been reasonably cared for and maintained.

c. The waiver is the payer of last resort for items that are covered under the state DME list. Equipment requests for items that have a basic counterpart on the state DME list must contain an explanation of why the item on the DME list will not meet the needs of the beneficiary.

d. Adaptations that add to the total square footage of the primary private residence are excluded from this service.

5.9.9 Case Management

a. CAP program beneficiaries shall not receive another Medicaid-reimbursed case management service in addition to CAP/DA case management.

b. Case management is limited to 80 hours (320 units) per calendar year (January 1 – December 31).

5.9.10 Financial Management Services (CAP/Choice only)

Monthly financial management fees are 4 units per month. Start-up financial management fees are 4 units. Transfer financial management fees are 4 units when new to FI provider. Transfer financial management fees are 2 units when transitioning back to existing FI provider.

5.10 Waiver Service Requests and Required Documentation

5.10.1 Assistive Technology, Equipment, Supplies and Home Modifications

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

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

b. statement of medical necessity by a physician;

c. shipping costs, itemized in the request proposal;

d. other information as required for the specific equipment or supply requested;

e. when quotes are required for purchase, adaptation or modification, DMA determines how many quotes are required; and

f. DMA determines the appropriate professional(s) that make written recommendations for services that require those recommendations.

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

a. An assessment or recommendation by an appropriate professional that identifies the beneficiary’s need(s) regarding the equipment and supplies being requested. The assessment or recommendation must state the cost of an item that a beneficiary requires.

b. Supplies that continue to be needed at the time of the beneficiary’s annual assessment must be recommended by an appropriate professional and contained in
the annual assessment package. The assessment or recommendation must be reevaluated if the amount of the item the beneficiary needs changes.

For Home Modification, the following additional information is required:
Assessment by an appropriate professional that identifies the beneficiary’s need(s) regarding a home modification request.

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

a. **Community Transition:**
   A completed Community Transition Checklist.

b. **Caregiver Training, Education and Consultative Services:**
   Short and long-range outcomes directly related to the needs of the beneficiary and primary caregiver(s) to provide care and to support the CAP beneficiary is required.

c. **Consumer-Directed election:**
   1. A completed self-assessment questionnaire;
   2. Representative Needs Assessment and Representative Designation or Agreement, as applicable;
   3. Verification of required training; and
   4. Consumer-directed Agreement packet approved by DMA.

Beneficiaries receiving CAP services may receive all regular Medicaid services.

5.10.3 General Lead Agency Responsibilities
DMA is the administrative authority of the CAP/DA waiver. DMA appoints CAP Lead Agencies to provide specific day-to-day administrative responsibilities to include:

a. Develop referral procedures according to DMA standards and local policy and share these procedures with the appropriate providers and organizations;

b. Educate the caregiver of children, the elderly and disabled adult community about CAP Waiver;

c. Process referrals and manage waiting lists based on DMA standards and local policy;

d. Provide assistance in obtaining documentation from medical staff to determine level of care;

e. Provide assistance in verifying with DHHS Fiscal Contactor whether medical documentation supports nursing facility level of care;

f. Assess beneficiary’s appropriateness for CAP services;

g. Provide case management or care advisement to the CAP beneficiary;

h. Lead agency to ensure budget, service limits, beneficiary monitoring details, quality assurance reporting and beneficiary risk mitigation; and

i. Complete critical incident reports within 72-hours of the incident.
The CAP Lead Agency shall comply with the following DMA guidelines:

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

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

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

6.1 Provider Qualifications and Occupational Licensing Entity Regulations and Medicaid Provider Requirement to Provide CAP Waiver Services

Medicaid providers seeking to provide CAP services shall be approved by DMA through a managed change request. Each selected Medicaid provider of CAP services shall undergo a CAP overview and orientation training prior to rendering authorized services, and annually thereafter.

The CAP provider shall provide a copy of his or her policies and procedures that identifies the assurance of nonuse of restraints and seclusions.

6.1.1 Adult Day Health Services

Health Centers providing Adult Day Health services must be certified by the Division of Aging and Adults Services in compliance with North Carolina Statute 131-D-6 and 10A NCAC 06 Subchapters R and S.

6.1.2 Assistive Technology

Assistive technology professionals, nursing facility (rehab), hospital, or certified home health agency that are State licensed occupational therapists (OT), physical therapists (PT) or speech language pathologists. Licensure to include certification of clinical competency, which is required for augmentative communication evaluations, shall provide assistive technology. Additional provider qualifications may include assistive technology practitioners (ATP) or assistive technology
suppliers (ATS) certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). Assistive technologists shall hold a bachelor’s degree in a human services field, special education or related degree, and two (2) years of experience working with assistive technology. The CAP/DA lead agency and North Carolina assistive technology are authorized through NC Tracks to submit Medicaid claims for services of assistive technology.

6.1.3 Case Management Services
Social workers and registered nurses shall provide case management services. Case managers must meet the requirements of the NC Division of Public Health (DPH) Nurse I or Social Worker I or higher and the training requirements listed in Subsection 6.4.

6.1.4 Community Transition
Medicaid providers who have the capacity as verified by the lead agency to provide items and services of sufficient quality to meet the need for which they are intended shall provide transition services. Items and services (with rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary. The beneficiary shall provide a receipt for each purchase or invoice for each payment. Some items may be purchased directly through a retailer, as long as the item meets the specifications of this service definition.

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

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

6.1.7 Meal Preparation and Delivery
Agencies and organizations providing nutrition services shall meet DAAS requirements for home delivered meals in compliance with 10A NCAC 06K.0101.

6.1.8 Non-Institutional Respite Services
Non-institutional respite services must be provided by a homecare agency licensed by the State of North Carolina in accordance with 10A NCAC 13J.1107, In-Home Aide Services. If the beneficiary's service plan requires the personal care aide, which includes extensive assistance and substantial hands-on care to a CAP beneficiary who is only able to perform part of the activity, the In-Home Aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-256. This applies to provider-managed non-institutional respite.
The aide providing this service can be the legal representative or legal guardian as long as the individual works for a provider agency, is licensed as a Nurse Aide I and meets the hiring criteria of the agency providing the service.

6.1.9 In-Home Aide Service

In-Home aides are provided by home care agencies licensed by the State of North Carolina who comply with NC General Statutes 131E-135 through 142 and 21 NCAC 36.0403 (a) and 21 NCAC 36.0403 (b). Workers providing level III – personal care tasks shall be listed as a Nurse Aide I. The employment of a spouse, parent, child or sibling of the CAP/DA or CAP/Choice beneficiary must provide this service 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.1110; and
c. Any employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the CAP beneficiary. This restriction also applies to other relatives and hired personnel.

6.1.10 Participant Goods and Services

These services, equipment, and supplies are purchased through the lead agency. Medicaid providers who have the capacity as verified by the case manager or care advisor shall provide items and services of sufficient quality and appropriate to the needs of the beneficiary. Some items may be purchased directly through a retailer as long as the items meet the specifications of the service definition.

6.1.11 Personal Emergency Response Services (PERS)

The emergency response provider must have the capability to provide a 24-hour monitoring system in accordance with the service definition.

6.1.12 Specialized Medical Equipment and Supplies

The lead agency, through a service authorization, authorizes providers who have demonstrated the ability to supply requested equipment and supplies. Waiver supplies are specialized medical goods that the provider shall be capable of providing of sufficient quality verified by the case manager or care advisor.

6.1.13 Training, Education and Consultative Services

An organization with a training or class curriculum approved by the DMA including universities, colleges and community colleges shall provide training and education services.

6.1.14 Care Advisor (CAP/Choice Only)

Care advisor service providers include social workers and registered nurses. Care advisors must meet the requirements of the DPH Nurse I or higher or Social Worker I or higher and the training requirements listed in Subsection 6.4.

6.1.15 Personal Assistant Services (CAP/Choice Only)

Personal care assistants hired by beneficiaries to provide personal care services qualify to provide the service based on the following criteria;

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;

c. Be absent of a history of abuse, neglect, exploitation, and violent crimes against a child or vulnerable adult;

d. Be absent of substantiated allegation of abuse, neglect or exploitation listed with the N.C. Health Care Registry;

e. Be absent of 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; and

f. Meet other reasonable requirements as specified by the beneficiary.

g. The financial intermediary shall be responsible for background checks. Lifetime hiring ban is placed on any individual who has any of the following findings on his or her 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.

6.1.16 Financial Management Services (CAP/Choice Only)

The provider for financial management shall:

a. be approved by Medicaid as a fiscal intermediary and have the capacity to provide financial management services through both the Agency with Choice and Fiscal or Employer Agent model;

b. be authorized to transact business in the State of North Carolina;

c. have three years of financial management experience; and

d. be approved by the Internal Revenue Service (IRS) to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6.

The following licensure rules apply:

Home Care Agency: 10A NCAC Chapter 13 Subchapter J

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

Nurse Aides

N.C. Home Care Licensure Rules (10A NCAC 13J)
GS Chapter 90, Article C – The Nurse Aide Registry Act
NC Board of Nursing, Nurse Aide I Tasks
http://www.ncbon.com/

6.2 Contract Requirement for e-CAP Portal
The Contracted Vendor IT system shall:
   a. Processes participant waiver enrollment;
   b. Data-mines waiver enrollment against approved limits (includes management of a wait list);
   c. Data-mines waiver expenditures against approved limits;
   d. Processes level of care evaluation;
   e. Creates prior authorization notices for use by the CAP Lead Agency;
   f. Data-mines utilization management;
   g. Generates adverse notices that are in compliance with the DMA’s Due Process procedures;
   h. Provides access to frequently asked questions (FAQs) and CAP/DA memos and trainings; and
   i. Abides by Confidentiality regulations and protects health information.

6.3 Care Coordination Performed by Lead Agency
CAP beneficiaries are eligible to receive all Medicaid services according to Medicaid policies and procedures, except when those policies or procedures restrict participation or duplicate another Medicaid or other insurance service. Case management entities are responsible for the following activities: care coordination through assessing, care planning, referring or linking and monitoring and following-up. Case management and care coordination services are necessary to identify needed medical, social, environmental, financial, and emotional needs. These services are provided to maintain the beneficiary’s health, safety, and well-being in the community. It is a required component of the CAP Waiver that a case management activity is performed at least monthly.

The principle activities of case management are:

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

   b. Case Manager - Assessment Core Knowledge, Skills, and Abilities
The case manager or care advisor shall possess the knowledge, skills and abilities:

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

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

c. Care Planning

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

Amount, duration, frequency, and provider type of services are indicated in the beneficiary’s CAP plan of care (POC). Approval for non-CAP services remains with the approval authority for the specific service. The local approval authority (LAA) (refer to Subsection 5.10.3) approves CAP services and the overall POC (refer to Subsection 5.3.1).

Services are provided in accordance with all requirements specified in this policy: all applicable federal and state laws, rules, and regulations; the current standards of practice; and lead agency policies and procedures.

d. Case Manager - Care Planning Core Knowledge, Skills, and Abilities

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

Knowledge of:
1. The values that underlie a person-centered approach to providing service to improve beneficiary functioning within the context of the beneficiary's culture and community.
2. Models of wellness-management and recovery.
4. Processes used in a variety of models for group meetings to promote beneficiary and family involvement in case planning and decision-making.
5. Services and interventions appropriate for assessed needs.
Skills and Abilities to:
1. Identify and evaluate a beneficiary’s existing and accessible resources and support systems.
2. Develop an individualized care plan with a beneficiary and his or her supports based on assessment findings that include measurable goals and outcomes.

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

Referral and Linkage Core Knowledge, Skills, and Abilities
The case manager or care advisor shall possess the knowledge, skills, and abilities:
Knowledge of:
1. Community resources such as medical and behavioral health programs, formal and informal supports, and social service, educational, employment, recreation, and housing resources.
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 the beneficiary in accessing a variety of community resources.

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

g. Case Manager - Monitoring and Follow-up Knowledge, Skills, and Abilities
The case manager or care advisor shall possess the following knowledge, skills and abilities:
Knowledge of:
1. Outcome monitoring and quality management.
2. Wellness-management, recovery, and self-management.
3. Community beneficiary-advocacy and peer support groups.

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

**Note:** Contacts may be made by teleconferencing or by visit unless otherwise specified.

### 6.4 Staff Qualification

a. The case manager or care advisor shall meet one of the following qualifications:

1. Bachelor’s degree in social work from an accredited school of social work, and one (1) year of directly related experience of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA certified training program within 90 calendar-days of employment;

2. Bachelor’s degree in a human services or equivalent field from an accredited college or university with two (2) or more years of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA certified training program within 90 days;

3. Bachelor’s degree in a non-human services field from an accredited college or university with two (2) or more years of community experience (preferably case management) in the health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA certified training program within 90 days; or

4. Registered nurse who holds a current North Carolina license, two (2) year or four (4) year degree, one (1) year case management in homecare, long-term care, personal care or related work experience and the completion of a DMA certified training program within 90 days.

**Note:** Candidates with a higher educational background than listed shall also have one (1) year of community experience (preferably case management in the health or medical field directly related to homecare, long-term care, or personal care). Trainee Status Candidates shall be directly supervised for one (1) year by the Supervisor and complete a DMA certified training program within 90 days of employment. The supervisor must approve and sign all work produced by the trainee. Case managers without a college degree whom have been employed with an existing CAP lead agency before the implementation of this clinical coverage policy will be eligible for a grandfathering clause. The case manager or care advisor shall have been employed with the organization for more than five (5) years and have an equivalent combination of education and experience that equal 10 years. Case managers or care advisors who do not meet these criteria shall not be eligible for this grandfather clause.

b. Case Manager or Care Advisor Supervisor Qualifications
The case manager or care advisor supervisor shall meet one of the qualifications of the qualification of a case manager or case advisor, possess three (3) or more years of directly related experience in the health or medical field directly related to homecare, long-term care, or personal care, one (1) of those years to have been in case management.

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

6.5 Case Manager Continuing Education Requirements

The lead agency shall be responsible for ensuring and documenting that each case manager or case advisor participant complete minimum training requirements for Home and Community Based Services as identified by DMA. The case manager or care advisor shall complete nine (9) contact hours or continuing education hours per year of which person-centered training; legislation training related to health care disability and reimbursement strategies; abuse, neglect, exploitation, and program integrity (PI) are mandatory. The required training curriculum is listed below:

a. Bloodborne Pathogens and Infection Control;
b. Health Insurance Portability Accountability Act (HIPAA);
c. End of Life planning;
d. Cultural Diversity;
e. Completion of the following DMA program-specific training modules within one (1) year of implementation of this clinical coverage policy and within one (1) year for a newly hired case manager or care advisor:
   1. Introduction to Community Alternative Program for Disabled Adults
   2. Case Management 101 for HCBS providers;
   3. Prior approval policies and procedures;
   4. Health, Safety and Well-being and Individual Risk Agreement;
   5. Consumer-Directive;
   6. Medicaid Due Process Appeal Rights;
   7. EPSDT;
   8. Money Follows the Person Transition Coordination;
   9. Improving the Quality of Home and Community Based Waiver Services located at http://www.hcbsassurances.org;
   10. PI;
   11. Quality Assurance and Performance Outcomes, and
   12. Critical Incident Reporting.
7.0 Additional Requirements

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

7.1 Compliance

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

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All DMA’s clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by CMS, DHHS, its divisions or its fiscal agent.

