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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:
Since 1982 The Community Alternatives Program for Disabled Adults (CAP/DA) has successfully served thousands of North Carolina's citizens who live with disabilities.
The following interventions will be accomplished during the life of the 2013 CAP/DA Renewal Waiver and are intended to provide more flexibility for the individuals it supports. These interventions will also provide clear indication of acuity for those participating in the waiver:
1) There are two options under the CAP/DA waiver, the traditional program referred to as CAP/DA and consumer-directed option referred to as CAP/Choice. Under consumer-directed care option, beneficiaries are eligible to direct their own care. Individuals selecting this option must show capability to self-direct or delegate this responsibility to a representative of their choice.
2) For consistency among other waivers managed by the state Medicaid agency, four waiver services will be renamed. The name changes will include: Home Modification and Mobility Aids renamed Home Accessibility and Adaptation; Waiver Supplies, renamed specialized medical equipment and supplies; Transition Services, renamed Community Transition Services and Training and Education Services renamed Training, Education and Consultative Services. The current service definitions identified in the clinical coverage policy and within the 2008 waiver application will not change nor exclude beneficiaries from receiving any one of these services. In addition to name changes, two other waiver services were modified since the approved 2008 waiver. Case management has a maximum per beneficiary limitation per calendar year of 42 hours/168 units from January 1st-December 31st. The definition of case management expanded to include four core functions: assessing, care planning, referral and linkage and monitoring and follow-up. Assistive Technology definition expanded to allow CAP/DA lead agencies the authority to authorize this service, file claims to Medicaid to reimburse authorized vendors of this service.
3) The renewal waiver will continue to have case management as a waiver service to assist the case managers in assessing, reassessing and planning the medical and function needs of waiver participants. Eligible waiver participants must require two waiver services which exclude incontinence supplies, Personal Emergency Response Services and Delivery and preparation of meals. This change allows the identification of direct hands-on personal care that is consistent with institutional care. Incontinence supplies, PERS and delivery and preparation of meals are services that are provided through other community resources regardless of waiver participation. Eligible beneficiaries participating in the waiver would not be impacted at the onset of the approved waiver. At the annual recertification, each eligible beneficiary will be reassessed to determine institutional level of care need and those who only require assistance with incontinence supplies, PERS and delivery and preparation of meals will be referred to appropriate community resources through a coordinate transition process. Each beneficiary who falls into this category during the annual recertification will be granted an opportunity to appeal the adverse decision.
4) All CAP/DA beneficiaries must develop an emergency back-up plan to include disaster planning. The requirement assures health and welfare of the beneficiary as well as continuity of care when previously arranged formal supports are not available.

5) The Division of Medical Assistance (DMA) has elected to implement a unified approach to meet its responsibilities as a waiver administrative authority. This approach will introduce a three-way waiver partnership: DMA (Administrative Authority-Operating waiver agency); Contracted Waiver Entity (day-to-day oversight of the waiver) and Lead Agency (case management providers of waiver services). This three-way execution of the waiver provides efficient and consistent administrative management of waiver programs offered by DMA. The Contracted Waiver Entity (CWE) will provide the day-to-day oversight functions of the waiver and also provide for the continuous quality improvement. The Contracted Waiver entity oversees program operations and assures all policies and procedures are followed; processes referrals; ensures beneficiary freedom of choice; ensures quality services; and cooperates with monitoring and reporting activities.
6) Individuals who qualify under Medicaid categories of MAA, MAD and MAB and need a level of care consistent with institutional LOC are eligible for a level of care determination and an assessment to identify their imminent risk of institutionalization. Each individual who is screened through a referral and screening process is most likely considered at risk of institutionalization. Therefore, individuals applying for participation in the waiver are considered on a first-come-first-serve basis. To plan continuity of care, individuals who want to be deinstitutionalized and individuals in need of immediate protection from abuse, neglect or exploitation are placed in a priority category and are expedited for immediate consideration for waiver participation. If there is an existing waitlist in the county of residence, these individuals are prioritized to the top of the waitlist. An additional subset of individuals are prioritized for immediate waiver participation, refer to Appendix B-3(f).
7) In the 2008 waiver, waiver participants were assessed under two Levels of Care (intermediate and skilled). The renewal waiver will assess each applicant under one LOC, nursing facility as defined by NC State Plan. This transition allows consistency with State Plan institutional LOC. An updated LOC Instrument that is comparable to the FL-2 will be utilized. The LOC instrument is named the Service Request Form. The new LOC tool is a combination of the FL-2 the state uses for NF and HCBS programs and the PASARR that is used only for nursing facilities. The new LOC tool is comparable to the institutional LOC tool and will meet the level of care for individuals in a NF and HCBS programs. The new LOC tool will be more robust and more versatile than the current FL-2 level of care instrument. It is designed to support more consistent review for level of care/eligibility determination and also incorporate essential PASARR functionality through expanded questions related to diagnoses, behavior, mood and interpersonal functionality. The Service Request Form will establish the basic LOC eligibility. A needs assessment will be utilized to identify LOC acuity (low, intermediate or skilled). A scoring logic will be applied in the assessment to identify the acuity level (skilled, intermediated or low) of each beneficiary. Assessment components include: Personal health information; Caregiver information; Medical diagnoses; Medication and precautions; Skin; Neurological; Sensory and communication; Pain; Musculoskeletal; Cardio-Respiratory; Nutritional; Elimination; Mental Health; Informal support; Housing and finances. This new process will promote a comprehensive interdisciplinary team planning approach that identifies a holistic view of functional, medical and social needs. This process will yield a comprehensive person-centered assessment and service plan of ongoing community needs.

8) A specialized definition for HCBS LOC will be utilized when assessing and screening a referral for participation in the waiver. This specialized definition provides for intervention, safeguarding or stabilization of waiver beneficiaries to promote continuous community living which will reduce or prevent institutionalization or re-institutionalization. The definition includes:
A disability of medical and physical abnormalities includes a primary medical diagnosis (es) that is 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.
Comparability to State Plan nursing facility:
The HCBS LOC is comparable to the 2B-1, Nursing Facility Clinical Coverage Policy LOC criteria with the following exclusions:
• Registered nurse not required for a minimum of 8 hours daily.
• Medical intervention does not require the degree of medical consultation, observation and support services available by licensed nurse.
• Includes assessing, planning, observing and management of a recorded treatment plan according to that which is established and approved by a physician, practitioner or clinician, and rendering direct services to the beneficiary.
9) The case management qualification will change to include: 4 year Bachelor Social Work Degree with one (1) year of direct experience in long-term care or home and community services; or a 4 year Bachelor Human Services Degree with two (2) years of direct experience in long-term care or home and community services; or registered nurse who holds a current NC license with one (1) year of case management experience in long-term care or home and community services. Must complete a DMA certified training program within 90-days of employment. Adding these qualifications will identify competencies necessary to meet the needs of physically disabled and aging beneficiaries.
10) A Risk Assessment and Mitigation Tool will be utilized through this waiver. An Individual Risk Agreement Form was developed to allow responsibility for the agreed upon course of action and the accountability for choice when an individual

selects to assume risk in his or her choices. The tool sets a framework of person-centered planning while promoting flexibility and responsibility for continuity of care needs.

11) A critical incident report (CIR) reporting system has been developed to track, trend and mitigate occurrences of: deaths; thefts; injuries; abuse, neglect or exploitation; admissions to a facility; health, safety and well-being; medication errors; unplanned hospitalizations; missing person; restraints or seclusions; and other. These critical incidences are categorized as a Level I or a Level II event.
12) The Quality Framework Management System (QIS) will be provided through e-CAP (web-based case management and business process tool). The e-CAP system is a business and case management system that provides case managers, beneficiaries and providers the means by which continuous quality improvement strategies are organized, tracked and made more effective. The system also provides access to beneficiary eligibility, assessed needs, care planning, monitoring, due process and critical incidences.
13) Qualified Case Management Agencies- Service providers in addition to the four entities currently acting as CAP/DA Lead Agencies with three (3)direct years of case management experience in home and community-based services consistent with HCBS waiver programming are eligible to be case management providers for this waiver upon DMA's approval and successful enrollment as a Medicaid provider. The four entities (DSSs, health departments, aging agencies, and hospitals) as identified in the 2008 waiver will continue to be eligible to provide case management; however, not appointed by the local county commissioners. DMA will appoint CAP/DA lead agencies.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):
2008 CAP/DA Renewal (3.5)

C. Type of Request:renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NC.0132
Waiver Number:NC.0132.R06.00
Draft ID: NC.15.06.00

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

E. Proposed Effective Date: *(mm/dd/yy)*
10/01/13
Approved Effective Date: 10/01/13

1. Request Information (2 of 3)

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

☐ **Hospital**

Select applicable level of care

○ **Hospital as defined in 42 CFR §440.10**
If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

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

☑ **Nursing Facility**

Select applicable level of care

◉ **Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155**

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

- ○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140**
- ☐ **Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150)**

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

1. Request Information (3 of 3)

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

- ◉ **Not applicable**
- ○ **Applicable**

Check the applicable authority or authorities:

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

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

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

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

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

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

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

Specify the program:

H. Dual Eligiblity for Medicaid and Medicare.
Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.
In an effort to offer community-based care as an alternative to individuals whose needs were typically met in a nursing facility, North Carolina's General Assembly instructed the State's government to apply for and develop an HCBS Waiver in House Bill 405. In 1982, the Health Care Financing Administration (HCFA), presently CMS, granted approval of the