The case management agency shall retain the referral, all assessments, POCs, case management notes, service authorizations, copies of claims generated by the case management agency and required documents generated by other providers and approved by the case management agency, and related correspondence in compliance with all applicable federal and state laws, rules and regulations, and agency policy from date of services.

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

7.2 Coordination of Care

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

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

7.3 Budget and Use of Funds

The CAP/DA beneficiary plan of care is developed on a year-to-year basis or revised as needed by the case manager or care advisor. Plans of care require local approval by the local lead agency. DMA approves monthly budget limits based on
the level of care. Certain waiver services dollar amount limits require approval by the DMA CAP/DA consultant.

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

a. Develop a cost utilization plan with a timeline of 90 calendar-days to align the care needs within the CAP budgetary limits;
b. Implement a 60 calendar-day cost adjustment plan if the 90 calendar-day cost utilization plan is not able to align with the established budgetary limits; and At end of the 60 calendar-days, if the cost adjustment plan fails to align the waiver budget with the established budgetary limit, individual service utilization limits shall be implemented until the waiver is within the cost neutrality limits. Individuals impacted by utilization limitation during this period of time will be referred to other formal and informal resources.

7.4 Health, Safety, and Well-being

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

a. Assessment of the beneficiary’s medical, mental, psychosocial, physical condition, and functional capabilities may indicate inability to participate in the CAP Waiver when one of the following conditions cannot be mitigated for the CAP beneficiary:

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

6. The beneficiary’s continuous intrusive behavior impedes the safety of self and others by attempts of suicide, injury to self or others, verbal abuse, destruction of physical environment, or repeated noncompliance with the service plan and written or verbal directives;

7. The beneficiary’s primary caregiver or responsible party continuously impedes the health, safety, and well-being of the beneficiary by:
   A. refusal to comply with the terms of the service plan;
   B. refusal to sign a plan and other required documents;
   C. refusal to keep the lead agency informed of changes in the status of the beneficiary; or
   D. refusal to remove or lessen the risk or hazard that create an unsafe environment; or

8. The beneficiary chooses to remain in a living situation where there is a high risk or an existing condition of abuse, neglect, or exploitation as evidenced by an Adult Protective Services (APS) assessment or care plan.

The CAP/DA program complies with the definition of restraint 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. CAP/DA does not permit the use of restraints or seclusion, including:
   a. personal restraints;
   b. drugs used as restraints;
   c. mechanical restraints;
   d. or seclusion;


CAP provider or beneficiary’s caregiver shall not use interventions that:
   a. restrict CAP beneficiary’s movement;
   b. restrict CAP beneficiary access to other individuals, locations, or activities;
   c. restrict participant rights; or
   d. employ aversive methods to modify behavior, (unless provided for a CAP beneficiary for whom it is not used as a restraint, but for safety such as bed rails, Gerri chair, lift chair, and safety straps on wheelchairs.
7.5 Individual Risk Agreement

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

7.6 Absence from CAP Participation

7.6.1 Hospital Stays of 30 Calendar-days or Less

When a CAP/DA beneficiary is temporarily absent from CAP participation as well as a break in services, the case manager or care advisor shall take the following course of action:

If a hospital stay of 30 calendar-days or less is anticipated, the case manager does the following:

a. Determines the reason for the admission, the prognosis, and anticipated length of the absence from the primary private residence;
b. Suspends all CAP services except for case management and PERS;
c. Notifies the discharge planner that the beneficiary is a CAP participant;
d. Notifies the county DSS that the beneficiary has been hospitalized;
e. Monitors the beneficiary’s progress through contact with the discharge planner and other appropriate parties;
f. Monitors any changes that can extend the hospitalization beyond 30 calendar-days or result in a transfer to a nursing facility or rehabilitation center;
g. Determines, as necessary, the medical and related home care needs with the physician, discharge planner, and other appropriate parties when the beneficiary is released;
h. Alerts CAP providers when to resume care;
i. Informs the DSS Medicaid staff that the beneficiary continues on CAP; and
j. Revises the POC, if needed, and sends notices of change to service providers.

7.6.2 Hospital Stays Longer than 30 Calendar-days

Hospital stays of more than 30 calendar-days affect Medicaid eligibility and CAP participation. If the beneficiary is hospitalized for more than 30 calendar-days, the CAP case manager or care advisor shall contact the local DSS staff to learn when the beneficiary’s Medicaid status will change to long-term-care budgeting. The case manager or care advisor shall coordinate with the Medicaid worker the effective date of disenrollment from the waiver based on the date of the change in Medicaid eligibility for the beneficiary.

Hospital stays of more than 30 calendar-days affect Medicaid eligibility and CAP participation. If the beneficiary is hospitalized for more than 30 calendar-days, the CAP lead agency shall contact the local DSS staff to learn when the beneficiary’s Medicaid status will change to long-term-care budgeting. The lead agency shall coordinate with the DSS worker the effective date of disenrollment from the CAP Waiver based on the date of the change in Medicaid eligibility for the beneficiary. The lead agency initiates the disenrollment.
7.6.3 Nursing Facility Admissions

Because the beneficiary has already been terminated from CAP participation due to the nursing facility admission, the case manager or care advisor shall suspend all CAP services for 30 calendar-days from the admission date. Service providers are notified of the nursing facility placement. For short-term rehabilitation stays that do not exceed 30 calendar-days, the beneficiary can resume the CAP services. For nursing facility stays greater than 31 days but less than or equal to 90 calendar-days, the beneficiary can be expedited back on the CAP program with a change in status assessment and POC.

7.6.4 Temporary Out of Primary Private Residence

If a beneficiary temporarily (for 30 calendar-days or less) leaves his or her primary private residence, the case manager or care advisor shall suspend the delivery of CAP services by contacting the provider agencies. No CAP services can be provided during this absence. The local DSS Medicaid eligibility staff is notified when an extended absence occurs. The CAP slot remains available to the beneficiary. The case manager or care advisor shall track the absence, since an extended absence can affect Medicaid eligibility and continued CAP/DA participation. Unless prior approved by the case manager or care advisor, CAP participation will be terminated after 90 calendar-days of absence from the primary private residence.

7.7 Voluntary Withdrawals

A CAP beneficiary can make a decision to withdraw from CAP participation at any time. The CAP beneficiary shall submit a written notice containing the date of withdrawal from CAP and the beneficiary’s or his or her responsible party’s signature to the lead agency. The lead agency coordinates the CAP disenrollment activity. The planning process for disenrolling the CAP beneficiary must coincide with the date the beneficiary makes the request.

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

7.8 Disenrollment

The lead agency shall disenroll the beneficiary when CAP is no longer appropriate, in accordance with CAP policies and procedures implemented by DMA as listed in Subsections 4.2.1 and 4.2.2. When a CAP beneficiary’s participation is terminated, the beneficiary’s responsible party is notified in writing. Refer to http://dma.ncdhhs.gov/, for information on due process.

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

a. The beneficiary’s Medicaid eligibility is terminated;
b. The beneficiary’s physician does not recommend nursing facility;
c. The SRF is not approved for nursing facility LOC;
d. DSS removes the CAP evidence;
e. The CAP lead agency has been unable to establish contact with the beneficiary or the primary caregiver(s) for more than 60 calendar-days despite two written and verbal attempts;

f. The beneficiary fails to use CAP services as listed in the service plan during a 90 consecutive-day time period of CAP participation;

g. The beneficiary’s health, safety, and well-being cannot be mitigated through a risk agreement;

h. The beneficiary or primary caregiver will not participate in development of or sign the service plan;

i. The beneficiary or primary caregiver(s) fails to comply with all program requirements, such as failure to arrive home at the end of the approved hours of service, or manipulation of the coverage schedule without contacting the case manager for approval; or

j. The beneficiary or primary caregiver demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP Waiver as outlined in the “Beneficiary Rights and Responsibilities,” form signed by the CAP beneficiary.

Note: Disenrollment from CAP, under items “e.” through “j.” above, may ensue if:

a. there are three (3) such occurrences, and the beneficiary or primary caregivers have been counseled regarding this issue; or

b. after one occurrence, if the beneficiary’s health and welfare is at risk and cannot be mitigated.

7.9 General Documentation Requirements

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

For Adult Day Health, bill the days that the CAP beneficiary received Adult Day Health services at the Adult Day Health Care Facility. If the CAP beneficiary attended only part of the day and the center has a partial day rate, bill that rate. Documentation must in compliance with NC General Statutes 1321-D-6.

For Specialized medical equipment and supplies, bill cost for the item, including delivery charges and taxes. The cost is what is invoiced by the supplier. The charge to Medicaid must not exceed the maximum reimbursement rates for the equipment or supply. Documentation must comply with Subsection 5.10

For Home accessibility and adaptation, bill cost for the item, including applicable installation and delivery charges, taxes, and permit fees. The cost is what is invoiced by the supplier/installer.

For Meals Preparation and Delivery, bill the customary charge for the preparation and delivery of the meal for each day a meal is supplied. Documentation must comply with 10A NCAC Chapter 06 Subchapter K.
For Institutional Respite Care, bill the Medicaid Nursing Facility rate for the CAP beneficiary’s catchment area for the calendar-day(s) of respite provided to the CAP beneficiary. Documentation must comply with Subsection 5.9.2.

For Personal emergency response services, bill the customary monthly service charge for each month the CAP beneficiary receives the service. Documentation must comply with Subsection 5.94.

Non-institutional Respite, bill the customary charge for the units provided to the CAP beneficiary for each date of service. Documentation must comply with Subsection 5.9.3.

For Financial Management, bill Medicaid rate for units provided to the CAP beneficiary for each month fiscal intermediary services are provided. Documentation must comply with Subsection 5.9.10 and Appendix B.

For Community Transition, participant good and services and training, education and consultative services, bill the cost for the item, including applicable delivery charges, and taxes. The cost is what is invoiced by the supplier. Documentation must comply with Subsection 5.10.2.

The case manager or care advisor shall document the following information in the beneficiary’s record as specified below:

The documentation for CAP waiver services must fully detail the purpose of the intervention along with the date and duration of time taken to complete the approved service or task. The documentation must be completed within 72 hours of the intervention and signed and dated by the personnel performing the service or task. The lead agency’s case management activities.

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

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

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

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

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

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

7.10 Frequency of Monitoring of Beneficiary and Services

The lead agency and CAP providers shall conduct:

a. a monthly contact by telephone or in person with the CAP beneficiary to monitor and assess CAP services;

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

c. a monthly or quarterly (based on risk indicators) contact visit, with the CAP beneficiary or responsible party, to monitor health and well-being and assess CAP services; and

d. monthly review ensuring that respite service is rendered as authorized; and

e. quarterly review monitoring total use of respite services over the previous 90-day period.

7.11 Corrections in the Service Record

Changes or modification in the original documentation to make a correction can be made at any time, when in compliance to licensure or certification rules governing the CAP waiver service. Whenever corrections are necessary in the beneficiary’s record, lead agency shall seek technical assistance from the DHHS designated contractor (IT contractor) to make the changes to the electronic record and CAP providers shall follow his or her internal policies and procedures.

7.12 Waiver Service Specific Documentation

The lead agency shall obtain the below required documentation prior to the approval and implementation of the following CAP services:

a. Assistive Technology;

b. Home Accessibility and Adaptation Services;

c. Specialized Medical Equipment and Supplies;

d. Training, Education and consultative Services; and

e. Participant Goods and Services.

The required documents for the above services are:

a. Comprehensive Interdisciplinary Needs Assessment completed by the case manager identifying equipment, supply, adaptation, or modification needs;

b. copy of the physician’s attestation, order, or signature certifying medical necessity along with the request for equipment, supply, adaptation, or modification needs. The recommendation must be less than one calendar year from the date the request is received;

c. recommendation by an appropriate professional that identifies the beneficiary’s need(s) with regard to the equipment, supply, adaptation, or modification being requested;
d. the estimated life of the equipment as well as the length of time the beneficiary is expected to benefit from the equipment, must be indicated in the request;

e. an invoice from the supplier that shows the date the equipment, supply, adaptation, or modification were provided to the beneficiary and the cost, with related charges and maintained in the e-CAP system;

f. long-range outcomes related to training needs associated with the beneficiary’s utilization and procurement of the requested equipment, supply, adaptation or modification are reported in the Service Plan, as appropriate; and

g. documentation for specific equipment, supplies, adaptation, and modification as outlined in the definition. Refer to Subsection 7.9 for these requirements.

The consumer-directed beneficiary shall maintain timesheets and workflow sheets of his or her hired assistance that are consistent with the record and retention policy, refer to Subsection 7.9.

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

### Respite Service

The lead agency shall authorize respite services to the approved, selected Medicaid provider. The lead agency and the Medicaid provider shall document respite service as requested based on the category for either; emotional balance, or physical time away, and the required documentation must contain the following components:

a. Name of the CAP beneficiary;

b. Medicaid identification;

c. Type of respite service provided;

d. Date of the service;

e. Location the service was provided;

f. Duration of the service;

g. Task performed; and

h. Completed and signed service note.

Note: It is the responsibility of the lead agency to monitor the respite hours so not to exceed maximum limits.

### 7.13 General Records Administration and Availability of Records

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

a. Service authorization submitted by the lead agency; and

b. Service documentation, required for service billed.

The lead agency shall retain the following documentation in the service record:

a. the referral:

b. all assessments;

c. service plans;

d. case management notes;

e. service authorizations;
7.14 Quality Assurance

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

a. The quality, appropriateness, and outcomes of services provided to CAP beneficiaries; and
b. The cost efficiency of the CAP beneficiary’s care.

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

7.14.1 Objectives

Quality improvement activities are a joint responsibility of DMA and its appointed agencies. The case management entities and providers cooperate with all quality management activities by submitting all requested documents, including self-audits, within defined timeframes and by providing evidence of follow-up and corrective action when review activities reveal his or her necessity.

State Assurances:

a. Participant Access: CAP beneficiary has accesses to home and community-based services and supports in his or her communities.

b. Participant-Centered Service Planning and Delivery: Services and supports are planned and effectively implemented in accordance with each CAP beneficiary’s unique needs, expressed preferences, and decisions concerning his or her life in the community.

c. Provider Capacity and Capabilities: There are sufficient HCBS providers, and they possess and demonstrate the capability to effectively serve CAP beneficiary.
d. Participant Safeguards: CAP beneficiary is safe and secure in his or her homes and communities, taking into account his or her informed and expressed choices.

e. Participant Rights and Responsibilities: CAP beneficiary receives support to exercise his or her rights and accept personal responsibilities.

f. Participant Outcomes and Satisfaction: CAP beneficiary is satisfied with his or her service(s) and achieved desired outcomes identified in the service plan.

g. System Performance: The system supports CAP beneficiary efficiently and effectively, and constantly strives to improve quality.

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

a. Review of initial applications and continued need reviews for appropriateness, accuracy and outcomes;

b. Review of effectiveness of and compliance to authorized CAP services a quarterly basis;

c. Annual Participant experience survey sent by DMA to a representative sample of CAP beneficiaries;

d. Critical incident reporting; complaints and grievances; and

e. Site or desk-top audits of case management entities and CAP provider agencies.