Community Alternatives Program for Disabled Adults (CAP/DA) waiver.
The CAP/DA waiver has two options for an individual to select, traditional services or consumer-direction. The traditional services of the CAP/DA waiver allows providers to take the lead role in directing beneficiaries service; whereas, consumer-directed care allows the beneficiary, or their appointed representative, to take lead in the development of the plan of care. This lead role offers the authority and responsibility to manage and make decisions regarding waiver services. The consumer-directed option was introduced in 2005 in four pilot counties under a separate waiver. However, in 2008 the consumer-directed option was incorporated in the renewal of the 2008 CAP/DA waiver. In 2010, consumer-direction was available to all 100 counties in North Carolina.
The waiver comprehensive service package includes: adult day health, personal care services, specialized medical equipment and supplies, home accessibility and adaptation, meal preparation and delivery, personal emergency response system, non-institutional respite, institutional respite, case management, participants goods and services, community transition services, training, education and consultative services and assistive technology. Individuals choosing the consumer-direction option are eligible for the above listed services as well as care advice, financial management, and personal assistant services. In addition, approved beneficiaries are eligible for State Plan services when medical necessity is determined.
Upon the completion of a thorough needs assessment, all waiver services and State Plan services are included in a person-centered Plan of Care (POC), which is based on the identification of a beneficiary's needs. This person-centered POC makes it possible for eligible beneficiaries to be cared for safely in their homes.
CAP/DA serves individuals who are 18 years of age and older and who are:
1. Eligible for Medicaid in one of the benefit categories of Medicaid for the Aged (MAA), Blind (MAB) or Disabled (MAD);
2. Reside in a private residence-beneficiaries may be living in institutions such as nursing facilities at the time of application, screening, and assessment, but must be discharged to a private residence before they can receive in-home services;
3. Require the approved Home and Community Based Services nursing facility LOC as determined by DMA;
4. Meet the required level of care and are at risk of institutionalization within 30 calendar days after the findings of a completed interdisciplinary comprehensive assessment;
5. Choose CAP/DA services instead of institutional care as evidenced by the written statement of the beneficiary or primary caregiver;
6. Require long-term care support at a level typically provided in an institution directly related to a documented medical diagnosis and functional care need as assessed quarterly.
7. Require two waiver services monthly (excluding incontinence supplies, personal emergency response system, and meals preparation and delivery);
8. Able to have his or her health, safety and well-being maintained at home within the CAP/DA budgeting methodology; and
9. Have an emergency back-up plan with adequate formal and informal support to meet the basic needs outlined in the CAP/DA assessment and Plan of Care to maintain their health, safety and well-being.
The individual choosing the consumer-directed option must meet all of the criteria above as well as the following:
1. Understands the rights and responsibilities of directing one's own care;
2. Willing and capable to assume the responsibilities for self-directed care, or selects a representative who is willing and capable to assume the responsibilities to direct the Beneficiary's care; and
3. Complete a self-assessment questionnaire to determine ability to direct care or identify training opportunities to build competencies to aid in self-direction.
The CAP/DA Program is administered in a three-way partnership: administrative authority (DMA), contracted waiver entity (contracted non-governmental entity), and case management agency (contracted non-governmental entity). The administrative and operating authority of the waiver is the State Medicaid Agency (Division of Medical Assistance-DMA). The Contracted Waiver Entity is a non-state entity that will manage the day-to-day oversight functions of the waiver and also provide for the QIS Framework. The Contracted Waiver Entity oversees program operations and assures that all policies and procedures are followed; processes referrals; ensures beneficiary freedom of choice; ensures quality services; and cooperates with monitoring and reporting activities. The case management agency is appointed by DMA to be the local lead agency in a prospective county. The lead agency must assess applicants, provide case management, provide home accessibility and adaptation and specialized medical equipment and supplies, manage caseloads, approve plans of care, disseminate waiver information and authorize waiver services to approved Medicaid providers.
NC DMA is committed to expanding the accessibility of CAP/DA program statewide. DMA engages in collaboration with various system-change projects including the Money Follows the Person Demonstration, The Medicaid Infrastructure Grant/Ticket to Work, the Rebalancing Grant, and the Systems Transformation Grant.

3. Components of the Waiver Request

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

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

B. **Participant Access and Eligibility. Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

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

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

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

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

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

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

4. Waiver(s) Requested

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

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

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

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

- (●) **No**
- ( ) **Yes**

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

☐ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

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

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

procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Improvement. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:
Small work groups and a steering committee were developed to discuss and design the renewal waiver. The work groups and steering committee consisted of internal and external stakeholders. The work groups and steering committee were charged with:
• Consolidating and refining target Populations
• Clarification of Coverage definition
• Streamline Eligibility
• Development of Level of Care criteria for home and community based services waiver participants
• Identification of Staff Qualifications and training requirements
• Identification of Medicaid Providers Qualifications with clear standards of practice
• Identification of a Contracted Waiver Entity for waiver oversight tasks
CAP/DA providers, participants, family, advocates, key DHHS officials, all native American tribal leaders in North Carolina, and professional associations including Adult Day Care and Home Care and Hospice were sent notice of the waiver renewal to solicit input.

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

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

7. Contact Person(s)

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

Last Name:
Bratts-Brown

First Name:
WRenia

Title:
Program Manager

Agency:
North Carolina Division of Medical Assistance

Address:
2501 Mail Service Center

Address 2:

City:

State: Raleigh

Zip: **North Carolina**

Phone: 27699-2501

Fax: (919) 855-4371 **Ext:** ☐ **TTY**

E-mail: (919) 733-2632

wrenia.bratts-brown@dhhs.nc.gov

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

Last Name: Thompson

First Name: Thomas

Title:

Agency: Division of Medical Assistance

Address: 2501 Mail Service Center

Address 2:

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State: **North Carolina**

Zip: 27699-2501

Phone: (919) 855-4115 **Ext:** ☐ **TTY**

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid

agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Teresa Smith

State Medicaid Director or Designee

Submission Date: Sep 26, 2013

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

Last Name: Steckel

First Name: Carol

Title: Director

Agency: Division of Medical Assistance

Address: 2501 Mail Service Center

Address 2: 1985 Umstead Drive

City: Raleigh

State: **North Carolina**

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

A project team and a steering committee were created to secure program strengths, concerns, and recommendations to plan the development of this waiver renewal. The project team in conjunction with the steering committee identified innovative ideas for an integrated home and community-based case management model. The project team and steering committee included representation from agency leadership, stakeholders, and state associations. The CAP/DA Staff advertised the clinical coverage policies for the waiver on the division's webpage. Stakeholder forums were also held to secure public input and feedback concerning program strengths, concerns and recommendations for change. The CAP/DA stakeholders

include: providers, participants, family, advocates, key DHHS officials, all Native American tribal leaders in North Carolina, and professional associations including Adult Day Care and Home Care and Hospice. Community stakeholders are aware of the proposed changes in this waiver and the anticipated implementation.

The timely submittal of this renewal waiver is anticipated to provide continuous waiver participation for eligible beneficiaries and future potential beneficiaries. When the existing waiver expires on 9/30/13, NC DMA plans for the renewal waiver to be approved and executed by 10/01/13 for continuous waiver planning. The waiver service package will not change other than the names of four services. Edits in the Medicaid Management Systems to approve or deny services and service limits are current and up to date. The HCBS waivers managed by DMA will transition to a new QAQI contractor and case management web-based tool. This transition is anticipated to be a smooth and efficient process. There will be an extensive training session to orient providers to the new web-based tool. Another 1915 (c) HCBS waiver managed by the state Medicaid agency has been instrumental in the design and implementation of this web-based tool, and has been using this web-based tool for approximately 9 months. A planned pilot of CAP/DA case managers has performed testing of this web-based system to validate programming for the physically disabled and aged population.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

Appendix A: Waiver Administration and Operation

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

   - (●) **The waiver is operated by the State Medicaid agency.**

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

     - (●) **The Medical Assistance Unit.**

       Specify the unit name:
       Division of Medical Assistance
       (Do not complete item A-2)

     - ( ) **Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit.**

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

       (Complete item A-2-a).

   - ( ) **The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency.**

     Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. **Oversight of Performance.**

a. **Medicaid Director Oversight of Performance When the Waiver is Operated by another Division/Unit within the State Medicaid Agency.** When the waiver is operated by another division/administration within the umbrella agency designated as the Single State Medicaid Agency. Specify (a) the functions performed by that division/administration (i.e., the Developmental Disabilities Administration within the Single State Medicaid Agency), (b) the document utilized to outline the roles and responsibilities related to waiver operation, and (c) the methods that are employed by the designated State Medicaid Director (in some instances, the head of umbrella agency) in the oversight of these activities:
As indicated in section 1 of this appendix, the waiver is not operated by another division/unit within the State Medicaid agency. Thus this section does not need to be completed.

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

Appendix A: Waiver Administration and Operation

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

Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).
Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*
The administrative oversight of the waiver will be executed through a three-way partnership approach: DMA (Administrative Operating Authority); Contracted Waiver Entity (day-to-day oversight of the waiver) and Lead Agency (case management providers of waiver services). This three-way execution of the waiver provides efficient and consistent administrative and operational management. The Contracted Waiver Entity (CWE) will provide the day-to-day oversight functions of the waiver and also provide for the Quality Improvement Strategy (QIS) Framework. The role of the CWE will be defined in the scope of work section of an approved contract. The QIS Framework will comply with regulations that require the state have, at a minimum, systems in place to measure and improve its performance in meeting the six federal waiver assurance set forth in 42 CFR 444.301 and the state assurances set forth in 42 CFR 441.302 [health and welfare, financial accountability, evaluation of need-initial and periodic, alternatives, average per capita expenditures, actual total expenditure, institutional absent waiver, reporting, habilitation services, and day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness cost]. A web-based case management platform, known as e-CAP is provided in the local communities to assist the CAP/DA Lead Agencies in executing their assigned functions.
The CWE Waiver Administration and Operation Functions include:
• LOC approval and analysis per the 1915(c) HCBS Waiver guidelines
• Accurate and timely processing of referrals/screenings
• Maintenance of beneficiary records for compliance
• Person-centered care planning
• Freedom of choice
• Due Process
• Aggregate budget planning and analysis
• QIS and Continuous Quality Improvement Strategies
• Technical assistance and training/educational opportunities
Level of care evaluation: On-line request process for service/LOC determination that is standardized and computerized for CAP/DA Lead Agencies, beneficiaries and other service providers; an on-line module for electronically-generated prior approvals of LOC and waiver participation; an interface to MMIS to transmit prior approvals.
Quality assurance and quality improvement activities: Quality assurance reporting that allows service provider, case management and DMA interface. Reporting model for CQI that allows DMA to analyze quality data and

direct targeted, time-limited quality improvement initiatives statewide in response to identified quality problems or best practices. Randomly selected beneficiaries' case files from the lead agency to ensure compliance with the six federal waiver assurances, state and federal rules and regulations, and agency policy; monitoring the CAP/DA Lead Agencies through various audits and reports including on-site visits and desk reviews. Web-based model for continuing education designed to support DMA implementation of CQI and video conferencing for use in the provision of case management for selected beneficiaries.
Participant waiver enrollment: Ensures basic eligibility criteria are met; approves initial LOC; provides Freedom of Choice information; manage screening and referrals; and track mediations and appeals for Due Process.
Waiver enrollment against approved limits: Management of approved waiver allotment annually; assignment of approved referral to CAP/DA Lead Agency; management of waitlist.
Waiver expenditures managed against approved limits: Assessment of acuity level, placement of prior approval limits on all waiver services; and tracking of mediations and appeals for Due Process.
Review participant service plans: On-line comprehensive assessment; monitors and reviews approved CAP/DA assessments and POCs for all waiver beneficiaries to assure compliance to waiver assurances.
Prior authorization of waiver services: Approval of basic LOC and acuity level; placement of service limits on waiver services.
Utilization management: Assures maximum number of served individuals does not exceed limit; assures cost neutrality is maintained annually; assures monthly budget limits for each waiver participant is maintained.
The CWE must:
• Establish ongoing communication mechanisms with CAP/DA providers to include:
• Posting FAQs to the DMA website (http://www.dhhs.state.nc.us/dma).
• Providing instructional memos to CAP/DA providers when changes occur to the program.
• Provide training and technical assistance to lead agency
• Practice ethical standards:
• Understand the consequences of violating ethical standards;
• Use quality assurance practices and standards;
• Follow Confidentiality regulations;
• Follow performance standards and case management best practices;
• Understand definitions and fundamental concepts of culture and diversity;
• Use critical thinking skills and consultation with other professionals to make ethical decisions;
• Use initiative and creative problem solving to support lead agencies in accessing case management and business processing to conduct their job responsibilities; and
• Form constructive, collaborative relationships with DMA and lead agencies for continuous quality assurance measure
DMA exercises oversight through quarterly QI reports received from CWE and annual audits.
DHHS contracts with Computer Science Corporation (CSC) to provide the Medicaid Management Information System (MMIS) for DMA. CSC will upload in MMIS LOC prior approvals and eligibility information for waiver participants. CSC will also reimburse Medicaid claims for waiver and state plan services.
DHHS will also contract with a financial management agency to provide Financial Intermediary (FI) for waiver participants selecting participant-directed care. This FMS will provide FI services, perform criminal background checks on applicants and file personal care assistant Medicaid claims on behalf of the waiver beneficiary.

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

Appendix A: Waiver Administration and Operation

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

- ○ **Not applicable**
- ◉ **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions. Check each that applies:
  - ☑ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the State and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

Qualified Case Management Agencies (CAP/DA Lead Agencies) described in Major Changes section #15 will provide the day-to-day case management for waiver participants. Their primary responsibilities will include assessing, care planning, referral or linkage and monitoring and follow-up. These local counties agencies will assure the beneficiary's health, safety, and well-being in the community.
A Qualified Case Management Agency shall:
Waiver Administration and Operation Function-Waiver enrollment managed against approved limits: Assures waiver participation does not exceed the approved slot allotment assigned to said CAP/DA Lead Agency.
Waiver Administration and Operation Function-Participant waiver enrollment:Provides assistance in obtaining and verifying level of care and other medical and functional needs.
Waiver Administration and Operation Function-Level of care evaluation: Completes comprehensive assessments to ascertain medical, psychosocial and functional needs for waiver participation.
Waiver Administration and Operation Function-Waiver Expenditures managed against approved levels: Develops and authorizes a person-centered service plans that identifies the amount, duration and frequency of each service and task the responsible party shall render. Locates and coordinates sources of assistance from the family and community, so the burden of care is not exclusively the responsibility of formal health and social agencies.
Waiver Administration and Operation Function- Utilization management: Assures cost neutrality of the each waiver participant is within the approved level of care monthly budget limit.
Waiver Administration and Operation Function-Review of Participant service plan: Reviews all initial/revised service plans to provide written authorization for approval and participation in the program. Provides each beneficiary/primary caregiver freedom of choice among services/providers. Provide monthly monitoring (every 30 calendar days) of the service plan with beneficiary and quarterly (every 90 calendar days) interdisciplinary monitoring with all approved services providers; concerns must be mitigated through an individual risk agreement, referral to Adult Protective Services (APS) or a revision to the service plan. Provides quarterly direct observation of hands-on personal care performed with the beneficiary to include personal care and participation in adult day health to assure beneficiary's needs, services and supplies are adequately met, and to ensure appropriateness and satisfaction. The case manager or care advisor shall observe the home environment for continued health and welfare. Ensures beneficiaries are aware of their right to appeal the case manager's decision to deny, reduce, terminate, or suspend CAP/DA waiver services.
Waiver Administration and Operation Function-prior authorization of waiver services: Provides assistance, when requested, in verifying whether medical documentation supports nursing facility level of care.
Waiver Administration and Operation Function- Quality assurance and quality improvement activities Develops policies and procedures according to DMA standards and uphold to maintain the health, safety, and well-being of the beneficiary. These procedures must be shared with the waiver participants, appropriate providers and organizations. Educates the aging and disabled community about CAP/DA. Determine case mix and caseloads. Uses critical thinking skills and consultation with other professionals to make ethical decisions and conduct ethical case management. Use effective strategies to develop constructive, collaborative relationships with a culturally diverse beneficiary population and other medical other service professionals; communicates clearly, both verbally and in writing; discerns when the severities of family problems are beyond the case manager's scope and when to make appropriate referrals to specialty professionals. Enhances professional qualification through continuing education and enrichment. Conducts an annual visit to perform the continued need review assessment and the plan of care. Home visits are conducted with the goal of ensuring the development of a safe and person-centered treatment plan. Document changes in medical, functional and psychosocial status continue to meet need. Reviews quality assurances reports monthly from e-CAP and address any identified issues. Contacts the beneficiary or responsible party following the construction of or installation of home modifications to confirm that the modifications were constructed to building code and safely meet the beneficiary's needs. Contacts the beneficiary or responsible party within 48-business hours of learned discharge from a hospital or rehabilitation facility to assess the beneficiary's health status and changes in his or her needs

DMA exercises oversight through quarterly QI reports from CWE and annual on-site and desk audits.

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

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

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:
DHHS and DMA are responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions. Monitoring is achieved through an IMOU and performance contract.

Under the three-way partnership for administering the waiver. DMA's monitoring will be achieved through a performance contract outlined with objectives and benchmarks in which the CWE, the appointed CAP/DA Lead Agencies and the FMS must meet monthly. DMA will conduct quarterly oversight of each of these entities to assure the performances measures as outlined in the IMOU and contract are executed as per waiver guidelines. DMA will monitor on a quarterly basis:
participant waiver enrollment
waiver enrollment against approved limits (includes managing a wait list)
waiver expenditures managed against approved limits
level of care evaluation
beneficiary service plans
prior authorization of services
utilization management
quality assurance and quality improvement strategy (QIS Framework)
randomly selected beneficiaries case files from the local lead agency to ensure compliance with the six federal waiver assurances, state and federal rules and regulations, and agency policy

DMA will perform:
continuous quality improvement
criminal background and registry checks

DMA will monitor CWE to assure:
ease of access to the web-based automation tool (e-CAP) by DMA, Lead Agencies, providers and beneficiaries to conduct waiver processes
monthly execution of continuous quality improvement strategies.
ongoing communication mechanisms with providers to include frequently asked questions (FAQs) and dissemination of educational information concerning the waiver

DMA will monitor the FMS quarterly to assure:
criminal background checks were conducted according to the performance measure of the waiver

DMA will assess performance of these entities against the 6 waiver assurances and associated performance measures.
Upon discovery of non-compliance, DMA notifies the CWE, Lead Agency and FMS; requests a corrective action plan to correct the non-compliance and provide technical assistance and/or training on policies and procedures. DMA approves the corrective action plan and follows-up with the Lead Agency, CWE and FMS to ensure the corrective action plan is completed; if warranted by persistent non-compliance, sanctions may be imposed or the removal of the authority to serve as a Lead Agency, CWE or FMS.

DHHS has a fiscal agent, CSC to execute provider enrollment and Medicaid Management Information System. Medicaid Provider Applicants must meet all program requirements and qualifications for which they are seeking enrollment before enrollment as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once participation as a Medicaid provider has been approved, providers are assigned a NPI with an effective date and are notified by mail. Providers may begin submitting claims to Medicaid upon receipt of their NPI. DMA cannot provide special consideration for processing enrollment applications due to provider error, incomplete information, or due to a delay in obtaining credentialing, endorsement or licensure information from another agency. Upon discovery of non-compliance, DMA’s appointed fiscal agent notifies the provider via letter and electronically and returns the provider application noting the areas of non-compliance. Information is provided on how to re-submit the application for reassessment. Failure to comply with

the specified timeline will result in the provider application will be voided.