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


b. Improve beneficiary compliance with accepted health and wellness prevention, screening and monitoring standards.

c. Reduce beneficiary health and safety risks.

d. Implement strategies to avoid unplanned hospitalizations.

e. Avoid emergency room visits as a means for receiving primary care.

f. Enhance beneficiary socialization and reduce social isolation.

g. Reduce risks of caregiver burnout.

h. Increase caregiver capacities.

i. Enhance beneficiary awareness self-management of chronic conditions

j. Foster a more engaged beneficiary.

k. Promote a positive beneficiary personal outlook.

l. Improve informal caregiver(s) outlook and confidence in his or her caregiving role.

Mandated Waiver Assurances

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

a. Level of Care

1. CAP applicants for whom there is reasonable indication that services may be needed in the future are provided an individual LOC evaluation;

2. The LOC of enrolled CAP beneficiaries is reevaluated at least annually or as specified in the approved waiver; and

3. The processes and instruments described in the approved waiver are applied to LOC determination.
b. Service Plan
   1. Service plans address all CAP beneficiary’s assessed needs, as found in Subsection 6.3.b and person-centered goals, either by the provision of CAP services or through other means;
   2. The state monitors services plan development in accordance with its policies and procedures;
   3. Service plans are updated or revised in the same month as the CAP effective date or when warranted by changes in CAP beneficiaries;
   4. Services are delivered in accordance with the service plan, which lists the type, scope, amount, duration and frequency of the services; and
   5. CAP beneficiaries are afforded choice between CAP services and institutional care and between and among CAP services and providers.

c. Qualified Providers
   1. The state verifies that providers initially and continually meet required licensure and certification standards and adhere to other standards prior to his or her furnishing CAP services;
   2. The state monitors non-licensed and noncertified providers to assure adherence to CAP requirements; and
   3. The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

d. Administrative Authority
   DMA retains administrative authority and responsibility for the operation of the CAP Waiver by exercising oversight of the performance of CAP Waiver function by other state and local and regional non-State agencies and contracted entities.

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

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

**Home and Community Characteristics**
CAP/DA service providers shall adhere to the home and community characteristics in all service settings by assuring:

a. The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community;

b. Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources;

c. Individuals receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;

d. Individuals select the setting from among available options, including non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources);

e. Each individual’s rights of privacy, dignity, respect and freedom from coercion and restraint are protected;

f. Settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices; and
g. The direct provider facilitates individual choice regarding services and supports, and who provides these.

The following additional HCBS Characteristics must be met in Provider Owned or Controlled Residential Settings:

a. Provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the state, county, city or other designated entity;

b. Provide privacy in sleeping or living unit;

c. Provide freedom and support to control individual schedules and activities, and to have access to food at any time;

d. Allow visitors of choosing at any time; and

e. Are physically accessible

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

Monitoring for Home and Community Character:

Adult Day Health Facilities must follow the Home and Community Based Services Final Rule as outlined in North Carolina’ DHHS State Transition Plan.

7.15 Program Integrity (PI)

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

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

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

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

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

7.16 Use of Telephony and Other Automated Systems

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

Providers may utilize telephony and other automated systems to document the provision of CAP/DA services. Guidelines for use of telephony are provided in January 2009 general Medicaid bulletin at http://www.ncdhhs.gov/dma/bulletin/0109bulletin.htm#tele.
7.17 **Beneficiaries with Deductibles**

A CAP/DA beneficiary who has a deductible is able to participate in the CAP/DA waiver; however, the beneficiary as well as the service provider or personal assistant must understand and agree to the conditions of incurring and paying a monthly deductible. The deductible is met monthly and the CAP/DA beneficiary may use the cost of CAP/DA services approved on the POC they are provided during the deductible period.

The beneficiary shall understand when participating in CAP/Choice, they are solely responsible to pay his or her deductible in order for the service provider and personal care assistant to get reimbursed for services rendered while the beneficiary is in the deductible status. The service provider and personal assistant shall understand and accept that if the beneficiary does not pay for incurred services rendered, the service provider or personal care assistant will not be reimbursed for service rendered during the deductible status. The service provider and personal assistant bills the beneficiary and it is the responsibility of the beneficiary to pay the service provider or personal assistant directly. Medicaid does not pay for services while in the deductible status.

7.18 **Marketing Prohibition**

Agencies providing CAP services are prohibited from offering gifts or service related inducements of any kind to entice beneficiaries to choose it as his or her CAP provider, or to entice beneficiaries to change from his or her current provider.

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

Original Effective Date: October 1, 1982

Revision Information:

<table>
<thead>
<tr>
<th>Date</th>
<th>Section Revised</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/01/2012</td>
<td>All sections and attachment(s)</td>
<td>Initial promulgation of current program coverage.</td>
</tr>
<tr>
<td>03/01/2012</td>
<td>All sections and attachment(s)</td>
<td>Technical changes to merge Medicaid and NCHC current coverage into one policy.</td>
</tr>
<tr>
<td>03/01/2012</td>
<td>All sections and attachment(s)</td>
<td>Waiver renewal</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>All sections and attachment(s)</td>
<td>Policy name changed from, “Community Alternatives Program for Disabled Adults and Choice Option (CAP/DA-Choice)” to “Community Alternatives Program for Disabled Adults (CAP/DA).”</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>All sections and attachment(s)</td>
<td>Policy revision for waiver renewal.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>All sections and attachment(s)</td>
<td>Updated policy template language</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Section 1.0</td>
<td>The Clinical Coverage Policy name was changed to Community Alternatives Program for Disabled Adults (CAP/DA). The target population was defined to be adults with disabilities 18 years of age and older. The description of the procedure, product or service were revised and expanded. Two service options under the waiver were identified, CAP/DA and CAP/Choice. The CAP/DA specific benefit services were renamed to include: a. Home modification and mobility Aid to Home accessibility and adaptation; b. Waiver supplies to Specialized medical equipment and supplies; c. Transition services to Community transition services; and d. Training and education to Training, education and consultative services. A note was added to give the website where information about Nursing Facilities, Home Health Services, Hospice Services, Home Infusion Therapy, and Durable Medical Equipment and supplies, could be found.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsections 1.1.1-1.1.30</td>
<td>Expanded some existing definitions and added new definitions.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.2</td>
<td>The definition of beneficiary added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.5</td>
<td>Header changed to CAP/Choice (Consumer-Directed Care). The</td>
</tr>
<tr>
<td>Date</td>
<td>Section Revised</td>
<td>Change</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.6</td>
<td>Header changed to Comprehensive Interdisciplinary Needs Assessment. This definition is new to the policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.7</td>
<td>Header was changed to Disenrollment.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.8</td>
<td>Header changed to Division of Medical Assistance (DMA). This changed to provide a more comprehensive description.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.9</td>
<td>Header was changed to e-CAP Web-based Tool. This definition is new to the policy. E-CAP will replace the functionality of AQUIP.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.10</td>
<td>Header changed to Emergency Back-up plan. This definition is new to the policy. The definition of participant was deleted from the policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.11</td>
<td>Header was changed to Financial Management Services. This definition is new to the policy.</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.12</td>
<td>Header was changed to Free Choice of Provider. This definition of Free Choice of Providers is new to the policy.</td>
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<td>10/01/2013</td>
<td>Subsection 1.1.13</td>
<td>Header was changed to Freedom of Choice. This definition of Freedom of Choice is new to the policy. The definition of Recipient was deleted from this section.</td>
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<td>10/01/2013</td>
<td>Subsection 1.1.14</td>
<td>Header was changed to Health and Welfare. This definition of Health and Welfare is new to the policy.</td>
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<td>10/01/2013</td>
<td>Subsection 1.1.16</td>
<td>Header was changed to Individual Risk Assessment. This definition of Individual Risk Agreement is new to the policy.</td>
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<td>10/01/2013</td>
<td>Subsection 1.1.17</td>
<td>Institutional Respite Care added. This definition is new to the policy.</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.18</td>
<td>Instrumental Activities of Daily Living (IADL’s ) was added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.19</td>
<td>Level of Care for the CAP/DA Program was added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.20</td>
<td>Meal Preparation and Delivery added. This definition of Meal Preparation and Delivery is new to the policy.</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.21</td>
<td>The definition of NC Tracks added.</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.22</td>
<td>Non-Institutional Respite Services added. This definition is new to the policy.</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.25</td>
<td>The definition of Permanent Private Place of Residence (Home) added. The title of this section was changed from Primary Residence (Home).</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.26</td>
<td>Personal Care Aide was added.</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.27</td>
<td>The definition of Personal Care Assistant added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.28</td>
<td>The definition of Responsible Party added. This definition of Responsible Party is new to the policy.</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.29</td>
<td>Risk of Institutionalization was added. This definition was amended to provide a more comprehensive description.</td>
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<tr>
<td>10/01/2013</td>
<td>Subsection 1.1.30</td>
<td>The definition of Service Request Form added. This definition of Service Request Form is new to the policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Section 2.0</td>
<td>The title of this section was changed from Eligible Recipients to Eligibility Requirements.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsections 2.1</td>
<td>Was divided into subsections: General, and Specific.</td>
</tr>
<tr>
<td>Date</td>
<td>Section Revised</td>
<td>Change</td>
</tr>
<tr>
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<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 2.1.2</td>
<td>New section; EPDST lists specific Medicaid criteria for the CAP/DA Program. It replaces Subsection 2.4 in the previous policy. A Note was added to this section to emphasize that it is not appropriate to consider a person for CAP/DA simply to qualify him or her for Medicaid.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 3.2.1</td>
<td>The criteria that a beneficiary be 18 years of age or older and eligible for Medicaid in one of the specified benefit categories, has been removed from this section and referenced in Subsection 2.1.2. Another criterion for the beneficiary to meet was added to this section before Medicaid will pay for CAP/Choice waiver services. The completion of a self-assessment questionnaire was added to this section and removed from a note in Subsection 3.2 in the previous policy. The Level of Care (LOC) Determination Criteria is a new section in this policy. It tells the minimum requirement of LOC necessary to qualify for participation in the CAP/DA program. This section also explains how often an evaluation of LOC should occur. The Level of Care Criteria for CAP/DA describes the Home and community based care nursing facility LOC criteria for CAP/DA which is comparable to 2B-1, Nursing Facility Clinical coverage policy. A listing of exceptions of the HCBS LOC to 2B-1 clinical coverage policy is identified. Added a Note: When a waiver beneficiary is participating in the consumer-directed option (CAP/Choice), supervision of a registered nurse or licensed practical nurse; and other personnel working under the direct supervision of a registered nurse or licensed practical nurse is not a requirement. Consumer-directed care allows choice of service providers. The area listing the conditions that must be present in combination to justify nursing facility level of care has been moved. This information was in Subsection 5.4.1.2 of the previous policy. Diabetes was also added to the list of conditions. The Expedited Criteria (Prioritization) area in this section is new. This section lists situations in which an individual would be placed at the top of CAP/DA waitlist.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 3.2.2</td>
<td>Expands description of Case Management services, which was originally located in Subsection 5.19. A definition for waiver case management services has been placed</td>
</tr>
</tbody>
</table>
The section introduces and describes four principles of Case Management: Assessing, Care Planning, Referral/Linkage and Monitoring and follow-up, have been updated, and formatted differently. Each section now contains an area listing the core skills and competencies of that case management component. These sections were previously located in Subsections 5.19.1, 5.19.2, 5.19.3, and 5.19.4 of the prior policy.

10/01/2013 Subsection 3.2.3 New section; Medicaid Additional Criteria describes additional CAP/DA waiver services that may be covered by Medicaid.

The Adult Day Health Services area in this section was located in Subsection 5.7 of the previous policy. The website where additional information can be found about the Adult Day Health Services has been updated.

The Assistive Technology area in this section was located in Subsection 5.18 in the previous policy.

The Community Transition area in this section was located in Subsection 5.16 of the previous policy.

The Home Accessibility and Adaptation (previously known as Home Modification and Mobility Aids) area was in Subsection 5.9 of the previous manual.

The description of Institutional Respite Care has been clarified. This information was located in Subsection 5.11 in the previous policy.

The description of Non-Institutional Respite Care has been updated. This information was located in Subsection 5.12 of the previous policy.

The information about Participant Goods and Services in this section remains the same. It was located in Subsection 5.15 of the previous policy.

The information about Personal Care Aides was located in Subsection 5.8 of the previous policy.

The area discussing Specialized Medical Equipment and Supplies was titled Waiver Supplies in the previous policy; it was located in Subsection 5.14.