CSC also processes data systems to ensure all claims are paid in accord with established waiver coverage policy and rates. CSC is monitored according to the contract outlining the responsibilities of the claims processing data systems.

DHHS has benchmark and performance outcomes that are measured monthly to assure seamless and accurate performance of these functions. If the fiscal agent is experiencing poor performance, DHHS will impose sanctions.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:
DMA achieves assessment of performance through quarterly monitoring of CWE, Lead Agencies, FMS and by conducting yearly accountability audits of the CWE, Lead Agencies, FMS and providers using a standardized review instrument.
DMA monitors the utilization review vendors and the vendor contracted to complete rate setting by:

o Developing expectations through the promulgation of performance contracts with the vendors
o Monitoring processes and timelines.
o Reviewing a sample of POC and Medicaid claims quarterly to ensure the appropriate review and authorization of services.

Benchmarks and performance outcomes have been established which the CWE, Lead Agency, FMS must meet monthly, quarterly and annually. Upon discovery of non-compliance, DMA notifies the CWE, Lead Agency and FMS of the non-compliance; requests a corrective action plan to correct the non-compliance and provide technical assistance and/or training on policies and procedures. DMA approves the corrective action plan and follows-up with the Lead Agency to ensure the corrective action plan is completed; if warranted by persistent non-compliance, sanctions may be imposed or the removal of the authority to serve as a Lead Agency.

Appendix A: Waiver Administration and Operation

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

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☑
Waiver enrollment managed against approved limits	☑	☑	☑
Waiver expenditures managed against approved levels	☑	☑	☑
Level of care evaluation	☑	☑	☑
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☑	☑	☑
Utilization management	☑	☑	☑
Qualified provider enrollment	☑	☐	☐
Execution of Medicaid provider agreements	☑	☐	☐
Establishment of a statewide rate methodology	☑	☐	☐

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

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

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
Performance Measure: Number and percent of lead agencies audited that have passing score for compliance with waiver requirements Numerator: Lead Agencies with passing score Denominator: Number of Lead Agencies Audited

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:
State Medicaid Agency and Contracted Waiver Entity

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Delegated Task - Level of Care Evaluation PM: Number and percent of LOC determinations completed by the delegated entity in accordance with waiver requirements Numerator: LOC determinations completed in accordance with waiver requirements Denominator: Total Number of LOC determinations

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Delegated Task: Waiver Enrollment Managed Against Approved Limits PM: Number and percent of lead agencies that maintained allocated slots according to the levels established by DMA Numerator: Lead Agencies that maintained allocated slots according to levels established by DMA Denominator: Total Number of Lead Agencies

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

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

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CWE, e-CAP CSC/NCTracks	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Delegated Task: Waiver Expenditures Managed Against Approved Levels PM: Number and percent of lead agencies that maintain waiver expenditures according to the amounts established by DMA Numerator: Lead Agencies that maintain waiver

expenditures according to the amounts established by DMA Denominator: Total number of Lead Agencies

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Delegated Task: Review of Participant Service Plans PM: Number and percent of waiver participant's POC that was approved by the Lead Agency prior to implementation of services. Numerator: Number of waiver participant's POC that was approved by the Lead Agency prior to implementation of services Denominator: Total number of service plans

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Reports to State Staff of administrative waiver functions

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

Data Aggregation and Analysis:

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

Performance Measure:
Delegated Task: Prior Authorization of Waiver Services PM: Number and percent of service authorizations conducted by the Lead Agency for prior authorization prior to the receipt of waiver services Numerator: Number of service authorizations provided by the Lead Agency to service providers prior to the authorization of waiver services Denominator: Total number of service authorization

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

Specify:

Data Aggregation and Analysis:

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

Performance Measure:
Delegated Task: Utilization Management PM: Number and percent of participants with delivery of services that are managed by the Delegated Entity according to the approved waiver Numerator: Number of participants with delivery of services that are managed by the Delegated Entity according to the approved waiver Denominator: Total number of participants

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Delegated Task: Qualified Provider Enrollment PM: Number and percent of enrolled providers by the Fiscal agent (delegated entity) according to waiver policy Numerator: Number of enrolled providers by the Fiscal agent (delegated entity) according to waiver policy Denominator: Total enrolled providers

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

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

Specify:

Data Aggregation and Analysis:

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

Performance Measure:
Delegated Task: Execution of Medicaid Provider Agreements PM: Number and percent of provider agreements executed by the Fiscal agent (delegated entity) according to state Medicaid qualifications. Numerator: Number of provider agreements executed by the Fiscal agent (delegated entity) according to state Medicaid qualifications Denominator: Total provider agreements

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Delegated Task: Quality Assurance/Quality Improvement Activities PM: Number and percent of reports submitted by the delegated entity using the correct format and according to time frames in the approved waiver Numerator: Number of reports submitted by the delegated entity using the correct format and according to time frames in the approved waiver Denominator: Total number of reports

Data Source (Select one):
Operating agency performance monitoring
If 'Other' is selected, specify:

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

☑ **Other** Specify: CWE, e-CAP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Delegated Task: Monitoring of Fiscal Management PM:Number/percent of consumer-directed personal care assistant waiver services and other services claims paid by the FMS according to the service authorization Numerator:consumer-directed personal care assistant waiver services and other services claims paid by the FMS according to the service authorization Denominator:Total number of claims

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CWE, e-CAP FMS, CSC/NCTracks	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The Service Review Form is designed to determine the basic eligibility of nursing facility level of care. This service review form will identify medical, functional, social behavioral and mental conditions to aid in a comprehensive overview of potential needs. The data gathered through the form will auto-populate the needs assessment to reduce data entry error which provides smart logic methodology. The DMA will provide TA

on clinical policies to CWE and CAP/DA lead agencies, implement corrective action plan, and initiate recoupment of payment when in non-compliance of waiver performance measures. The e-CAP system will track slot allocation and manage assigned slots as per DMA's policy.
The e-CAP system will place service utilization limits on all services authorized by the CAP/DA Lead Agency to prevent over utilization. By placing prior approval limits, a 100% compliance rate of waiver services paid as per POC will be achieved. Submitted claims will not reimburse if the claims exceed the prior approval limits. The prior approval limits will be based on the acuity needs of the beneficiary and captured in the amount, frequency and duration indicated in plan of care. The placement of prior approval limits will also prevent paid claims prior to the effective date of service implementation.

Provider applicants must meet all program requirements and qualification for which they are seeking enrollment, before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider qualifications and requirement checklist. Once participation as a Medicaid provider has been approved, providers are assigned an NPI with an effective date. An approved Medicaid provider is notified by mail. At that time, providers may begin submitting claims to Medicaid upon receipt of their NPI. DMA does not provide special consideration for processing of enrollment applications due to provider error, incomplete information, or delay in obtaining credentialing, endorsement or licensure information from another agency.
CWE will provide a Quality Improvement Strategy Framework that complies with regulations that require the state to have, at a minimum, systems in place to measure and improve its performance in meeting the six federal waiver assurance [Level of Care, Service Plan, Health and Welfare, Qualified Providers, Administrative Authority, Financial Accountability] set forth in 42 CFR 444.301 and the state assurances set forth in 42 CFR 441.302 [health and welfare, financial accountability, evaluation of need-initial and periodic, alternatives, average per capita expenditures, actual total expenditure, institutional absent waiver, reporting, habilitation services, and day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services for individuals with chronic mental illness. The State must, in addition, implement a continuous quality improvement program, Quality Improvement Framework.
The e-CAP system will:
• support program participation, case management services and the provision of service delivery in a manner that is efficient and effective and constantly strives to improve quality
• support level of care determination, prior approval for the entry into waiver and service maximum, and mediation and appeal tracking
• support the QIS Framework and CQIS for the waiver programs (data tracking and trending)
• support a no-wrong door referral/request for services
• support freedom of choice
• support critical incident reporting
• interface with the Medicaid Management system
• maintain cost-neutrality formula
• provide aggregate budget-analysis/planning/recommendations
• Have knowledge Exchange, Discussion forums, on-line education and training
• Conduct participant and provider surveys
• Have participant, caregiver and provider interface
• Perform on-site and desk compliance audit

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Upon discovery of non-compliance, DMA notifies the Lead Agency of the non-compliance; request a corrective action plan to correct the non-compliance and provide technical assistance and/or training on policies and procedures. DMA approves the corrective action plan and follows-up with the Lead Agency to ensure the corrective action plan is completed. If warranted by persistent non-compliance, sanctions may be imposed or the removal of the authority to serve as a Lead Agency.

Upon discovery of non-compliance, DMA notifies the CWE of the non-compliance; request a corrective action plan to correct the non-compliance and provide technical assistance and/or training on policies and procedures. DMA approves the corrective action plan and follows-up with the CWE to ensure the corrective action plan is completed; if warranted by persistent non-compliance, sanctions may be imposed or the removal of the authority to serve as a CWE.

Upon discovery of non-compliance, DMA's appointed fiscal contractor notifies the provider via letter and

electronically and returns the provider application noting the areas of non-compliance with information on how to re-submit an application. Failure to comply with the specified timeline, the provider application will be voided.

Upon discovery of non-compliance, CWE/DMA notifies the FMS of the non-compliance; request a corrective action plan to correct the non-compliance and provide technical assistance and/or training on policies and procedures. CWE/DMA approves the corrective action plan and follows-up with the FMS to ensure the corrective action plan is complete; if warranted by persistent non-compliance, sanctions may be imposed or the termination the contract.

ii. **Remediation Data Aggregation**

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

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

c. **Timelines**

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

◉ **No**

○ **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
◉ **Aged or Disabled, or Both - General**					
	☑	**Aged**	65		☑
	☑	**Disabled (Physical)**	18	64	
	☑	**Disabled (Other)**	18	64	

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
Aged or Disabled, or Both - Specific Recognized Subgroups					
		Brain Injury			
		HIV/AIDS			
		Medically Fragile			
		Technology Dependent			
Mental Retardation or Developmental Disability, or Both					
		Autism			
		Developmental Disability			
		Mental Retardation			
Mental Illness					
		Mental Illness			
		Serious Emotional Disturbance			

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

The target population must also:
• Meet the following definition: Have a disability of medical and physical abnormalities to include a primary medical diagnosis (es) that is 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.
• Require the approved HCBS nursing facility LOC as determined by DMA;
• Meet the required level of care when a slot is available, and the completed assessment must find that there is a reasonable indication that the individual would need services in the appropriate level of care within 30 days of the evaluation;
• Require 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;
• Able to have his or her health, safety and well-being maintained at their primary private residence within the waiver budgeting methodology;
• Have an emergency back-up plan with adequate formal and informal support to meet the basic needs outlined in the CAP/DA assessment and plan of care (POC) to maintain their health, safety and well-being.

The target population choosing consumer-directed care must also:
• Understand the rights and responsibilities of directing one's own care;
• Be willing and capable to assume the responsibilities for beneficiary (self)-directed care, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care; and
• Complete a self-assessment questionnaire to determine ability to direct care or identify training opportunities to build competencies to aid in self-direction.

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

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

When individuals in the "Disabled (Physical)" and "Disabled (Other)" populations reach age 65 they will be served in the "Aged" Category. There is no difference in services between these population categories.

Appendix B: Participant Access and Eligibility

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

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

- ○ **No Cost Limit.** The State does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c.*
- ○ **Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c.*

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

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

    Specify the percentage:

  - ○ **Other**

    Specify:

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

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

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

  - ○ **The following dollar amount:**

    Specify dollar amount:

    The dollar amount *(select one)*

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

      Specify the formula:

- **May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.**

- **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

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

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

The totality of the service request form and comprehensive assessment process will be used to determine if the individual's needs can be met under the waiver.

Beneficiary's medical, functional, behavioral, mental and social information will be assessed utilizing a screening tool (Service Request Form). This screening tool will establish initial basic eligibility determination of nursing LOC. This screening tool provides for a comprehensive medical overview and information to help determine intensity of support needs as well as risk factors that may impede health, safety and well-being. This screening tool has a built-in smart logic mechanism that auto-fills the assessment to reduce data entry errors.

An interdisciplinary comprehensive needs assessment is conducted by Lead Agency's social worker and registered nurse initially and annually on each beneficiary to determine medical, functional and social acuity level to plan for all the beneficiary's assessed needs to assure health safety and well-being. The interdisciplinary comprehensive assessment addresses the following areas to assure health, safety and well-being can be maintained within the cost limit:
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.

The assessment has a scoring logic which yields acuity of care needs. There are three levels of needs that an individual is categorized: high (skilled), medium (intermediate) and low. An acuity level budgeting limit has been established based on the participant's level of care. All waiver services are to be included as part of the established monthly budget to assure health, safety and well-being of the waiver participant. Acuity needs that are discovered to be greater than cost limits of the waiver, the Lead Agency consults with the beneficiary to identify an alternative care planning that may include additional assistance from informal supports systems or a coordinated referral to a more appropriate level of service.

If waiver participation is denied due to health, safety and well-being cannot be maintained within the cost limits

under the waiver, other services are offered and the participant is offered due process rights.

If the beneficiary health, safety and well-being is able to be maintained within the cost limits, the case manager corresponds with the beneficiary and service providers to assure that the services authorized on the POC are adequate in the amount, frequency and duration. Each service provider must be credentialed and an approved Medicaid provider in the area in which services will be provided prior to rendering services.

On a monthly basis, the assigned case manager or care advisor will assess the beneficiary's needs and service provision to assure health, safety and well-being are maintained within the waiver cost limit. Every three months, the case manager or care advisors is required to conduct a home visit to observe hand-on assistance of service to assure amount, frequency and duration are sufficient to needs and health, safety and well-being is maintained in cost limits.

Upon discovery or by request, adjustments are made to the POC or level of care. The case manager or care advisor must review supporting documentations to determine the need for a reassessment to determine a change in the beneficiary's level of acuity. A reassessment is performed within 30 days of the request or discovery to review personal health information; caregiver information; medical diagnoses; medication and precautions; skin; neurological; sensory and communication; pain; musculoskeletal; cardio-respiratory; nutritional; elimination; mental health; informal support; and housing and finances to identify medical, functional and social needs. The new assessment is scored through the scoring algorithm that determines the level of acuity. The beneficiary's POC is planned based on the identified LOC identified in the reassessment. If beneficiary is not in agreement with the results of the reassessment, an appeal can be requested by the beneficiary/responsible care giver

After admission to the waiver, QA activities related to health, safety and well-being and cost limits are performed by the CWE and local lead agencies, and DMA for continuous quality improvement.

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

- [ ] **The participant is referred to another waiver that can accommodate the individual's needs.**
- [ ] **Additional services in excess of the individual cost limit may be authorized.**

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

- [x] **Other safeguard(s)**

  Specify:

  The case manager or care advisor corresponds with the beneficiary and service providers within 30-days of the change in the participant's condition to identify an alternative care plan to meet the beneficiary's current needs. A reassessment of needs is performed through a comprehensive interdisciplinary assessment conducted by both the social worker and nurse. Adjustments are made to the POC or level of care based upon the summary of findings. If the beneficiary's needs cannot be maintained within the budgetary limits of the waiver despite additional support from formal, informal and community resources, arrangements must be made to transition the participant to another community resource that is able to meet the new level of acuity. A coordinated and seamless transition will be executed. If beneficiary is not in agreement, an appeal can be requested.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	13363
Year 2	13647
Year 3	13936
Year 4	14231
Year 5	14533

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

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

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

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	11214
Year 2	11214
Year 3	11214
Year 4	11214
Year 5	11214

Appendix B: Participant Access and Eligibility

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

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

- ○ **Not applicable. The state does not reserve capacity.**
- ◉ **The State reserves capacity for the following purpose(s).**

Purpose(s) the State reserves capacity for:

Purposes	
Reserve Capacity for Community Transition and Waitlist Prioritization	

Appendix B: Participant Access and Eligibility

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

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

Reserve Capacity for Community Transition and Waitlist Prioritization

Purpose *(describe):*

The CAP/DA program has a maximum limit of waiver slots that can be utilized at any given time. As a result of the demand for waiver participation and the selection of entrant in the waiver on a first-come- first-served basis, the State desires to maximize waiver slots to prevent extended wait time. Division of Medical Assistance will ensure assurances for the Money Follows the Person rebalancing demonstration as well as prioritization of waiver participants. The waiver will prioritize slots to plan for transition back to the community utilizing MFP funding and prioritization of waitlist. Eligible waiver participants who are prioritized include the following:
• Age 18-21 transitioning from the children's 1915 (c) HCBS waiver (CAP/C).
• Individuals with an active AIDS diagnosis with a T-Count of 200 (discontinued 1915 (c) HCBS waiver that merged participants in the disabled adult waiver).
• Eligible approved disabled waiver beneficiaries who are transferring to another county.
• Previously approved disabled waiver beneficiaries who are transitioning from a short-term rehabilitation placement within 90 days of the placement.
• Individuals transitioning from a nursing facility with Money Follows the Person designation.
• Individuals transitioning from a nursing facility utilizing service of Community Transition.
• Individuals identified at risk by their local Department of Social Services who have an order of protection by Adult Protective Service for abuse, neglect or exploitation.

Describe how the amount of reserved capacity was determined:

The amount of reserved capacity was determined through aggregate data of the number of MFP participants entering the waiver from SFY 2009-2013 as well as the number of priority slots assigned to waiver participants from SFY 2009-2013.

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

Waiver Year	Capacity Reserved
Year 1	75
Year 2	125
Year 3	150
Year 4 (renewal only)	175
Year 5 (renewal only)	200

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

- ( ) **Waiver capacity is allocated/managed on a statewide basis.**
- (●) **Waiver capacity is allocated to local/regional non-state entities.**

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

Waiver capacity and waiting lists are managed by the Contracted Waiver Entity (CWE) in conjunction with DMA. Waiting lists are tracked statewide by the state Medicaid agency and the CWE. Each appointed Local Lead Agency must draft an operating manual with waiver policies, processes and procedures that include a Waiting List Policy. The Wait List Policy must be consistent with the guidelines provided by the state Medicaid agency (listed above in question 5a) and will be audited for compliance. The CWE will complete an annual audit of each lead agency's operating manual to assure compliance with waiver policies and procedures. The CWE will monitor waitlist across the state monthly to assure accuracy of individuals on the waitlist; prioritization of referrals, actual wait time for each referral per county and statewide; and slot utilization managed against the waitlist.

Slot capacity is allocated to the local lead agencies by DMA and dually managed and maintained by the CWE and each local lead agency. The allocation of slots is distributed to all 100 counties based solely on the percentage of the Medicaid aged, blind, and disabled beneficiaries ages 18 and older residing in each county. The most recent Medicaid eligibility data available in DRIVE (DMA's MMIS support system) is used for this formula.