The area in this section discussing Training, Education and Consultative Services was in Subsection 5.17 of the previous policy.
<table>
<thead>
<tr>
<th>Date</th>
<th>Section Revised</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/01/2013</td>
<td>Subsection 3.2.4</td>
<td>The information about the Care Advisor, Personal Assistant Services, and Financial Management Services was previously located in Subsections 5.20, 5.21, and 5.22 of the previous policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 3.2.5</td>
<td>New section to the policy and describes the Medicaid State Plan Services. This Home Health Services information was previously located in Subsection 5.23.2 of the previous policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 4.2.1</td>
<td>Added to the policy:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Termination of Medicaid;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. The required annual LOC determination was not approved;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. A timeline to return back to the CAP/DA program of not to exceed 90-days for short-time rehabilitation;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. An assessment of medical and functional needs has not been completed by an RN or social worker to determine risk of institutionalization, defined in Subsection 1.1.29;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>e. The beneficiary does not require and use case management and one or more waiver services monthly (excludes incontinence products, personal emergency response system and meal preparation and delivery);</td>
</tr>
<tr>
<td></td>
<td></td>
<td>f. The beneficiary resides in an unsafe home environment placing the eligible beneficiary’s health, safety and well-being at risk, listed in Subsection 7.4; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>g. More than two verbal and written attempts added to establishing contact with the beneficiary.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 4.2.2</td>
<td>Medicaid additional Criteria Not Covered; a listing of items is identified.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.1</td>
<td>Updated to: Medicaid shall require prior approval for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. HCBS nursing facility LOC for CAP/DA participation; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. All waiver service limits.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.2.2</td>
<td>Specific added as a header.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.3</td>
<td>Header changed to CAP/DA Comprehensive Interdisciplinary Needs Assessment.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.3.1</td>
<td>Header added: Initial Interdisciplinary Comprehensive Assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Added:</strong> Note: Upon the completion and approval of the Service Request Form, a referral for long-term care Medicaid for waiver participation must be made by the lead agency.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.3.2</td>
<td>Header added: CAP/DA Plan of Care (POC).</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.3.3</td>
<td>Header added: Continued Need Review (CNR).</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.3.4</td>
<td>Header added: Continued Need Review Plan of Care (CNR POC).</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.3.5</td>
<td>Header added: Changes and Revision to the Plan of Care.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.4</td>
<td>Header changed to CAP Effective date.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.5</td>
<td>Header changed to Authorization of services.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.6</td>
<td>Header changed to Transfer of Eligible Beneficiaries.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.7</td>
<td>Header changed to CAP/DA Waiver Benefit Specific Service Limitations.</td>
</tr>
<tr>
<td>Date</td>
<td>Section Revised</td>
<td>Change</td>
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</tr>
<tr>
<td>10/01/2013</td>
<td>Subsections 5.7.1-5.7.12</td>
<td>Specific CAP/DA Waiver Benefits limitation added. Statement added to 5.7.10- The FI service is an administrative activity for initial consumer-direction financial management start-up and monthly ongoing financial management This service can be included in the cost summary of the POC. Specific guidance will be provided on an annual basis.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 5.7.12</td>
<td>Program Administration Authority Responsibility is new.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Section 6.0</td>
<td>Header changed to Provider Qualifications and Occupational Licensing Entity Regulations.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsections 6.1.1-6.1.16</td>
<td>The CAP/DA waiver specific services updated.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Section 6.3</td>
<td>Lead Agency Responsibility</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 6.4</td>
<td>Staff Qualification added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 6.5</td>
<td>Training Requirements added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.1</td>
<td>Compliance updated and expanded to include record retention.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.3</td>
<td>Header changed to Budget and Use of Funds.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.4</td>
<td>Header changed to Health, Safety and Well-being.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.5</td>
<td>Individual Risk Agreement added; new to the policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.6</td>
<td>Header changed to Absence from CAP/DA Participation; new to policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsections 7.6.1-7.6.4</td>
<td>Added to policy</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.7</td>
<td>Header changed to Voluntary Withdrawals. The section is new to the policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.8</td>
<td>Header changed to Disenrollment</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.9</td>
<td>Header changed to Documentation Requirements; new to the policy.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.10</td>
<td>Quality Assurance added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.10.1</td>
<td>Quality Assurance Objectives added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.10.2</td>
<td>Quality Assurance Components added.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.11</td>
<td>Program Integrity</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Subsection 7.12</td>
<td>Use of Telephony and Other Automated Systems</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Attachment A</td>
<td>The billing methodology for HIT was added in letter C (codes).</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Attachment A - Letter E</td>
<td>Billing Units updated.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Attachment A - Letter F</td>
<td>Place of Service updated.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Attachment A - Letter G</td>
<td>Header changed to Co-payments or Deductibles; provides instructions on deductible for CAP/DA and CAP/Choice beneficiaries.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Attachment A - Letter H</td>
<td>Reimbursement was updated.</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Appendix A</td>
<td>Added to the policy</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Appendix B</td>
<td>Added to the policy</td>
</tr>
<tr>
<td>10/01/2013</td>
<td>Appendix C</td>
<td>Added to the policy</td>
</tr>
<tr>
<td>02/22/2017</td>
<td>All Sections and Attachments</td>
<td>Amended policy posted on this date, with an EFFECTIVE Date of 10/1/2013.</td>
</tr>
<tr>
<td>Date</td>
<td>Section Revised</td>
<td>Change</td>
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</tr>
<tr>
<td>01/01/2017</td>
<td>Section 1.0</td>
<td>Non-waiver services available to CAP beneficiaries were updated. The description of 1915(c) HCBS waiver and assurances of the waiver were updated. Definitions in this section were moved to Appendix F.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Section 2.0</td>
<td>Updated the note in this section to read: It is not appropriate to consider a person for CAP who is not at-risk of institutionalization simply to qualify him or her for Medicaid.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Section 3.0</td>
<td>This section was updated to clarify eligibility criteria of when CAP is covered. Some items in this area were moved to another section for clarity of waiver processes.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Section 4.0</td>
<td>This section was updated to clarify when CAP services are not approvable.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Section 5.0</td>
<td>This section was updated to describe CAP approval processes and the minimum requirements of completing a referral, assessment and service plan and all limitation imposed. This section was updated to describe the required documentation for waiver service requests. This section was updated to clarify the role of the CAP lead agency’s responsibilities.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Section 6.0</td>
<td>This section was updated to provide clarity of each waiver service and the provider’s eligibility and required credential/licensure to render CAP services. This section was updated to include the care coordination responsibilities of the CAP lead agency.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Section 7.0</td>
<td>This section was updated to provide clarity in the areas of waiver compliance. A description of the general documentation requirements, frequency of monitoring and corrections made to the service record was added to this section.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Attachment A</td>
<td>This section updated to identify new processes for claim-related information.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Appendix A</td>
<td>Form was replaced with newly revised Service Request Form</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Appendix B</td>
<td>Self-Assessment Questionnaire for Consumer-Direction was updated with newly revised questionnaire.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Appendix C</td>
<td>Individual Risk Agreement was updated with newly revised form.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Appendix D</td>
<td>Appendix added to describe waiver services and elaboration on requirements.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Appendix E</td>
<td>Appendix added to identify the updated Beneficiary Rights and Responsibilities requirements to participate in CAP program.</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Appendix F</td>
<td>Appendix added to define CAP terms and to replace definitions in Section 1.</td>
</tr>
<tr>
<td>04/18/2017</td>
<td>All Sections and Attachments</td>
<td>Amended policy posted on this date, with an <strong>EFFECTIVE Date</strong> of 01/01/2017.</td>
</tr>
<tr>
<td>07/21/2017</td>
<td>Appendix G</td>
<td>Corrected page numbering. No change to Amended Date.</td>
</tr>
</tbody>
</table>
Attachment A: Claims-Related Information

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

A. **Claim Type**

   Professional (CMS-1500/837P transaction)

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

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

C. **Code(s)**

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

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

<table>
<thead>
<tr>
<th>HCPCS Codes</th>
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<tbody>
<tr>
<td>B4100BO</td>
<td>S5125</td>
</tr>
<tr>
<td>B4150BO</td>
<td>S5135</td>
</tr>
<tr>
<td>B4152BO</td>
<td>S5150</td>
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<td>B4153BO</td>
<td>S5161</td>
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<td>B4154BO</td>
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<td>H0045</td>
<td>T2041</td>
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<td>S5102</td>
<td>T4535</td>
</tr>
<tr>
<td>S5111</td>
<td>T4539</td>
</tr>
</tbody>
</table>

HIT drug therapies are covered under a per diem charge. The per diem covers the therapy administration, supplies, and the nursing component (teaching, monitoring) of the therapy. HIT
drug therapy must be billed using two HCPCS codes for each day of service to comply with national coding standards in accordance with HIPAA requirements. The applicable therapy code plus the nursing component code must be used for each day of therapy.

**Unlisted Procedure or Service**

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

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

**D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

**E. Billing Units**

Refer to the CAP/C, CAP/DA and CAP/Choice fee schedules for current rate and billing units: [http://dma.ncdhhs.gov/](http://dma.ncdhhs.gov/)

The lead agency or designated entity, shall bill for case management services, home accessibility and adaptive services, assistive technology, training and education services, community transition services other specialized medical equipment and supplies in accordance with this CAP policy and his or her own agency policy.

**F. Place of Service**

Case management services are provided in the case manager’s office, a beneficiary’s primary private residence, Acute Inpatient Hospital, or Nursing Facility. Acceptable places for all other waiver services to be provided are dependent on service type.

**Note:** Beneficiaries may be living in institutions such as nursing facilities at the time of application, screening, and assessment, but shall be discharged to a primary private residence before they can receive in-home services.

**G. Co-payments or Deductible**


Medicaid does not pay for services while in the deductible status.

**H. Reimbursement**

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

For a schedule of rates, see: [http://dma.ncdhhs.gov/](http://dma.ncdhhs.gov/)

**Date of Service:** Date of service billed must be the date the service is provided or rendered.
CAP Claim Reimbursement
The lead agency shall bill for case management services, home accessibility and adaption, adaptive tricycles, adaptive car seats, training and education services, community transition services, participant goods and services, according to this policy, his or her own agency policy, and NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

Approved CAP providers shall bill for adult day health, financial management, In-Home aide, geriatric and pediatric nurse aide, CAP nursing, home accessibility and adaptation, assistive technology, meal preparation and delivery, medical equipment and supplies and personal emergency response service according to Subsection 5.9, his or her own agency policy and NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

CAP services are provided in an amount, duration, and scope, consistent with the beneficiary’s medical needs and must be provided in accordance with the service authorization. The amount of service provided cannot exceed what is contained in the approved CAP service plan. A provider shall not bill for a service if the procedure is not valid for the CAP benefit program, or if the policies and procedures relevant to that service were not adhered to. CAP providers shall not file a claim for a beneficiary who is ineligible for CAP services.

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

a. Assessing the individual for CAP participation. This includes the time for both members of the assessment team (if applicable) to arrange, coordinate, and complete assessment activities.
b. Planning CAP services, including completing the service plan and revising the plan as needed.
c. Locating service providers for approved CAP services and ordering the services from those providers. Locating and arranging informal support to meet the beneficiary’s needs.
d. Coordinating the provision of other Medicaid home care services, such as Private Duty Nursing, Home Health and DME.
e. Monitoring CAP services, including the delivery of the services and reviewing claims and related documentation.
f. Monitoring the beneficiary’s situation, including the continuing need for CAP participation, the level of care and the appropriate services, as well as taking appropriate action on your findings.
g. Working with the CAP beneficiary, family, and others involved in the beneficiary’s care to assure the health, safety, and well-being. This includes emergency planning and backup planning activities.
h. Coordinating Medicaid eligibility issues with DSS, including those related to helping the beneficiary get information to DSS.
i. Arranging and coordinating activities related to the disenrollment of CAP that occurs prior to the disenrollment date.
j. Time spent talking with those involved in the beneficiary’s care.
k. Time coordinating the service authorizations.
l. Time spent completing other correspondence directly related to the beneficiary’s care.
A request for payment for an assessment of an individual who does not become a CAP beneficiary can be made if all of the following conditions are met:
   a. The individual has a properly approved SRF.
   b. The assessment was completed according to CAP policies and procedures.
   c. The assessment is documented and certified by both assessors on the CAP assessment form.
   d. The individual is authorized for Medicaid in a Medicaid category eligible for CAP coverage on the date of service.

A claim for the assessment of an individual who will not be participating in CAP is called an “assessment only” claim. The claim is paid directly by DMA instead of through NCTracks. To submit an “assessment only” claim:
   a. Prepare a paper claim for the service
   b. Prepare a cover letter that includes:
      1. The Individual’s name and Medicaid ID number; and
      2. The reason the individual will not be participating in CAP.

The following case management activities are considered administrative costs are not allowed to be billed separately:
   a. outreach;
   b. travel time;
   c. activities after the beneficiary’s discharge; termination, or death;
   d. attending training;
   e. completing time sheets;
   f. recruiting, training, scheduling, and supervising staff;
   g. billing Medicaid;
   h. documenting case management activities; and
   i. gathering information to respond to quality assurance request are not covered activities for case managers and care advisors.

Beneficiaries in a facility (nursing home or hospital) may receive CAP Waiver Services on the date of admission and the date of discharge.
Appendix A: CAP/DA Service Request Form

<table>
<thead>
<tr>
<th>Service Request Form for CAP Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Request Date:</strong> 01/03/2016</td>
</tr>
</tbody>
</table>

**Beneficiary Demographics**
- **Beneficiary's First Name:**
- **Last Name:**
- **Beneficiary has Medicaid?**
- **Medicaid ID:**
- **Social Security Number:**
- **Medicare ID:**
- **Date of Birth:**
- **Gender:**
- **Marital Status:**
- **County:**
- **Primary language:**

**Beneficiary Address**
- **Address 1:**
- **Address 2:**
- **City:**
- **State:** NC
- **Zip:**
- **Phone:**

**Other Services Beneficiary is Receiving**
- **Home Health:**
- **PCS:**
- **Hospice:**
- **CAPCO or CAPOA:**
- **Independent Living Services:**
- **Skilled nursing services:**
- **Is beneficiary receiving another Medicaid program to which he/she is entitled?** Specify
- **Is beneficiary has been informed regarding their choice of providers:**
- **Is beneficiary interested in the CAP Choice Option?**
- **Beneficiary (legal guardian) has agreed to this request?**
- **Is beneficiary currently in an institution (hospital or nursing facility)?**

**Beneficiary Conditions and Related Support Needs**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD Code</th>
<th>Diagnosis Information</th>
<th>ICD Version</th>
<th>Primary Dx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an active AIDS diagnosis?</td>
<td>select</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>if AIDS co-morbidities: current CD4 (T) count?</td>
<td>select</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a HIV diagnosis?</td>
<td>select</td>
<td></td>
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<tr>
<td>Is there a CBD diagnosis?</td>
<td>select</td>
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<td></td>
</tr>
<tr>
<td>Is there a HCC diagnosis?</td>
<td>select</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a HCC diagnosis?</td>
<td>select</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is currently on therapy?</td>
<td>select</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prognosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Medication Name

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>PRN</th>
<th>Strength</th>
<th>If PRN, req. every 4 hrs?</th>
</tr>
</thead>
</table>

### Sensory/Communication Limitations

- Speech ability/making self-understood (Rarely/never) *
- Hearing (Severe difficulty or none) *
- Vision (Severe difficulty or blind) *

### Orientation and Cognitive Status

- Is beneficiary oriented
  - To Time *
  - To Person *
  - To Place *
- Beneficiary has Cognitive Skills for Daily Decision-making *

### Mood

- Unrealistic fears
- Sad, depressed, somber facial expressions
- Persistent anger
- Elevated mood, euphoric
- Unpleasant mood in morning
- Excessive irritability

### Behavior

- Wandering
- Repetitive verbalizations
- Repetitive physical movements
- Self-deprecation
- Insomnia/disturbed sleep patterns
- Suicide attempt/ideation

### Interpersonal Functioning

- Homicidal
- Dangerous to others
- Verbally abusive
- Evictions due to inappr. behavior
- Fear of strangers
- Reduced social interaction/isolation
# NC Division of Medical Assistance
## Medicaid and Health Choice
### Clinical Coverage Policy No: 3K-2
#### For Disabled Adults (CAP/DA)

**Amended Date:** January 1, 2017

## Clinical Coverage Policy

### Cardio-Respiratory Support Needs

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suctioning - tracheal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suctioning - other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventilator dependent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vent Type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection treat?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse oximetry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-vent tracheostomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebulizer care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest physiotherapy/use of chest PT vest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of cough assist device</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apnea monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPAP/IPPAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory assessment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Nutrition-Related Support Needs

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enteral Feeding/Tube Feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of daily nutrition/fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parenteral Nutrition (TPN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Soft Mechanical Soft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thicken Diet</td>
<td></td>
<td></td>
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<tr>
<td>Pureed Diet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplemental formula diet physician prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes management (daily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluid mgmt/force fluids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Input/output monitoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other nutrition treatment Diet?</td>
<td>Other Des.</td>
<td></td>
</tr>
</tbody>
</table>

### Ancillary Therapies Being Received

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy Details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Therapy Details</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Support Needs

<table>
<thead>
<tr>
<th>Service</th>
<th>select</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continence Management</td>
<td></td>
</tr>
<tr>
<td>Indwelling Catheter</td>
<td></td>
</tr>
<tr>
<td>Colostomy Bag</td>
<td></td>
</tr>
<tr>
<td>Seizure management</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td>Wound Care</td>
<td></td>
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<tr>
<td>Ular Care</td>
<td></td>
</tr>
<tr>
<td>Isolation - infection/disease</td>
<td></td>
</tr>
</tbody>
</table>
### Functional Limitations

#### ADL Limitations
- Bathing - Does beneficiary need hands-on assistance? [select]
- Personal Hygiene - Does beneficiary need hands-on assistance? [select]
- Dressing - Does beneficiary need hands-on assistance? [select]
- Bed Mobility - Does beneficiary need hands-on assistance? [select]
- Mobility - Does beneficiary need hands-on assistance? [select]
- Transfer - Does beneficiary need hands-on assistance? [select]
- Toiletting/Elimination - Does beneficiary need hands-on assistance? [select]
- Eating - Does beneficiary need hands-on assistance? [select]

#### Other Functional Limitations
- Can the beneficiary ambulate without person assistance? [select]
- Is the beneficiary confined to a wheelchair or bedbound? [select]
- Contractures
- Paralyzed
- Fatigue

### Additional Comments about Treatment Needs

### Informal Caregiver Availability

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Relationship</th>
<th>Lives with Beneficiary</th>
<th>Contact Phone</th>
</tr>
</thead>
</table>

#### Caregivers Entry
- Will 24-hour caregiver availability be required to ensure beneficiary safety? [select]

#### Beneficiary Consent
- The beneficiary has consented to sharing the information documented in this Service Request Form with any agency or organization responsible for enrolling or assisting the beneficiary once enrolled in the requested service or program? [select]

#### Submitting Agency Identification and Beneficiary Primary Care Physician

<table>
<thead>
<tr>
<th>Submitter Name</th>
<th>CAP Case Management Agency</th>
<th>Submitting Agency Name (If not a CAP Agency)</th>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

#### Required Document List

<table>
<thead>
<tr>
<th>Document</th>
<th>Present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer Consent (Release of Information) Form</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### Supporting Documentation

<table>
<thead>
<tr>
<th>Record Date</th>
<th>Supporting Documentation Type</th>
<th>Record</th>
</tr>
</thead>
</table>

#### Comments

Is Request Complete? [ ]
- Yes [ ]
- No [ ]

Date GRP Completed

Save | Show Errors
Appendix B: Waiver Service Definitions

3K-2 CAP/DA Waiver Service Definitions and Provider Requirements for each definition:

ADULT DAY HEALTH
A service for CAP beneficiaries to attend certified Adult Day Health Care facilities. The service cares for persons who do not have other appropriate day supports and who need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting. The program supports the CAP beneficiary’s independence and promotes social, physical, nutritional needs and emotional well-being. Services are health services and a variety of program activities designed to meet the CAP beneficiary’s needs and interests. Nutritional needs are met through personally prepared meals and snacks consistent with medical needs and dietary restrictions. The meals received as a part of adult day health services do not constitute a full nutritional regimen.