When authorized, the allocation of new slots that become available will be distributed to counties based solely on the percentage of the number of individuals on waitlist and the approximate wait time. Counties with a maximum utilization rate and a wait time more than 12 months will be considered priority for new allocated slots. The most recent Medicaid eligibility data available in DRIVE (DMA's MMIS support system) will be used for this formula.

If a county determines that it will not be able to fully utilize their assigned slots, it may refuse all or some of the slots by submitting an official letter to DMA that outlines the reasons why they are surrendering the slots. The total "surrendered slots" will be immediately reallocated on a statewide basis to counties based on the population-based formula mentioned above or the percentage of the number of individuals on waitlist and the approximate wait time.

Each quarter, the CWE will identify each lead agency that consistently under utilize their assigned slots and send a report to DMA. These lead agencies will be required to provide a utilization action plan within 30 days of how these slots will be filled. At the next quarterly review, if that lead agency has not met the conditions of their action plans, their underutilized slots will be reassigned to another lead agency.

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

Individuals 18 years and older who are disabled or aged with a physical or cognitive disability are eligible for entrants in the waiver. Individuals who qualify under Medicaid categories of MAA, MAD and MAB and need a level of care consistent with institutional care are eligible for a level of care determination and an assessment to identify their imminent risk of institutionalization. Each individual who is screened through a referral and screening process is most likely considered at-risk of institutionalization given the overarching eligibility for waiver participation. Given the number of referrals received countywide with similar levels of acuity, individuals applying for participation in the waiver are considered on a first-come first-served basis. To plan continuity of care for individuals currently eligible for participation in a 1915 (c) HCBS waiver managed by state Medicaid agency, those who want to be deinstitutionalized and those who need immediate protection from abuse, neglect or exploitation are placed in a priority category and are expedited for immediate consideration of waiver participation. If there is an existing waitlist in the county of residence, these individuals are prioritized to the top of the waitlist.
Eligible waiver participants who are prioritized include the following:
• Age 18-21 transitioning from the children's 1915 (c) HCBS waiver (CAP/C).
• Individuals with an active AIDS diagnosis with a T-Count of 200 (discontinued 1915 (c) HCBS waiver that merged participants in the disabled adult waiver).
• Eligible approved disabled waiver beneficiaries who are transferring to another county.
• Previously approved disabled waiver beneficiaries who are transitioning from a short-term rehabilitation placement within 90 days of the placement.
• Individuals transitioning from a nursing facility with Money Follows the Person designation.
• Individuals transitioning from a nursing facility utilizing service of Community Transition.
• Individuals identified at risk by their local Department of Social Services who have an order of protection by Adult Protective Service for abuse, neglect or exploitation.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a.

1. **State Classification.** The State is a *(select one)*:
   - (●) **§1634 State**
   - ( ) **SSI Criteria State**
   - ( ) **209(b) State**

2. **Miller Trust State.**
   Indicate whether the State is a Miller Trust State *(select one)*:
   - (●) **No**
   - ( ) **Yes**

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

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

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

  Select one:

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

  Specify percentage: [ ]

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

  Specify:

  Individuals receiving under 42 CFR 435.135 (Passalong)

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

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

Select one and complete Appendix B-5.

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

Check each that applies:

- [ ] **A special income level equal to:**

Select one:

- ( ) **300% of the SSI Federal Benefit Rate (FBR)**
- ( ) **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage: [ ]

- ( ) **A dollar amount which is lower than 300%.**

Specify dollar amount: [ ]

- [ ] **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**
- [ ] **Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Medically needy without spend down in 209(b) States (42 CFR §435.330)**
- [ ] **Aged and disabled individuals who have income at:**

Select one:

- ( ) **100% of FPL**
- ( ) **% of FPL, which is lower than 100%.**

Specify percentage amount: [ ]

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

Specify:

[ ]

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 4)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 4)

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 4)

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

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

Appendix B: Participant Access and Eligibility

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

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

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

   i. **Minimum number of services.**

   The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 2

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

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

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

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

- **Directly by the Medicaid agency**
- **By the operating agency specified in Appendix A**
- **By an entity under contract with the Medicaid agency.**

Specify the entity:

The Service Request form is the first tool used for eligibility of waiver participation. The CWE is responsible to assure the service request form is easily accessible on-line and is completed to its entirety before LOC is established.
The CAP/DA Lead Agencies have the responsibility to perform evaluations and reevaluations of needs through a comprehensive assessment. The CWE is responsible to assure the evaluations and reevaluations are performed consistently with waiver policy.
The renewal waiver will continue to have case management as a waiver service to assist the case managers in assessing and reassessing waiver participants. Case management will be utilized initially and annually to assess medical necessity and plan the needs of each waiver participant. To be eligible for participation in the waiver, an individual must require two waiver services (excluding incontinence supplies, personal emergency response system, and meals preparation and delivery) on a monthly basis that mitigates institutionalization. Coordinated efforts of assessing, care planning, linkage and monitoring of assistance with ADLs and IADLs to mitigate emergency visits, multiple doctor's visits, polypharmacy, unplanned hospitalization and exacerbation of morbidity promote continuous community inclusion.

Individuals whom solely need incontinence supplies, personal emergency response services and delivery and preparation of meals (other waiver services identified in this waiver) will be referred to other community resources as these services are provided by other community resources regardless of waiver participation. At the initial and annual evaluation, each potential waiver participant will be assessed to determine need, and those who only need incontinence supplies, Personal Emergency Response Services and Delivery and preparation of meals will be referred to appropriate community resources through a coordinate transition process. Initial beneficiaries and annually assessed beneficiaries who are assessed to only need incontinence supplies, Personal Emergency Response Services and Delivery and preparation of meals will be provided an opportunity for an appeal.

- **Other**

Specify:

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

A Service Request Form (SRF) is the initial LOC eligibility criteria for waiver participation. The Service Request Form is fluid and can be initiated by the beneficiary, social worker, family/friend or physician. The CWE is primarily responsible to assure that the SRF is accurate (the fields corresponds with other fields), completed to its entirety and attested by the physician. Upon the validation that the form is completed and signed by the physician, the CWE will process the SRF through the programmed algorithms to establish basic LOC eligibility (described in B -6 f).
When initial basic LOC is established through the Service Request Form, an assessment is conducted to identify the acuity LOC (high, medium or low). This assessment is performed by a Social Worker and Registered Nurse. The qualifications of these professionals include:
1. Bachelor's degree in social work from an accredited School of Social Work, and (1) years 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 days;
2. Bachelor's degree in a human services or equivalent field from an accredited college or university with (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 (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 hold a current North Carolina license, two year or four year degree, (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.

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

The beneficiary shall meet the minimum requirement for HCBS nursing facility LOC criteria prior to participation in the CAP/DA Waiver approved by DMA. A HCBS Service Request Form with clear indication of nursing facility level of care needs must be completed and signed by a designated clinician to establish need for CAP/DA waiver participation. A LOC determination must be completed at initial enrollment, with each annual reevaluation, and as needed when significant changes in condition occur.

A beneficiary considered for participation in the CAP/DA program shall meet Medicaid's approved HCBS nursing facility level of care criteria, comparable to the State Plan nursing facility criteria. A request for CAP/DA services is rendered through a Service Request Form. The Service Request Form establishes the basic eligibility criteria for nursing facility level of care. All sections and required fields on Service Request Form must be completed in its entirety to establish eligibility determination for waiver participation. The service request form fields include:
o Program request.
o Beneficiary demographics.
o Beneficiary conditions (medical, functional, behavioral and mental) and related support needs.
o Informal caregiver availability.
o Attestation by Physician.
o Date of LOC request and determination.

The Service Request Form establishes HCBS Nursing Facility Level of Care for any of the following:
a. Performance of direct services that by physician judgment requires:
1. Supervision of a registered nurse or licensed practical nurse
2. Other personnel working under the direct supervision of a registered nurse or licensed practical nurse

b. Observation and assessment of Beneficiary needs by a registered nurse or licensed practical nurse: The licensed nursing services should be intensive and directed to an acute episode or a change in the treatment plan that would require such concentrated monitoring. Once a Beneficiary's treatment plan becomes stable, restorative nursing measures are utilized to maintain or restore maximum function or to prevent the advancement of progressive disabilities as much as possible. Such measures may include, but are not limited to the following:
1. Encouraging and assisting Beneficiaries to achieve independence in activities of daily living (i.e. bathing, eating, toileting, dressing, and transfer/ambulation)
2. Use of preventive measures/devices to prevent or retard the development of contractures, such as positioning and alignment, range of motion, use of pillows
3. Ambulation and gait training with or without assistive devices
4. Assistance with or supervision of transfer so, he/she would not necessarily require skilled nursing care.
5. Dialysis (hemodialysis or peritoneal dialysis) as part of a maintenance treatment plan.

c. A stabilization period if the Beneficiary's medical condition declines. A stabilization period is a period of time where the Beneficiary requires intensive intervention due to a recent decline of medical condition. Thus, skilled services may be needed.
1. Teaching: as part of the active treatment requiring a licensed nurse at the time of the skilled procedure.

2. Treatment for a specialized therapeutic supplemental formula diet (physician prescribed). Documentation must address the specific plan of treatment including the use of dietary supplements, therapeutic diets, and frequent recording of the Beneficiary's nutritional status.
3. Administration and/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
c. Frequent injections requiring nursing skills or professional judgment

d. Nasogastric/gastrostomy feedings requiring supervision and observation by licensed nurses:
1. Primary source of nutrition by daily bolus or continuous feedings
2. Medications per tube when Beneficiary on dysphasia diet, pureed diet or soft diet with thickening liquids
3. Tube with flushes

e. Respiratory therapy: oxygen as a temporary or intermittent therapy or for residents who receive oxygen continuously as a component to a stable treatment plan
1. Nebulizer usage.
2. Nasopharyngeal/tracheal suctioning.
3. Oral suctioning.
4. Pulse oximetry.

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

g. Wound care of decubitus ulcers or open areas

h. Hemodialysis or peritoneal dialysis as part of a maintenance treatment plan

Conditions That Must be Present in Combination to Justify Nursing Facility Level of Care

The following conditions when in combination may justify HCBS nursing facility level of care placement:
a. Need for teaching and counseling related to a disease process, disability, diet, or medication.
b. Adaptive programs: training the beneficiary to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must include the purpose of the beneficiary's participation in the program and the beneficiary's progress.
c. 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.
d. Injections: requiring administration and/or professional judgment by a licensed nurse or a trained personal assistance.
e. Diabetes: when daily observation of diary intake and/or medication administration is required for proper physiological control:
1. Vision, dexterity and cognitive deficiencies
2. Frequent hypoglycemic and DKA (high blood sugar) episodes with documentation requiring IV/IM oral intervention.
f. Treatments: temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction.
g. Psychosocial considerations: psychosocial condition of each beneficiary will 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 include:
1. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes and/or by nursing or therapy notes)
2. Age
3. Length of stay in current placement
4. Location and condition of spouse
5. Proximity of social support
6. 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 will help alleviate the fear and worry of transfer).
h. Blindness.
i. Behavioral problems such as:
1. Wandering
2. Verbal disruptiveness
3. Combativeness
4. Verbal or physical abusiveness
5. Inappropriate behavior (when it can be properly managed at the nursing facility level of care).
j. Frequent falls.

When nursing facility LOC is established through the Service Request Form, the CWE shall inform Medicaid's Fiscal Agent of the level of care decision to enter the prior approval eligibility in the Medicaid Management

System. A prior approved LOC indicates the eligibility to proceed to the next step of establishing the level of care acuity and appropriateness to participate in the waiver.

A social worker and registered nurse conduct an assessment of the beneficiary's medical, functional and social acuity level to plan for all the beneficiary's assessed needs. The interdisciplinary comprehensive assessment includes:
1. Personal health information.
2. Caregiver information.
3. Medical diagnoses.
4. Medication and precautions.
5. Skin condition.
6. Neurological.
7. Sensory and communication.
8. Pain.
9. Musculoskeletal.
10. Cardio-Respiratory.
11. Nutritional.
12. Elimination.
13. Mental Health.
14. Informal support.
15. Housing and finances.

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

- ○ **The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.**
- ◉ **A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

A different instrument is used in determining the level of care for waiver beneficiaries. This tool is referred to as a Service Request Form (SRF). The new LOC tool is a combination of the FL-2 the state uses for nursing facility and home and community based services program and the PASARR that is used only for nursing facility. The new LOC tool is comparable with the institutional LOC tool and will meet the level of care for individuals in a NF and home and community based services. The new LOC tool will be more robust and more versatile than the current FL-2 level of care instrument. It is designed to support more consistent review for level of care/eligibility determination and also incorporate essential PASARR functionality through expanded questions related to diagnoses, behavior, mood and interpersonal functionality. Also, for the first time, the Service Request Form, will provide DMA the capacity to implement a computerized approach to eligibility determination based on scoring algorithms tied to the information collected through the this newly revised LOC tool.

The Service Request Form was designed to take into account the previously used FL-2 tool to ensure consistency, where appropriate, but just as important to correct or compensate for gaps or deficiencies in the FL -2 form that hamper providers having a clear picture of the beneficiary being referred in addition to determining level of care. Consequently, the design of the new Service Request Form is reliable, valid and fully comparable to the previously used tool as result of the combination of information from the FL-2 form and the PASARR that nursing facility use after the initial LOC is determined. A mock LOC determination was conducted with existing waiver participants to identify comparability of this tool and the FL-2; this tool was determined to be valid and reliable.
This new LOC tool will be applied to initial waiver participants and during the annual reassessment. This new tool will not render an existing participant ineligible as the mock testing of the tool revealed comparability of the old FL-2 form. If a participant is deemed ineligible during an annual review, a thorough review of the process and any change in the participant's condition will be analyzed; the beneficiary will continue to receive services while LOC is being established. If after the analysis, the participant continues not to meet LOC, the old FL-2 will be used to determine LOC.

DMA's future goal is for the new LOC instrument to be used to determine eligibility on the institutional side in nursing homes. The new Service Request Form (LOC instrument) proposed for implementation for this waiver

will eventually replace the FL-2 used for admissions to nursing facilities and also become the new, uniform screening tool for multiple HCBS programs.

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

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

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

- ○ **Every three months**
- ○ **Every six months**
- ◉ **Every twelve months**
- ○ **Other schedule**
  Specify the other schedule:

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

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

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

The web-based case management tool will perform monthly reminders of the need to complete reevaluations. The CWE is responsible for management of this waiver assurance. The e-CAP system will track all Continued Need Reviews and reassessments. Monthly alerts will be provided to all case managers of when these annual reassessments are due. The Case Manager / Care Advisor will be responsible for assuring timely re-evaluations.

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

The CWE, lead agency and DMA's fiscal agent (CSC/NCTracks) will maintain evaluation/re-evaluation records. The e-CAP system will function as an electronic medical record and will store all beneficiaries' records.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

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

      Performance Measures

      For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of new enrollees who had a level of care indicating need for nursing facility level of care prior to receipt of services. Numerator: Number of new enrollees who had a level of care indicating need for nursing facility level of care prior to receipt of services. Denominator: Total number of new enrollees

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

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

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

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

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CWE, e-CAP	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of CAP/DA enrolled participants who received an annual reevaluation within twelve months of initial or previous evaluation Numerator: Number of CAP/DA enrolled participants who received an annual reevaluation within twelve months of initial or previous evaluation Denominator: Number of CAP/DA enrolled participants reviewed

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

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

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of CAP/DA waiver participants' LOC determinations signed by a qualified health professional Numerator: Number of CAP/DA waiver participants' LOC determinations signed by a qualified health professional Denominator: Number of CAP/DA waiver participants' LOC determinations reviewed

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of CAP/DA waiver participants' LOC determinations where the criteria was accurately applied. Numerator: Number of CAP/DA waiver participants' LOC determinations where the criteria was accurately applied. Denominator: Number of CAP/DA waiver participants' LOC determinations reviewed

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: CWE, e-CAP	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Sub-Assurance A - North Carolina Medicaid requires a level of care (LOC) determination is made on all beneficiaries seeking CAP/DA, by using a standardized prior approval tool. The FL-2 or service request form is completed and attested by the applicant's physician to initiates the CAP/DA admission process. A level of care analysis is in place to assure each individual accurately meets the established LOC prior to participating in the waiver.
The e-CAP system automatically tracks and counts the number of new enrollees with a request for whom a LOC is determined. All requests for waiver participation will have a LOC determination. The CWE will enter the requests for services in e-CAP except in instances where the referring entity is able to enter the request electronically via on-line accessibility.
Data queries will be obtained from the fiscal agent for all LOCs on a quarterly basis.
The Service Request Form and the comprehensive assessment will assure the beneficiary needs the required LOC.
Sub-Assurance B - Every 12 months, the case manager or care advisor is required to complete a Continued Need Review (CNR) to determine if the enrolled beneficiary continues to meet the established LOC requirements. The CNR must be completed during the month of the initial CAP/DA effective date. The lead agency's authorized approval agent must approve and sign the plan by the first day of the month following the CNR. This recertification process requires the case manager or care advisor to do the following:
1. Complete a new assessment performed by the RN and social worker.

The e-CAP system will capture the data when requests are entered into the web-based tool. The e-CAP system will aggregate the data automatically and provide reports to support waiver performance measures. Special queries are generated quarterly in e-CAP and provided to State Medicaid Agency to meet this performance measure.
Data queries will be obtained quarterly from the fiscal agent for all LOCs.
The CWE will validate each Service Request Form is completed to include a response in all fields of the form and that the qualified health professional have signed. The service request form will not be processed until the form is completed to its entirety.

Sub-Assurance C - All LOC determinations are monitored and reviewed by CWE via e-CAP as part of the prior approval process. DMA is responsible for assuring this process is conducted in accordance with the approved waiver assurances.
The e-CAP system will capture the data when requests are entered into the web-based system. The e-CAP system will aggregate the data automatically and provide reports to support performance measures. Special queries are generated in e-CAP and provided to State Medicaid Agency to meet this performance measure.

b. Methods for Remediation/Fixing Individual Problems

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

Sub-Assurance A – The e-CAP system provides an automated assessment and plan of care that captures data on all CAP/DA beneficiaries. The IT tool reviews 100 percent of level of care determinations. The CWE in conjunction with DMA will provide feedback to the lead agencies and, when necessary, establish a corrective action plan to ensure performance measures are met in all cases.
Upon discovery of non-compliance, CWE notifies the responsible Lead Agency of to request that an initial level of care to be completed approved and entered in e-CAP within 30 days. If the individual's LOC meets eligibility requirements, the individual continues to receive waiver services. If the individual is found ineligible, CWE/DMA disenrolls the individual from the CAP/DA waiver and issues appeal rights in accordance with Medicaid policy. The Lead Agency also assists the individual in identifying other Medicaid and non-Medicaid supports and services. Repeated findings of non-compliance by a Lead Agency may result in CWE/DMA issuing a corrective action plan, staff training and/or recoupment of Medicaid payments.
Sub-Assurance B – The CWE in conjunction with DMA will provide feedback to the lead agencies and, when necessary, establish a corrective action plan to ensure performances measures are met in all cases.
Upon discovery a LOC reevaluation was not completed, CWE notifies the responsible Lead Agency to complete and sign the reevaluation LOC within 30 calendar days. If the individual is found to meet eligibility, individual continues to receive waiver services. If individual is found ineligible, DMA disenrolls the individual from the CAP/DA waiver and issues appeal rights in accordance with Medicaid policy, http://ncdhhs.gov/dma/provider/priorapproval.htm. The Lead Agency also assists the individual in identifying other Medicaid and non-Medicaid supports and services.