Limits, Amount And Frequency
Services are organized and provided for four (4) hours minimum per day on a regularly scheduled basis for one or more days per week.

Qualified Provider(s)
a. Meet and maintain the Home- and Community-Based Final Rule requirements.
b. 10A NCAC Chapter 06 Subchapters R and S
c. Certified by the NC Division of Aging and Adult Services, according to NC General Statutes 131-D-6

Federa1y Recognized Tribes - Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2(10) be licensed or recognized under the State or local law where the provider is located shall be deemed to have been met:
a. When a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and
b. If the provider entity meets all applicable standards for such licensure or recognition.

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

CASE MANAGEMENT
A service that directs and manages the special health care, social, environmental, financial and emotional needs of a CAP beneficiary in order to maintain the beneficiary’s health, safety, and well-being and for continual community integration.

The case management entity shall retain the following documents:

a. Service Request Form;
b. all assessments;
c. service plan;
d. case management notes;
e. service authorizations;
f. copies of claims generated by the case management entity;
g. any required documents generated by other providers and approved by the case management entity; and
h. related correspondence in compliance with all applicable federal and state laws, rules and regulations.

Case management is a CAP service offered to CAP beneficiaries to assist in navigating community systems and gaining access to Medicaid services to meet their identified needs. The comprehensive interdisciplinary assessment identifies the lack of an informal support system and the need for intervention by a case manager. When the assessment identifies a CAP beneficiary to be at risk of institutionalization, case management must be listed in the service plan on a monthly basis. The CAP beneficiary has the option to select an approved case management provider, which is the sole case management provider for that CAP beneficiary. If a request is made to transfer to another case management entity, a root cause analysis must be performed within five (5) days to assure the health and well-being of the CAP beneficiary, as well as to identify utilization limits and access the performance of the newly selected case management entity. DMA shall approve the transfer of case management entity.

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

The two types of case managers are:

a. **Case Manager** provides services for a CAP beneficiary participating in provider-led services.
b. **Care Advisor** provides specialized case management to a CAP beneficiary participating in consumer-directed care. The care advisor focuses on empowering participants to define and direct their own personal assistance needs and services. The care advisor guides and supports the CAP beneficiary, rather than directs and manages the CAP beneficiary, throughout the service planning and delivery process. These functions are done under the guidance and direction of the CAP beneficiary or responsible party.

There are Four Principle Activities of Case Management:

a. Assessment
b. care planning
c. Referral and Linkage
d. monitoring & Follow-up

**Limits, Amount And Frequency**

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

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

Non-covered case management activities are:

a. employee training for the Case Manager;
b. completing time sheets;
c. traveling time;
d. recruiting staff;
Qualified Provider(s)
The case management entity is an agency approved by DMA to act as the lead entity in a county. The approved entity is the lead local entry point and approval authority for CAP services. The lead entity is responsible for the day-to-day case management activities for potential and eligible CAP beneficiaries. These agencies can be county departments of social services, county health departments, county agencies on aging, hospitals, or qualified case management agencies. The case management entity shall provide case management and lead entity services. The case management entity is responsible for issuing the Service Authorization to authorize a provider to render specialized medical equipment and supplies, as appropriate.

a. The case management entity shall be an organization with three (3) or more years of direct service experience in providing case management to individuals at risk of institutionalization and receiving home- and community-based services.

b. Each case management entity shall enroll as a NC Medicaid provider and be approved through an agreement by the State Medicaid Agency to provide lead entity CAP services. Every three (3) years, the case management entity shall recertify as a Medicaid provider.

Qualified Case Management Entities shall have:

a. Resource connection to the service area to provide continuity and appropriateness of care;

b. Experience in geriatrics, pediatrics, and physical disabilities;

c. Policies and procedures in place that align with the governance of the state and federal laws and statues;

d. Three (3) years of progressive and consistent home and community-based experience;

e. Ability to provide case management by both a social worker and a nurse;

f. Physical location;

g. Computer technology and IT web-based connectivity to support the requirement of current and future automated programs;

h. Met the regulatory criteria under DHHS and DHSR

i. Appropriate staff to participant ratio; and

j. Ability to implement services within five (5) calendar-days of POC approval;

The case manager or care advisor shall meet one of the following qualifications:

a. Bachelor’s degree in social work from an accredited school of social work, and one (1) year of directly related community experience (preferably case management) in a health or medical field directly related to homcare, long-term care, or personal care and the completion of a DMA-certified training program within three (3) consecutive months of employment;

b. Bachelor’s degree in a human services or equivalent field from an accredited college or university with two (2) or more years of community experience (preferably case management) in a health or medical field directly related to homcare, long-term care, or personal care and the completion of a DMA-certified training program within three (3) consecutive months;
c. Bachelor’s degree in a non-human services field from an accredited college or university with two (2) or more years of community experience (preferably case management) in a health or medical field directly related to homecare, long-term care, or personal care and the completion of a DMA-certified training program within three (3) consecutive months; or
d. Registered nurse who holds a current North Carolina license, two (2) year or four (4) year degree, one (1) year case management experience in homecare, long-term care, personal care or related work and the completion of a DMA-certified training program within three (3) consecutive months.

The case manager or care advisor shall complete nine (9) contact or continuing education hours per year of which person-centered training; legislative training related to health care disability and reimbursement strategies; recognition and reporting of abuse, neglect and exploitation; and program integrity (PI) are mandatory.

**RESPITE**

Respite care provides short-term support to a family caring for a CAP beneficiary. It can be used as day, evening, or overnight care to meet a range of beneficiary needs such as caregiver relief. Respite care may be provided either in the beneficiary’s residence or in a facility licensed to provide the LOC required by the beneficiary (such as a nursing facility or hospital).

**Institutional Respite** is a service for CAP beneficiaries that provides temporary support to the primary caregiver(s) by taking-over the care needs for a limited time. The provision of this service takes place in a Medicaid-certified nursing facility or a hospital with swing beds. Institutional respite is computed on a daily capitation rate per the current Fee Schedule.

**Non-Institutional Respite** is a for CAP beneficiaries to provide temporary support to the primary unpaid caregiver(s) by taking over the tasks of that person for a limited time. This service may be used to meet a wide range of needs, including family emergencies; planned special circumstances (such as vacations, hospitalizations, or business trips); relief from the daily responsibility and stress of caring for an individual with a disability; or the provision of time for the caregiver(s) to complete essential personal tasks.

Respite, total to 720 hours/fiscal year, can be used for the following two purposes:

a. CAP beneficiary or primary caregiver needs physical time away from home; or Caregiver personal time for emotional, physical or psychosocial balance (caregiver personal time for emotional balance such as sick and snow days, shopping, meeting friend- total time per fiscal year 420 hours); or

b. Primary caregiver or beneficiary needs physical time away from home (such as institutional placement, vacation, and business trips - total time per fiscal year 300 hours)

The request for respite must fall within the guideline and definition of respite. When weekly/daily requests are made for respite, a service plan must be implemented.

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

Respite hours can be used to approve extra hours that are needed due to:
a. a change in the beneficiary’s condition resulting in additional or increased medical needs;
b. caregiver crisis (illness or death in the family);
c. coverage for school holidays if the caregiver works outside the home and there is no other
caregiver available, and
d. occasional, intermittent work obligations of the caregiver when no other caregiver is available.

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

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

Any hours not used at the end of the fiscal year are lost. Hours may not be carried over into the next fiscal
year. It is the joint responsibility of the case manager, provider agency, and family to track the respite
hours used to ensure the beneficiary remains within the approved limits.

There are four categories of respite. The allotted respite hours may be used as any combination of the
following:

a. In-home Aide respite
b. In-Home Pediatric or Geriatric Nurse Aide respite
c. In-home nursing respite
d. Institutional respite

Respite hours are indicated on the cost summary and service authorization as a “per year” allotment.
Families may use as much or as little of their respite time as they wish within a given month, as long as
they do not exceed their approved allotment by the end of the fiscal year. Hours may be used on a
regularly scheduled or on an as-needed basis. The IT system reconciles respite utilization on quarterly
basis to maintain annual budget limits.

Limits, Amount and Frequency

The maximum allotted days/hours for respite include both institutional respite care and non-institutional
respite; in situation of more than one CAP beneficiary in a household, respite hours are assigned per
household. When acute care needs of one beneficiary in the household are identified, an assessment is
performed to determine if additional respite hours are needed.

Respite hours should not be used for situations in which short-term-intensive hours could be approved.

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

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

Qualified Providers

10A NCAC 13J .1107 IN-HOME AIDE SERVICES

Licensure: TITLE 10: CH22, 0.0100; 10 NCAC 06B .0101- Institution: settings of a hospital or a nursing
facility or similar setting.
Federally Recognized Tribes - Any requirement under a Federal health care program that a provider as defined in G.S. 108C-2(10) be licensed or recognized under the State or local law where the provider is located shall be deemed to have been met:

a. When a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and

b. If the provider entity meets all applicable standards for such licensure or recognition.

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

**CAP IN-HOME AIDE SERVICE**

A service for CAP beneficiaries that, during the hours of service provision, provides hands-on (not merely set-up or cuing) assistance with a minimum of two limited to extensive ADLs who are unable to perform these tasks independently due to a medical condition identified and documented on a validated assessment. The need for assistance with ADLs relates directly to the CAP beneficiary’s physical, social environmental and functional condition. Personal Care Aide Services, when medically necessary, shall be provided in the community, home, workplace, or educational settings. The personal care needs must fall within the NA I scope of nursing practice.

Tasks, amount, frequency, and duration must be clearly outlined in job duties developed by the CAP beneficiary or responsible party or representative.

Short-term intensive services may be used under this service. Short-term intensive services are used for a change in the status of the CAP beneficiary where the duration of care needs is less than three weeks. Short-term intensive services will be included in the service plan.

ADL care for children under the age of three (3) years is considered age appropriate and the responsibility of the parent or responsible representative.

A CAP beneficiary can use up to 14 days per year of recreational leave, when planned for in the initial and annual person-centered service plan. The exact dates of the leave do not have to be included in the service plan when the initial or annual plan is completed.

Assistance from this service when traveling out of state is allowed when the provision of this service complies with BON- licensure and certification rules.

An assigned worker may accompany a CAP beneficiary and the primary caregiver to a medical appointment, to and from school or other activities, if documented in the service plan to provide medical care or personal assistance for the CAP beneficiary.

ADL care for adults under the Medicaid Infrastructure Grant (MIG) with Vocational Rehabilitation can be provided in the workplace for those beneficiaries who qualify.
A spouse, parent, step-parent, child, sibling, or other relatives can be hired as the employee when a CAP beneficiary is 18 and over.

The employment of a spouse, parent, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if the person:

a. Is at least 18 years of age; and
b. Meets the qualifications based on needs assessment.

c. A provider’s external employment cannot interfere with or negatively affect the provision of services; nor supersede the identified care needs of the CAP beneficiary.

Tasks, amount, frequency, and duration must be clearly outlined in job duties developed by the CAP beneficiary or responsible party/representative.

Individuals with the following criminal records are excluded from hire:

a. Felonies related to manufacture, distribution, prescription, or dispensing of a controlled substance;
b. Felony health care fraud;
c. More than one felony conviction;
d. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
e. Felony or misdemeanor patient abuse;
f. Felony or misdemeanor involving cruelty or torture;
g. Misdemeanor healthcare fraud;
h. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
i. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry;

or

j. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC.

**Note:** Individuals with criminal offenses occurring more than 10 years previous may qualify for an exemption.

**Note:** Individuals directing their own care must comply with the US Department of Labor Fair Labor Standards Act.

**Limits, Amount And Frequency**
The number of hours of this CAP service is authorized based on medical necessity, caregiver availability, budget limits and other available resources.

Parents, step-parents, loco parentis, legal guardian, or significant others to a parent cannot be hired to provide personal care services to CAP beneficiaries under the age of 18. This applies for both traditional and consumer-directed services.
A spouse, parent, step-parent, child, sibling, or other relatives can be hired as the employee when a CAP beneficiary is 18 and over.

The employment of a spouse, parent, child, sibling, other relatives, and hired personnel of the CAP beneficiary shall provide this service only if the person:

h. Is at least 18 years of age; and
i. Meets the qualifications based on needs assessment.

A provider’s external employment cannot interfere with or negatively affect the provision of services; nor supersede the identified care needs of the CAP beneficiary.

CAP funding cannot be used to pay for services provided in public schools.

In-Home Aide services may not be provided at the same day/time as CAP Nursing Services or CAP Nurse Aide services. Nurse Aide Services may not be provided if it duplicates other Medicaid or non-Medicaid services.

Qualified Provider(s)
Refer to Subsection 6.6.

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

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

a. When a provider entity is operated by the Service, an Indian tribe, tribal organization, or urban Indian organization; and

b. if the provider entity meets all applicable standards for such licensure or recognition.

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

Consumer-Directed Providers
Consumer-directed providers must:

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

b. demonstrate competencies and skill sets to care for the CAP beneficiary as documented by the consumer-directed participant/responsible party and uploaded to case file.

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

FINANCIAL MANAGEMENT SERVICES

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

An approved financial manager performs financial intermediary (FI) services to reimburse the personal assistant(s) and designated providers.

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

The FMS must have experience and knowledge of the following:

a. Automated standard application of payment;
b. Check Claims;
c. Electronic Fund Transfer;
d. Electronic Fund Account;
e. International Treasury Service;
f. Invoice processing platform;
g. Judgment Fund;
h. Payment Application Modernization;
i. Prompt Payment;
j. Automated Clearing House;
k. Cash Management Improvement Act;
l. GFRS/FACTS I;
m. Government wide Accounting;
n. Intergovernmental Reconciliation;
o. Standard General Ledger;
p. Tax Payer Identification Number

**Limits, Amount And Frequency**
Financial management services are billed in 15-minute increments as per the established and approved Fee Schedule.

Start-up fee must be assessed the first month of enrollment and shall not exceed 4 units (1 hour). Monthly management fees shall be assessed each month and shall not exceed 4 units (1 hour) per month. CAP beneficiaries transferring from one fiscal intermediary to another

**Qualified Provider(s)**
Accountants, financial advisors/managers, attorneys, other individuals meeting qualifications of financial management. The FMS shall have a minimum of three (3) years of experience in developing,
implementing and maintaining a record management process that includes written policies and procedures. The FMS shall maintain current and archived participant, attendant, service vendors and FMS files as required by Federal and State rules and regulations, including HIPAA requirements. Internal controls for monitoring this process must be included in the system and described in the policies and procedures.

The FMS shall also:

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

The FMS must have experience and knowledge of the following:

a. Automated standard application of payment;
b. Check Claims;
c. Electronic Fund Transfer;
d. Electronic Fund Account;
e. International Treasury Service;
f. Invoice processing platform;
g. Judgment Fund;
h. Payment Application Modernization;
i. Prompt Payment;
j. Automated Clearing House;
k. Cash Management Improvement Act;
l. GFRS/FACTS I;
m. Government wide Accounting;
n. Intergovernmental Reconciliation;
o. Standard General Ledger; and
p. Tax Payer Identification Number.

ASSISTIVE TECHNOLOGY

Assistive technology for CAP beneficiaries includes items, product systems, supplies, and equipment, acquired commercially, modified, or customized, and used for

a. improving or maximizing the functional capabilities of the beneficiary;
b. improving the accessibility and use of the beneficiary's environment; or
c. addressing 24/7 beneficiary coverage issues.
This service shall be used for:
   a. adaptive or therapeutic equipment designed to enable beneficiaries to increase, maintain, or
      improve functional capacity in performing daily life tasks that would not be possible otherwise;
   b. specialized monitoring systems; and
   c. specialized accessibility and safety adaptations or additions.

This service includes technical assistance in device selection and training in device used by a qualified
assistive technology professional, assessment and evaluation, purchases, shipping costs, and as necessary,
the repair of such devices.

This CAP service also includes a plan for training the CAP beneficiary, family, primary caregiver,
personal aides, or assistants who will assist in the application or use of the device(s).

Repairs of assistive technology are covered as long as the cost of the repairs does not exceed cost of
purchasing a new piece of equipment. CAP funding must not be used to replace equipment or devices that
have not been reasonably cared for and maintained.

In some cases, the use of assistive technology may reduce the number of hours of personal care that the
beneficiary needs. Professional consultation must be accessed to ensure that the equipment or supply meet
the needs of the CAP beneficiary.

**Limits, Amount And Frequency**
The cost of assistive technology is limited to $3,000 per beneficiary per the life of the CAP, which is
renewed every five years.

Adaptations that add to the total square footage of the home are excluded from this service.

**Qualified Provider(s)**
Assistive Technology Professionals, Nursing Facility (Rehab), Hospital, or Certified Home Health
Agency that are State licensed Occupational Therapists, Physical Therapists or Speech Language
Pathologists (Licensure to include certification of clinical competency which is required for augmentative
communication evaluations) shall provide assistive technology. Additional provider qualifications may
include Assistive Technology Practitioners (ATP) or Assistive Technology Suppliers (ATS) certified by
RENSA. Assistive Technologists shall hold a bachelor’s degree in a human services field, special
education or related degree, and two years of experience working with assistive technology.

**COMMUNITY TRANSITION SERVICES**
A service for prospective CAP beneficiaries for transitioning from an institutional setting to a community
setting. The funds are used to pay the necessary expenses for a CAP beneficiary to establish a basic living
arrangement.

Community transition services are available to cover one-time expenses. These expenditures are for initial
set-up expenses who make the transition from an institution to their own primary private residence in the
community. Community Transition Services may cover:
   a. Equipment, essential furnishings, and household products;
   b. Moving expenses;
c. Security deposits or other such payments (e.g., first month's rent) required to obtain a lease on an apartment or primary private residence;
d. Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating);
e. Environmental health and safety assurances, such as pest eradication, allergen control, one-time cleaning prior to occupancy;
f. Personal hygiene supplies;
g. First week supply of groceries;
h. Up to a one month supply of medication in instances when the beneficiary is not provided with medication upon discharge from the nursing facility; and
i. Service does not include ongoing payments for rent.

Items and services (including rental housing) must be of sufficient quality and appropriate to the needs of the beneficiary. The beneficiary shall provide a receipt for each purchase or invoice for each payment. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service definition.

Limits, Amount And Frequency
Community transition services are available to cover one-time, initial set-up expenses, not to exceed $2,500 over lifetime of the CAP, five (5) years.
Service must be utilized with 90 calendar-days from the date of beneficiary’s discharge from an institution.

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

HOME ACCESSIBILITY AND ADAPTATION
Home accessibility and adaptation provides equipment and physical adaptations or minor renovations, as identified during an assessment, to enhance the CAP beneficiary's mobility, safety, and independence in the primary private residence. This service often plays a key role in preventing institutionalization.

An assessment must be completed by a Physical Therapist (PT), Occupational Therapist (OT), Rehabilitation Engineer, or Assistive Technology Professional (for ECUs/EADLs) certifying medical necessity. A copy of the assessment must be submitted with the request for Home Modifications (with the exception of floor coverings, air filters, and generators). A physician’s signed order may be needed to certify that the requested adaptation is medically necessary. The physician’s order must be on file with the case manager’s records. When feasible there must be up to two competitive quotes for home modifications to determine the most efficient method to complete the request. An appropriate professional shall provide the modifications or adaptations to the primary private residence.

Construction and installation must be completed according to state and local licensure regulations and building codes when applicable. All items must meet applicable standards of manufacture, design and installation.
The case management entity shall file a claim to Medicaid for this service to reimburse the contractor. The original invoice must be retained in the beneficiary’s record.

Home modifications can be provided only in the following settings:

a. A primary private residence where the CAP beneficiary resides that is owned by the individual or the family;

b. A rented residences when the modifications are portable; or

c. A rented residence, when the modifications are allowed by the owner.

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

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

a. Wheelchair ramps, stationary or portable;

b. Threshold ramps, used to allow wheelchairs to move over small rises such as doorways or raised landings;

c. Grab bars or safety rails mounted to wall;

d. Modification of bathroom facilities to improve accessibility for a disabled individual, including: roll in shower, sink modifications, water faucet controls, tub modifications, toilet modifications (such as raised seat, rails), floor urinal adaptations, and plumbing modifications that are necessary for the above listed items;

e. Widening of doorways for wheelchair access, turnaround space modifications for wheelchair access;

f. Bedroom modifications other than doorway widening to accommodate hospital beds and wheelchairs (for example, removing a closet to add space);

g. Lift systems and elevators, that are used inside a beneficiary’s private primary residence and are not otherwise covered under DME (for example, ceiling track);

h. Porch stair lifts;

i. Floor coverings when existing floor coverings are in disrepair and pose increased risk to a beneficiary with documented fall risk, or when those floor coverings are contributing to asthma exacerbations requiring repeated emergency room or hospital treatment;

j. Portable or whole house air filtration system and filters under the following circumstances:

1. For beneficiaries with severe allergies or asthma, when all other preventive measures such as removal of the allergen or irritant, removal of carpeting and drapes have been attempted, and the beneficiary’s asthma remains classified as moderate persistent or severe persistent, and a physician has certified that air filtration is of benefit. Ozone generators and electronic or electrostatic or other air filters which produce ozone or less than or equal to 50 parts per billion ozone byproduct is not covered.
2. For beneficiaries susceptible to infection, when adequate infection control measures are already in place yet the beneficiary continues to acquire airborne infections, and when a physician has certified that air filtration is of benefit in preventing infection, a germicidal air filter (with UV light) may be provided.

3. The smallest unit that meets the beneficiary’s needs is covered; i.e., if a beneficiary spends most of his or her time confined to a specific area of the house, then a whole-house system is not approved.

k. Portal Back-up generator for a ventilator, when the beneficiary uses the ventilator more than eight hours per day and in the event of a power outage the beneficiary would require hospitalization if not for the presence of the generator.

l. An Environmental Control Unit (ECU) or Electronic Aid to Daily Living (EADL) that allows a beneficiary with a disability to control aspects of their environment that are operated by electricity (i.e. lights, door strikes and openers, HVAC, TV, telephone, hospital bed, computer, small appliances, etc.). All Environmental Control Units perform most of the same functions but vary by the method of control that best suits the beneficiary. An ECU or EADL can range from a single function device up to a whole house computer-based system.

The home accessibility and adaption service consists of the following:

a. Technical assistance in device selection;

b. Training in device use by a qualified assistive technology professional;

c. Purchase, necessary permits and inspections, taxes, and delivery charges;

d. Installation;

e. Assessment of modification by the case manager and by any applicable inspectors to verify safety and ability to meet beneficiary’s needs; and

f. Repair of equipment, as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment, and only when not covered by warranty. The CAP beneficiary or his or her family shall own any equipment that is repaired.

The case management entity authorize the services through a service authorization.

Note: Medicaid assumes no liability related to use or maintenance of the equipment and assumes no responsibility for returning the private primary residence to its pre-modified condition. Home modifications may not be furnished to adapt living arrangements that are owned or leased by providers of CAP services, unless the modification is to the provider's own home for the exclusive use of that CAP beneficiary.

Limits, Amount And Frequency

The case management entity shall track the cost of home accessibility and adaptation aids billed and paid during the plan year, in order to avoid exceeding the $10,000 limit over the lifetime of the waiver (five years).

Those items that are not of direct medical or remedial benefit to the beneficiary are excluded.
Items that are covered through DME, orthotics and prosthetics, home health supplies, and EPSDT are obtained through the respective programs prior to requesting from the CAP. The CAP does not cover items that are covered by one of these programs but were denied for the particular beneficiary for lack of medical necessity.

Home modification excludes the following:

- Home modifications that add to the total square footage of the home;
- Major home renovations;
- A dwelling where the owner refuses the modification;
- The modification in a rented residence is not portable;
- Purchase of locks;
- New construction;
- Service agreements, maintenance contracts, and extended warranties;
- Roof repair, central air conditioning,
- Swimming pools, hot tubs; spas, saunas
- Items that have general utility to non-disabled individuals;
- Replacement of equipment that has not been properly used, has been lost or purposely damaged;
- Computer desk and other furniture; and
- Plumbing.

Medicaid is the payer of last resort; if the beneficiary has private insurance that covers the item, this insurance is billed.

Funding for Home accessibility and adaptation is assigned on a per-residence and per beneficiary basis in the event there are (2) two or more CAP beneficiaries living in one primary private residence.

Qualified Provider(s)

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

MEAL PREPARATION AND DELIVERY

Meal preparation and delivery is service for a CAP beneficiary 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 CAP beneficiary’s home of one nutritious meal per day. Special diets may be included.

Oral nutritional supplement is not a covered service.

Limits, Amount And Frequency

One (1) meal per day

Qualified Providers(s)

Agencies or organizations that meet Division of Aging and Adult Services requirements for home delivered meals and comply with 10A NCAC Chapter 06 Subchapter K.
PARTICIPANTS GOODS AND SERVICES

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

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

Limits, Amount And Frequency

The cost of participant goods and services for each Beneficiary must not exceed $800.00 annually (July – June). DMA consultants shall approve any item over $200.00. Products and items listed on the State Medicaid Plan are prohibited from being reimbursed by this service unless approved by DMA.

Qualified Providers(s)

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

PERSONAL EMERGENCY RESPONSE SYSTEM

Personal emergency response system is a service for a CAP beneficiary that pays the monthly service charges for a system used to alert a central monitoring facility of medical emergencies.

Limits, Amount And Frequency

One (1) per month

Installation and maintenance are not covered.

Qualified Providers(s)

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

SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES

Specialized medical equipment and supplies are:

a. Oral Nutritional Supplement: Provided to promote the health and well-being by increasing the ability to perform ADLs and IADLs. These supplies and equipment are necessary to avoid institutionalization and promote continuous community integration.

   A signed physician's order certifying medical necessity for the supply is required.

b. Incontinence Supplies: These supplies and equipment are necessary to avoid institutionalization and promote continuous community integration.

   A signed physician's order certifying medical necessity for the incontinence supply is required.

c. Medication Dispensing Box provides assists the CAP beneficiary in knowing when to take their medication.

d. Adaptive Tricycles: A durable medical equipment used for the development of gross motor skills, range of motion, improved endurance, improved circulation, trunk stabilization and balance, or as an adjunct to gait training.

e. Vehicular transport vest: A durable medical equipment for safe transport.
Specialized medical equipment and supplies consists of the following:
   a. The performance of assessments to identify the type of equipment needed by the participant.
   b. Training the participant or caregivers in the operation and/or maintenance of the equipment or use of the supply.
   c. Repair of the equipment is covered as long as the cost of the repair does not exceed the cost of purchasing a new piece of equipment.

Limits, Amount And Frequency
Incontinence Supplies and Oral Nutritional Supplements: Based on comprehensive needs assessment
Medication Dispensing: One (1) per waiver year
Adaptive tricycles for individuals: - $600 per plan year

Vehicular transport vest for individuals between the ages of 0-20- children weighing over 30 pounds or with a seat to crown height that is longer than the back height of the largest safety car seat if the child weighs less than the upper weight limit of the current car seat. As priced per plan year.

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

TRAINING, EDUCATION AND CONSULTATIVE SERVICES
A service for a CAP beneficiary that provides for training, orientation, and treatment regimens, regarding the nature of the illness or disability and its impact on the CAP beneficiary and family for the individuals (such as family members, neighbors, friends, or companions) who provide unpaid care, support, training, companionship, or supervision. The purpose of this training is to enhance the decision-making ability of the beneficiary, the ability of the beneficiary to independently care for his or her self, or the ability of the family member or personal assistant in caring for the CAP beneficiary.
Training and education consists of information and techniques for the use of specialized equipment and supplies and updates as necessary to maintain health and safety and well-being. All training and education services are documented in the service plan as a goal with the expected outcomes. This service covers conference registration and enrollment fees for classes.
Service is provided by community colleges, universities, or an organization with a training or class curriculum approved by DMA.

Limits, Amount And Frequency
Service is limited to $500 per fiscal year (July 1- June 30).
This service does not include the cost of travel, meals, or overnight lodging to attend a training event or conference
Individuals who are paid service providers are excluded from this service.

Qualified Provider(s)
The case management entity shall verify and approve Medicaid providers who have the capacity to provide items and services of sufficient quality to meet the need for which they are intended.
Appendix C: Self-Assessment Questionnaire

SELF-ASSESSMENT TOOLS

Complete the self-assessment tools to determine if you are able to direct your own care. These self-assessment tools will identify areas that you are good at and areas that you may need additional help. These tools will also assist in identifying your care needs and the required skills your hired helper (personal assistant) will need to assure your health, safety and well-being. Additional training and education can be offered to you and your hired helper (personal assistant) to better assist you in directing your own care while ensuring your safety.

Once you complete these self-assessment tools keep them safe until the CAP agency requests them. After the CAP agency receives these forms, they will review the answer to each question to best identify the most appropriate program for you.

The self-assessment tools include:

- Is Consumer-Directed Care Right For Me?
- What Are My Health Care Needs?
- What Areas Do I Need Help?
- Making a Personal Care Task List
- Finding the Right Supports Network
- Hiring a Support Network
**Is Consumer-Directed Care Right For Me?**

Consumer-Directed Care offers freedom and independent. This program may not be right for everyone. Use the checklist below to help decide if Consumer-Directed Care is right for you.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't know what this means</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want to decide what services and helpers will best meet your needs?</td>
<td></td>
<td></td>
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<tr>
<td>Do you want to take charge of your care needs?</td>
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<tr>
<td>Do you know what your health care needs are?</td>
<td></td>
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<td></td>
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<tr>
<td>Do you know what services are available to meet your needs?</td>
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<tr>
<td>Do you know how to manage a budget to get all the things you need?</td>
<td></td>
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<tr>
<td>Do you know what skill needs your care require?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't know what this means</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>• Do you know how to select health care items?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't know what this means</td>
</tr>
<tr>
<td>• Do you know how to organize a schedule to help met your daily needs?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't know what this means</td>
</tr>
<tr>
<td>• Do you know what supplies you will need to help manage your medical diagnosis?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't know what this means</td>
</tr>
<tr>
<td>• Do you know who to call or how to get personal care and medically needy items?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't know what this means</td>
</tr>
<tr>
<td>Do you want to be an employer?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't know what this means</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Don't know what this means</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>---------------------------</td>
</tr>
<tr>
<td>• Are you ready, as an employer, to decide what is working and what is not?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>• Do you prefer friends, family, or neighbors to help you with your needs?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>• Are you able to list and describe your health care needs?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>• Are you able to write a job description?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>• Do you want to hire, train, and manage your own care providers?</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>• Will you tell your workers what you like and don’t like about the services they provide?</td>
<td>☐</td>
<td>☐</td>
<td></td>
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<tr>
<td>• Will you cooperate with the IRS tax</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>system?</td>
<td>Don't know what this means</td>
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<tr>
<td>• Are you able to communicate your needs and speak up for yourself?</td>
<td>□ Yes</td>
<td>□ No</td>
<td>□ Don't know what this means</td>
</tr>
</tbody>
</table>

If you find yourself answering “Yes” to most questions, you are probably right for Consumer-Directed care. If you find your answers to be a mix of “Yes” and “No”, a Care Advisor can help you in areas on how to find, select and train workers. A Care Advisor can also give you more information, make suggestions, and answer other questions. If you find your answers to be “Don’t know what this means”, the consumer-directed option may not be right for you.
What are your health care needs?

What is most important to you in meeting your health care needs?

List the things (supports and services) you need to maintain your quality of life and health and safety:

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________
5. __________________________________________

How would the listed items meet your health care needs?

1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________
5. __________________________________________
Do you have a support network (family, friends, or neighbors) who provide help to you?

☐ Yes  ☐ No

If yes, list these people:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If no, how would you build a support network (family, friends, or neighbors) to provide help to you?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
## What areas do I need help in?

<table>
<thead>
<tr>
<th>Area</th>
<th>I need a lot of help</th>
<th>I need some help</th>
<th>I need a review only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the importance of the IRS tax system</td>
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<tr>
<td>Finding dependable people and agency to provide care</td>
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<tr>
<td>Completing a job description and duty list for employees</td>
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<tr>
<td>Finding workers to provide personal care and home maintenance</td>
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<tr>
<td>Advertising for an employee</td>
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<tr>
<td>Screening applications and interviewing potential workers</td>
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<tr>
<td>Understanding the results of criminal background checks</td>
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<tr>
<td>Setting rules for employment (completing employer/employee agreement)</td>
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<tr>
<td>Deciding how much to pay workers</td>
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<tr>
<td>Training your workers</td>
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<tr>
<td>Reviewing employee's work tasks and timesheets to approve payment of wages</td>
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<tr>
<td>Assessing the quality of service provided by your workers</td>
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<tr>
<td>Communicating information about the quality of service provided (positive and negative)</td>
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<tr>
<td>Firing workers with poor job performance</td>
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<td></td>
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<tr>
<td>Planning for back-up or emergency care</td>
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<td></td>
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</tr>
</tbody>
</table>
What areas do I need help in (page 2)?

<table>
<thead>
<tr>
<th>Area</th>
<th>I need a lot of help</th>
<th>I need some help</th>
<th>I need a review only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting the best cost for needed services/help</td>
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<tr>
<td>Understanding warranties, service agreements, and return policies for purchases</td>
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<tr>
<td>Reading and comparing monthly financial reports</td>
<td></td>
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<tr>
<td>Working independently</td>
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<tr>
<td>Understanding my health insurance</td>
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<td></td>
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</tr>
<tr>
<td>Identifying your care needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing a care plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tracking what you spend each month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing what services/resources are available in your community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding Long Term Care services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing emergency contact numbers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asking others for help when you need it</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing what my diagnoses are</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing how to select is the best person to attend to my medical needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowing what my medications are</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understanding the need to work with a case manager</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Steps to Understanding what my Responses Indicate

Step 1: When you meet your Care Advisor talk about the areas you need help understanding. Your Care Advisor with provide you with training and guidance.

Step 2: After your first training session, go back through the list. Have any items moved from column 1 to 2 or from 2 to 3? If items have moved, you’re making progress. Refocus on any item still rated “I need a lot of help”, and discuss these with your Care Advisor to seek additional training and guidance.

Step 3: Rate yourself again after additional training. If you are understanding Consumer-Directed Care better most of your answers will be in columns 2 or 3.

Step 4: Repeat Step 3 till you are satisfied. Give yourself between three and six months to get all your answers into column 3.

If after several sessions of training you are still putting a lot of checkmarks in column 1, Consumer-Directed Care may not be appropriate for you. Talk with your Care Advisor about the most suitable program to meet your health care needs.

Making a Personal Care Task List

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For each of the following categories, write a brief description of the tasks you want your Personal Assistant(s) to perform:

**Basic Activities of Daily Living**

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Description of Help Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting around inside &amp; outside of the home&lt;br&gt;How much help?: independent, limited, extensive, dependent</td>
<td></td>
</tr>
<tr>
<td>Bathing/Assistance in the bathroom&lt;br&gt;How much help?: independent, limited, extensive, dependent</td>
<td></td>
</tr>
<tr>
<td>Dressing&lt;br&gt;How much help?: independent, limited, extensive, dependent</td>
<td></td>
</tr>
<tr>
<td>Mobility&lt;br&gt;How much help?: independent, limited, extensive, dependent</td>
<td></td>
</tr>
<tr>
<td>Eating (reminders, cutting food, holding utensils, etc.)&lt;br&gt;How much help?: independent, limited, extensive, dependent</td>
<td></td>
</tr>
<tr>
<td>Personal hygiene&lt;br&gt;(combing/washing hair, brushing teeth, shaving, etc.)&lt;br&gt;How much help?: independent, limited, extensive, dependent</td>
<td></td>
</tr>
<tr>
<td>Toilet use (reminders, assistance with BSC, incontinence supplies)&lt;br&gt;How much help?: independent, limited, extensive, dependent</td>
<td></td>
</tr>
<tr>
<td>Transfers (getting out of bed into a chair, getting up from the chair, etc.)&lt;br&gt;How much help?: independent,</td>
<td></td>
</tr>
</tbody>
</table>
Home Maintenance and Personal Needs

<table>
<thead>
<tr>
<th>Tasks</th>
<th>Description of Help Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Housekeeping</strong></td>
<td></td>
</tr>
<tr>
<td>Self-performance ability?: independent, minor help, moderate help, dependent</td>
<td></td>
</tr>
<tr>
<td><strong>Laundry</strong></td>
<td></td>
</tr>
<tr>
<td>Self-performance ability?: independent, minor help, moderate help, dependent</td>
<td></td>
</tr>
<tr>
<td><strong>Meal Preparation</strong></td>
<td></td>
</tr>
<tr>
<td>Self-performance ability?: independent, minor help, moderate help, dependent</td>
<td></td>
</tr>
<tr>
<td><strong>Correspondence/mail, Money Management</strong></td>
<td></td>
</tr>
<tr>
<td>Self-performance ability?: independent, minor help, moderate help, dependent</td>
<td></td>
</tr>
<tr>
<td><strong>Shopping</strong></td>
<td></td>
</tr>
<tr>
<td>Self-performance ability?: independent, minor help, moderate help, dependent</td>
<td></td>
</tr>
<tr>
<td><strong>Transportation</strong></td>
<td></td>
</tr>
<tr>
<td>How frequently is transportation needed?</td>
<td></td>
</tr>
<tr>
<td><strong>Community Involvement (exercise program, social events, etc.)</strong></td>
<td></td>
</tr>
<tr>
<td>How frequently?</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
</tbody>
</table>
What time of day do you need these services?

<table>
<thead>
<tr>
<th>Day</th>
<th>a.m.</th>
<th>p.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
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<tr>
<td>Wednesday</td>
<td></td>
<td></td>
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<tr>
<td>Thursday</td>
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<tr>
<td>Friday</td>
<td></td>
<td></td>
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<tr>
<td>Saturday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Finding the Right Support Network

How important are the following things when choosing a support network to provide your services? For each question, check the response that most nearly describes the importance of that item.

<table>
<thead>
<tr>
<th>Meeting my needs</th>
<th>Very Important</th>
<th>Somewhat Important</th>
<th>Not Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>The worker can provide services on a schedule (time of day/day of week/length of time) which is convenient to me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The worker arrives on time/stays the entire time scheduled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The worker is someone I know well or has been referred by someone I know well</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The worker accepts employment at a reasonable cost</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>The worker is already well qualified to do work (little training needed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The worker follows my instructions and performs work to my satisfaction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The worker is flexible about what services he/she provides</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I prefer an agency to provide services to me in a timely and appropriate manner</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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I believe agencies have reasonable and cost-effective products to meet my needs

Knowing what care, supplies, or equipment I need and how often I need this care

Knowing and understanding the cost of the care, supplies, and equipment I need
Hiring a Support Network

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

_____ Friend
_____ Family member
_____ Someone from a religious group
_____ Someone from the local Center for Independent Living
_____ An elder or someone from local adult service agency
_____ Put an ad in a newspaper
_____ Someone from a technical school
_____ Someone from a Home Health Agency
_____ Don’t know

How will you decide how much to pay your support network?

_____ Ask my current worker their wage and pay them the same
_____ Pay more than my current worker’s wage
_____ Pay what the worker I want to hire is asking
_____ Pay minimum wage
_____ Check advertisements to see what others are paying for the same service
_____ Ask my Care Advisor or Financial Manager for information about the average pay rate for the service
_____ Don’t know
### Competency/Skill Evaluation

<table>
<thead>
<tr>
<th>Waiver Beneficiary Name:</th>
<th>Direct Hired Staff can verbally explain and describe the importance of the following items:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Direct Hired Staff is able to demonstrate or show proof of competency in the areas listed below:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Competency Skill</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Equipment Check</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen</td>
<td></td>
<td></td>
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<tr>
<td>Ambu Bag</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flashlight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact List</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Items checked are the Skill needs identified in the Assessment

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
<th>NO</th>
<th>Not Identified in the Assessed Needs</th>
</tr>
</thead>
</table>

Ex: CPR certification
What are other certification or how to demonstrate?
Written documentation of CPR certification
Copy of Nursing License
<table>
<thead>
<tr>
<th>Nursing Assessment:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Vital signs</td>
<td></td>
</tr>
<tr>
<td>Pain assessment</td>
<td></td>
</tr>
<tr>
<td>Therapy reinforcements</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nutrition/Hydration</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake/Output monitoring</td>
<td></td>
</tr>
<tr>
<td>G Tube /J Tube</td>
<td></td>
</tr>
<tr>
<td>NG Tube</td>
<td></td>
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<tr>
<td>Mic-Key Button</td>
<td></td>
</tr>
<tr>
<td>IV fluids/site check</td>
<td></td>
</tr>
<tr>
<td>Central Lines/dressing change</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral</td>
<td></td>
</tr>
<tr>
<td>Rectal</td>
<td></td>
</tr>
<tr>
<td>G Tube</td>
<td></td>
</tr>
<tr>
<td>IM/IV</td>
<td></td>
</tr>
<tr>
<td>Nebulizer treatments</td>
<td></td>
</tr>
<tr>
<td>Diabetic/insulin monitoring</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular Evaluation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac monitoring</td>
<td></td>
</tr>
<tr>
<td>Apical/Peripheral/Radial Pulse</td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td></td>
</tr>
<tr>
<td>Capillary refill</td>
<td></td>
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<tr>
<td>Edema</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurological</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Orientation</td>
<td></td>
</tr>
<tr>
<td>Neuro checks</td>
<td></td>
</tr>
<tr>
<td>Seizure precautions</td>
<td></td>
</tr>
<tr>
<td>VNS swipe</td>
<td></td>
</tr>
<tr>
<td>Emergency back-up plan</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suction/oral</td>
<td></td>
</tr>
<tr>
<td>Lung sounds</td>
<td></td>
</tr>
<tr>
<td>Pulse oximeter</td>
<td></td>
</tr>
<tr>
<td>Chest PT</td>
<td></td>
</tr>
<tr>
<td>Oxygen administration/titratiion</td>
<td></td>
</tr>
<tr>
<td>Bipap/Cpap</td>
<td></td>
</tr>
<tr>
<td>Apnea Monitor</td>
<td></td>
</tr>
<tr>
<td>Respiratory Pacer</td>
<td></td>
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<tr>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Tracheostomy Care</strong></td>
<td></td>
</tr>
<tr>
<td>Cleaning of inner cannula</td>
<td></td>
</tr>
<tr>
<td>Cuffed/uncuffed</td>
<td></td>
</tr>
<tr>
<td>Trach ties/ trach changes</td>
<td></td>
</tr>
<tr>
<td>Stoma care</td>
<td></td>
</tr>
<tr>
<td>Tracheal suctioning</td>
<td></td>
</tr>
<tr>
<td>Changing suction catheters</td>
<td></td>
</tr>
<tr>
<td>Passy-Muir Valve (if applicable)</td>
<td></td>
</tr>
<tr>
<td>Heat moisture exchange</td>
<td></td>
</tr>
<tr>
<td>Supplemental oxygen</td>
<td></td>
</tr>
<tr>
<td>Emergency care/mucus plug</td>
<td></td>
</tr>
<tr>
<td>Emergency go bag</td>
<td></td>
</tr>
<tr>
<td><strong>Ventilators</strong></td>
<td></td>
</tr>
<tr>
<td>Circuit changes</td>
<td></td>
</tr>
<tr>
<td>PEEP</td>
<td></td>
</tr>
<tr>
<td>Cleaning filters</td>
<td></td>
</tr>
<tr>
<td>Power source</td>
<td></td>
</tr>
<tr>
<td>Oxygen source</td>
<td></td>
</tr>
<tr>
<td>Alarms/settings</td>
<td></td>
</tr>
<tr>
<td>Humidity</td>
<td></td>
</tr>
<tr>
<td>Emergency back-up plan</td>
<td></td>
</tr>
<tr>
<td>Emergency Go Bag</td>
<td></td>
</tr>
<tr>
<td><strong>Catheter care</strong></td>
<td></td>
</tr>
<tr>
<td>Male indwelling</td>
<td></td>
</tr>
<tr>
<td>Condom Catheter</td>
<td></td>
</tr>
<tr>
<td>Female indwelling</td>
<td></td>
</tr>
<tr>
<td>In/Out catheter care</td>
<td></td>
</tr>
<tr>
<td>Emptying leg bag</td>
<td></td>
</tr>
<tr>
<td><strong>Skin care/wound care</strong></td>
<td></td>
</tr>
<tr>
<td>Proper Hand washing</td>
<td></td>
</tr>
<tr>
<td>Dressing change</td>
<td></td>
</tr>
<tr>
<td>Sterile technique</td>
<td></td>
</tr>
<tr>
<td>Non-sterile technique</td>
<td></td>
</tr>
</tbody>
</table>
**ADL care needs**
- Bathing
- Grooming
- Transfer/Ambulation
- Positioning
- Toileting
- Feeding/eating/meal prep
- Bed making
- Fall prevention/management
- Good body mechanics/safety

**Documentation**
- Provides daily notes and flow charts
- Time Sheets
- Control substance documentation and count

### Total Responses

Based on the responses of this Competency/Skill Evaluation, my directly hired staff:

- [ ] Has the competencies and skills to meet my assessed needs
- [ ] Has some skills to meet my assessed needs, but will need additional training to include:
  - 
  - 
  - 
- [ ] Does not have the skills to meet my assess needs

__________________________  __________
Signature  Date

Reviewed by:

__________________________  __________
Name of Care Advisor  Date

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Appendix D: Individual Risk Agreement

INDIVIDUAL RISK AGREEMENT

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

<table>
<thead>
<tr>
<th>Name – CAP Waiver Beneficiary</th>
<th>Name – CAP Case Management Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Name(s) – Individuals involved in risk identification and reduction discussion</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>SIGNATURE – CAP Beneficiary / Legal Responsible Representative</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SIGNATURE – Case Management Entity</th>
<th>Date Signed</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

DMA-3073
Appendix E: Beneficiary Rights and Responsibilities

Beneficiary Rights and Responsibilities

By signing the form, I, as the waiver beneficiary or the responsible party (parent, legally responsible party, or designated caregiver) for [name of waiver beneficiary], MID# [insert MID #] acknowledge my understanding of the Community Alternatives Program (CAP) and my rights and responsibilities as a waiver participant.

I understand:

a. The CAP Waiver is an alternative option to institutionalization. I must meet a nursing facility LOC initially and annually to participate in this program.

b. I agree to select this program as an option to institutionalization.

c. The CAP Waiver waives some Medicaid requirements to allow in-home care services (institutional-like services) to be provided and received in my home and community.

d. This CAP Waiver supplements rather than replaces the formal and informal services already available to me and my family.

e. The CAP Waiver has two service options, direct-lead (in-home aide and home health providers), and consumer-lead (consumer-directed), from which to receive my services. To qualify for and maintain qualification for consumer-directed care, I or my designated representative must have mental capacity and be willing to direct my care as evidence by a self-assessment tool. Quarterly reviews of performance are conducted by the care advisor and financial manager to ensure ongoing competencies.

f. The CAP Waiver provides an array of services, known as waiver services, to meet my assessed needs to keep me integrated in the community.

g. The CAP Waiver allows me the right to select any of the available waiver services to meet my assessed needs and any provider to provide those services.

h. The waiver services I select to meet my needs will be listed on a service plan in the correct amount, frequency, and duration that are consistent with my assessed needs. The service plan will be assessed quarterly and can be revised at any time based on my changing needs.

i. If I have a concern, complaint or grievance, I can notify my case management entity, state staff or my provider agency to assist with my concerns. I also understand that a grievance or complaint does not result in a fair hearing.

j. If a waiver service I request is denied, reduced, terminated or suspended, I will be notified in writing and be given instructions on how to appeal the denial.

k. The CAP Waiver requires work verification documentation and a listing of household members to assist in planning for my care needs. Work time and family support must be reported accurately to prevent a program integrity review.

l. If I have a Medicaid spend down, deductible or premium, I must incur the established medical expenses before my CAP Medicaid is made available. I must also pay my identified providers the cost of these incurred medical expenses to prevent a gap in my care provision.

m. The CAP Waiver allows my waiver services to be provided by individuals and agencies of my choosing. However, waiver beneficiaries between the ages of 0-17, the following identified
parties cannot directly provide waiver services and receive payment through payroll: a parent, stepparent, parent’s spouse or significant other (live-in or not), foster parent, custodial parent or adoptive parent, sibling under the age of 18, anyone acting as “loco parentis.” The following identified parties cannot directly provide waivers services for waiver beneficiaries 0-18 years of age or older and receive payment through payroll: an appointed guardian appointed Health Power of Attorney or Power of Attorney or executor the estate.

n. The CAP Waiver is required to protect my health, safety, and well-being, at all times, while I participate in the program. I am able to assume some risks in my decisions making. This assumed risk must be outlined in an Individual Risk Agreement or emergency back-up plan. When choices are made that expose me to abusive situation, cause me to be neglected, abused, or exploited, the IRA may be terminated and referral made to Adult or Child Protective Services. An assessment of my continued eligibility to participate in the waiver must be conducted.

o. The CAP Waiver may initiate disenrollment from the waiver when any one of the following occurs:

1. The beneficiary’s Medicaid eligibility is terminated;
2. The beneficiary’s physician does not recommend nursing facility;
3. The SRF is not approved for nursing facility LOC;
4. DSS removes the CAP evidence code;
5. The CAP case management entity has been unable to establish contact with the beneficiary or the primary caregiver(s) for more than 60 calendar-days despite two written and two verbal attempts;
6. The beneficiary fails to use CAP services as listed in the service plan during a 90 consecutive day time period of CAP participation despite case management coordination;
7. The beneficiary’s health, safety, and well-being cannot be mitigate through a risk agreement and other interventions;
8. The beneficiary or primary caregiver will not participate in development of or sign the service plan;
9. The beneficiary or primary caregiver(s) fail to comply with all program requirements, such failure to arrive home at the end of the approved hours of service, or manipulation of the coverage schedule without contacting the case management entity for approval; or
10. The beneficiary demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of CAP as outlined in the “Beneficiary Rights and Responsibilities” form, and signed by the CAP beneficiary.

p. I, or the primary responsible party, shall participate in monthly telephone contact and monthly-to-quarterly face-to-face contact with the assigned case manager for the purpose of monitoring health and well-being and coordinating, along with referrals, linkage, assessing and care planning.

q. I, or the primary responsible party, shall receive an annual letter of appointment to complete my annual continued need review for going participation in the waiver program. Failure to comply or keep the arranged appointment may interrupt the provision of my services or initiate disenrollment from the CAP waiver.

r. The Division of Medical Assistance (DMA) has sole approval authority over the administration of the CAP waiver.
I have read and understand the above information. By signing this document, I willingly accept to participate in the CAP Waiver and agree to abide by the policies and procedures of the CAP Waiver. I also understand my rights and responsibility as a waiver participant.

| Signature: _________________________________ | Date: ________________ |
| Beneficiary or Primary Responsible Party |

| Signature: _________________________________ | Date: ________________ |
| Case Manager |
Appendix F: Glossary of CAP Terms

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

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

Assessment Assignment
Participants who have met the basic eligibility requirement of level of care and has been assigned a waiver slot. The participant is approved for an assessment to identify clinical need for waiver services.

Assurance
The commitment by a state to operate a HCBS waiver program in according with statutory requirements.

At-Risk of Institutionalization
Participants who meet nursing facility level of care (LOC) criteria with assessed acuity of needs ranging from intermediate to CAP nursing level and who do not have available resources to meet immediate needs - medical, psychosocial and functional.
Resources consist of both formal and informal such as willing and able family members.

Beneficiary
An individual receiving Medicaid benefits.

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

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

Care Coordination
Beneficiaries are eligible to receive all Medicaid services according to Medicaid policies and procedures, except when those policies or procedures restrict participation or duplicate another Medicaid or other insurance service. Waiver case management services are defined as services furnished to assist individuals in gaining access to needed medical, social, educational and other services.

CAP beneficiaries may receive all regular Medicaid services according to the Medicaid specific service policies and procedures. The beneficiary’s cost summary must include all CAP services provided in the primary private residence. The case management entity must coordinate the provision of all services and include in the plan of care.

Community Alternative Programs (CAP)
A Medicaid CAP Waiver authorized under § 1915(c) of the Social Security Act and Medicaid funds; to provide home and community based services to Medicaid beneficiaries who require institutional care, but for whom care can be provided cost effectively and safely in the community with CAP services. CAP beneficiaries must meet all Medicaid eligibility requirements. CAP Programs consist of the following:
   a. Community Alternatives Program for Children: CAP/C
   b. Community Alternatives Program for Disabled Adults: CAP/DA
   c. Community Alternatives Program for Disabled Adults choosing to self-direct: CAP/Choice

Community Alternative Program for Children (CAP/C)
A Medicaid HCBS Waiver authorized under § 1915(c) of the Social Security Act serving medically fragile children ages 0-21 years who are at risk of institutionalization.

Community Integration
The setting (living arrangement, place of services and types of services):
   a. Supports full access to the greater community;
   b. Is selected by the individual from among settings options;
   c. Ensures individual rights and privacy, dignity and respect, and freedom from coercion and restraints;
   d. Optimizes autonomy and independence in making life choices; and
   e. Facilitates choice regarding services and who provides them.
Consumer-Directed Care
An alternative option offered under the CAP Waiver. Consumer-directed is self-directed care option for CAP beneficiaries and his or her caregivers who wish to remain at his or her primary private residence and have increased control over his or her own services and supports. It offers beneficiaries the choice, flexibility and control over the types of services they receive, when and where the services are provided, and by whom the services are delivered.

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

- **Disenrollment**
The voluntary or involuntary dismissal from participation in CAP.

- **Division of Medical Assistance (DMA)**
The N.C. DMA is designated as the administrative authority over the Waiver. DMA manages the CAP Waiver. DMA develops policies and procedures based on federal guidelines for operating the program and is required to oversee the management and operation by the local lead agencies and other appointed entities. DMA is also required to provide training and technical assistance to lead entities.

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

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

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

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

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

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

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

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

**Freedom of Choice**
The right afforded to a beneficiary to choose to participate in the CAP Waiver and to select any and all CAP services to meet his or her needs.

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

**Home and Community Based Services**
Services, not otherwise furnished under the State's Medicaid plan, that are furnished under a waiver granted under the provisions of part 441, subpart G of this chapter.

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

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

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

**Individual Risk Agreement**
An agreement that outlines the risks and benefits to the beneficiary of a particular course of action that might involve risk to the beneficiary, the conditions under which the beneficiary assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement allows a beneficiary or responsible party to assume responsibility for his or her personal choices, through surrogate decision makers, or through planning team consensus.

**Informal Support System**
An informal support system, is defined as one or more of the following:

a. The beneficiary’s parent, stepparent, grandparent, foster parent, custodial parent, adoptive parent, sibling or other relative;

b. The spouse of an adult (18 years of age or older) beneficiary; or

c. Friends, neighbors, church member or anyone providing emotional physical or financial support.
Institutional Care
Refers to specific benefits authorized in the Social Security Act. These are hospital and the long-term care services. Institutions assume total care of the individuals who are admitted. Institutions must be licensed and certified by the state, according to federal standards. 42 CFR 440.40.

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

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

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

Money Follows the Person (MFP)
A state demonstration project that assists people who live in inpatient facilities to move into his or her own communities with supports. MFP has four objective components:
   a. Increase the use of home and community based services (HCBS) and reduce the use of institutionally based services;
   b. Eliminate barriers and mechanisms in state law, state Medicaid plans, or state budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of his or her choice;
   c. strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and,
   d. ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.

NC Tracks
A web-based service for North Carolina’s health care providers and consumers as part of the multi-payer system for NC Department of Health and Human Services, that allows provider enrollment in the Medicaid program and claim submittal to Medicaid program.
Non-Institutional Respite Services
Non-institutional respite care is the provision of temporary support to the primary unpaid caregiver(s) of the CAP beneficiary by taking over the tasks of primary caregiver for a limited period of time.

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

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

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

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

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

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

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

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

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

Quarterly
Three calendar months.

Responsible Party
A person who may act on behalf of the CAP beneficiary; a responsible party may be: a legal representative who is legally authorized to execute a contract for the beneficiary (examples: Power of Attorney, Health Power of Attorney, legal guardian, financial planner) or an individual (family member or friend) selected by the beneficiary to speak for and act on his or her behalf. For ages 0-21 the responsible party is considered to be the beneficiary’s parent, stepparent, foster parent, custodial parent, or adoptive parent. Anyone who has legal responsibility for the minor beneficiary.

Service Request Form
An individual being considered for the CAP Waiver must require the level of care provided by a nursing facility. A service request form replaces the FL-2 form and must be completed to determine the basic eligibility criteria for level of care and CAP participation. This form has a scoring logic that is comparable to the FL-2 that identifies nursing level.

Significant Change in Acuity
For purposes of requiring a different level of care determination, a significant change or decline in condition is defined as one of the following:
1. start or discontinuation of a tracheostomy tube;
2. start or discontinuation of tube feedings;
3. increase or decrease in seizure activity such that a revision to the service plan is needed;
4. increase or decrease in need for ADL assistance such that a revision to the service plan is needed;
5. a new medical diagnosis that requires more skilled care or monitoring.

Staff to Participant Ratio
A sufficient number or responsible persons to safely meet the needs of participants, including full or part-time direct service staff member. When identifying the appropriate staff to participant ratio, consideration of participants with greater needs must be emphasized.
Appendix G: Emergency Back-Up Plan
(DMA Form No. 3072)

My Emergency Back-Up Plan

In the event my Personal Care provider is not available to provide my care as listed in my service plan, I will arrange for ___________________________ to assist with my care. ___________________________ will understand my care needs as to immediately provide the personal care I need.

Contact information is:

Address: ______________________________

Phone: ________________________________

24/hour Contact Availability _____ □ Yes _____ □ No

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

The address of this house is: __________________________________________

Major cross streets near this address are: ________________________________

The phone number is: ________________________________________________

My Physician is __________________________

My Primary Caregiver is __________________________

My Emergency Contact is __________________________

My medications are kept: _____________________________________________

Important phone numbers:

Pharmacy: __________________________________________________________

Poison Control: ______________________________________________________

Primary Caregiver: __________________________________________________

Family at home: _____________________________________________________
Family at work: ____________________________________________________________

Neighbor: ________________________________________________________________

Care Advisor: ___________________________________________________________

**My Plan**

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

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

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
NC Division of Medical Assistance
Community Alternatives Program
For Disabled Adults (CAP/DA)

Medicaid and Health Choice
Clinical Coverage Policy No: 3K-2
Amended Date: January 1, 2017