When it is discovered a LOC reevaluation was not timely, CWE/DMA contacts the responsible Lead Agency and issues a directive providing technical guidance to the agency. Repeated findings of non-compliance by a Lead Agency may result in CWE/DMA issuing a corrective action plan, staff training and/or recoupment of Medicaid payments.
Sub-Assurance C - On-site reviews and e-CAP reports will be used to determine if the LOC process is completed correctly and if the required policies and procedures are used correctly. Remediation will include feedback to the lead agencies, technical assistance, and training.
If the validity of Service Request Form is questioned to not yield the required LOC, DMA will request completion and processing of the FL-2 for comparability.

The CWE will validate that each Service Request form is completed to include a response in all fields and that the qualified health professional have signed. The service request form will not be processed until the form is completed to its entirety.

Upon discovery of non-compliance, CWE notifies the responsible Lead Agency to obtain the waiver participant's signature within 30 days of notification as according to the CAP/DA policies and procedures. If after 60 days the LOC is not established, CWE/DMA disenrolls the individual from the CAP/DA waiver and issues appeal rights in accordance with Medicaid policy. The Lead Agency will assist the individual in identifying other Medicaid and non-Medicaid supports and services. Repeated findings of non-compliance by a Lead Agency may result in CWE/DMA issuing a corrective action plan, staff training and/or recoupment of payment.
The e-CAP system will capture the data when requests are entered into e-CAP. The e-CAP system will aggregate the data automatically and provide reports to support performance measures. Special queries are generated in e-CAP quarterly and provided to State Medicaid Agency for analysis.
Upon discovery of non-compliance, CWE notifies the responsible Lead Agency. The Lead Agency develops an action plan and submits to CWE/DMA within 30 days. The CWE/DMA reviews the action plan, makes a final decision, and issues directives for the Lead Agency to follow. If the individual's LOC meets eligibility requirements, the individual continues to receive waiver services. If the individual is found ineligible, CWE/DMA disenrolls the individual from the CAP/DA waiver and issues appeal rights in accordance with Medicaid policy. The Lead Agency will assist the individual in identifying other Medicaid and non-Medicaid supports and services. Repeated findings of non-compliance by a Lead Agency may result in CWE/DMA issuing a corrective action plan, staff training and/or recoupment of payment.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: CWE CSC/NCTracks	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

◉ **No**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

Individuals seeking nursing facility services are informed of the availability of the waiver program during the eligibility determination process through the county departments of social services. Information about the waiver program is also disseminated through the CWE, appointed lead agencies, hospital discharge planners, home care agencies, DHHS and advocacy groups. The individual is informed of any feasible alternatives under both options of the CAP/DA waiver and provided the choice of either waiver participation or institutional care. The individual's choice is documented by signing the service plan. The individual also signs a form indicating that he or she has been provided choice of providers. The form is referred to as a "Freedom of Choice Form". This form lists all CAP/DA Lead Agency's endorsed eligible Medicaid providers (providers officially requesting to be added to the Freedom of Choice list) in the beneficiary's community that is credentialed to provide a particular waiver or Medicaid service. The beneficiary is also able to request a provider that is not listed on the "Freedom of Choice" form. This form is completed and signed annually and as requested when a change in provider is needed. This form is filed in the beneficiary's electronic case record. The CWE is responsible to assure the "Freedom of Choice" form is completed and signed prior to the provision of services.

Prior to the approval and initiation of waivers services. The information and check points the CWE will assure as safeguards include the signatures and filing of the following:
• The beneficiary/responsible party original Freedom of Choice document detailing their choice of providers and waiver services and steps the CWE/DMA will take to mitigate influence of providers.

• The documentation lists all the known enrolled providers of Medicaid CAP/DA and regular Medicaid services working in or available to work in the county where the beneficiary/ responsible party resides.
• The beneficiary/responsible party choices of providers, in order of preference within categories, if there are multiple choices available.

In addition, the beneficiary/responsible party also receives information pertaining:
• All providers on the list have met specific DMA criteria for enrollment to provide the particular service.
• The lead agency can be requested by the beneficiary/responsible party to explore the possibility that a provider not listed, yet desired by the beneficiary/ responsible party, and may be added to the Freedom of Choice list.
• A statement to inform the beneficiary/ responsible party that a provider not currently enrolled with DMA would need to meet specific criteria to be enrolled with DMA before the provider could be authorized to provide service and be reimbursed by Medicaid for services rendered.
• The document will inform the beneficiary/responsible party how to contact the CAP/DA consultant in DMA assigned to their county if their problems are not resolved at the local level or by CWE.
• The beneficiary/ responsible party will be informed how to change agencies or lodge a complaint if they are unhappy about the care provided or the person rendering the care.

In addition, each approved CAP/DA beneficiary is provided a "Welcome Letter" within 30 days of the service plan. Some of the contents in the welcome letter will address this performance measure as listed as:
"While participating in the CAP/DA waiver, you are entitled to receive services that are assessed to meet your care needs as approved within an approved cost limit. These services can include: adult day health, personal care services, home accessibility and adaptation, respite services, home delivered meals, emergency response services, reusable incontinence supplies, liners, medication box, participant goods and services, training/education and consultative services, assistive technology, oral nutritional supplements, and case management. In addition, you are allowed the freedom to choose any provider within your community to provide these services and to assist you with your care needs. What this means is that you have the freedom to select any Medicaid approved agency in your community to provide the services listed above."

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

These forms will be maintained as an electronic file in the e-CAP system.

Provider(s) shall comply with the following in effect at the time the service is rendered:
All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

Appendix B: Participant Access and Eligibility

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

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

Scope of Policy

These requirements shall apply to the North Carolina Department of Health and Human Services (DHHS), all Divisions/Institutions within DHHS, all programs and services administered, established or funded by the Department, including contractors, vendors, and subbeneficiaries.

The Department and local entities shall ensure that LEP individuals are provided meaningful access to benefits and services provided through contractors or service providers receiving subgrants from the Department.

All Divisions/Institutions within DHHS and all local entities shall draft a Language Access Plan pursuant to this policy and update the Plan accordingly. The Plan shall include a system for assessing the language needs of LEP populations and individual LEP applicant/recipients; securing resources for language services; providing language access services; assessing and providing staff training; and monitoring the quality and effectiveness of language access services. The Plan shall

designate the department or specific staff position within the Division/Institution or local entity responsible for implementing activities related to this policy.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	Adult Day Health		
Statutory Service	Case Management		
Statutory Service	Institutional Respite Services		
Statutory Service	Personal Care Aide		
Supports for Participant Direction	Care Advisor		
Supports for Participant Direction	Financial Management Services		
Supports for Participant Direction	Personal Assistance Services		
Other Service	Assistive Technology		
Other Service	Community Transition Services		
Other Service	Home Accessibility and Adaptation		
Other Service	Meal Preparation and Delivery		
Other Service	Non-Institutional Respite Services		
Other Service	Participant Goods and Services		
Other Service	Personal Emergency Response Services		
Other Service	Specialized Medical Equipment and Supplies- Nutritional Supplements		
Other Service	Specialized Medical Equipment and Supplies- Reusable Incontinence supplies		
Other Service	Specialized Medical Equipment and Supplies-Disposable liners		
Other Service	Specialized Medical Equipment and Supplies-Medication Dispensing Boxes		
Other Service	Training/Education and Consultative Services		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

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

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

Service is not included in the approved waiver.

Service Definition *(Scope):*
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 (10A NCAC 06S). The service encompasses both health and social services needed to ensure the optimal functioning of the beneficiary. Refer to: http://www.ncdhhs.gov/aging/manual/adcadh/Standards2007.pdf. Adult Day Health Services are provided by Adult Day Health Centers certified by the North Carolina Division of Aging and Adult Services (DAAS) according to North Carolina Statute 131-D-6. The certification process is conducted by DAAS under 10A NCAC 06R, which states further that local departments of social services are responsible for on-going monitoring and annual certification of Adult Day Health Centers.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The services described in the definition refered above do not exist in state plan other than in the waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Health Center

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Adult Day Health

Provider Category:
Agency
Provider Type:
Adult Day Health Center
Provider Qualifications
License *(specify):*
10A NCAC 06R and 10A NCAC 06S
Certificate *(specify):*
Certified by the North Carolina Division of Aging and Adult Services, according to NC General Statute 131-D-6. Certification process is conducted by NC Division of Aging under NC Administrative Code Title 10, Chapter 42, Subchapter 42E and 42Z. As provided under Subchapter 42S, local departments of social services are responsible for ongoing monitoring and annual recertification.
Other Standard *(specify):*

Verification of Provider Qualifications
Entity Responsible for Verification:
1.NC Division of Aging and Adult Services
2.NC Division of Medical Assistance
Frequency of Verification:

The certificate will be in effect for 12 months from the date of issuance unless it is revoked for cause, voluntarily or involuntarily terminated, or changed to provisional certification status. Following review of the certification application, a pre-certification visit may be made by staff of the state Division of Aging and Adult Services.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

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

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

Service Definition *(Scope):*

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 to assist beneficiaries to remain safely in their communities with the support of home and community-based services. The providers of case management are from various governmental and non-profit entities. Case management services in the waiver do not duplicate state plan services.

Waiver case management services are defined as services furnished to assist individuals in gaining access to needed medical, social, educational and other services. These services are provided to maintain the beneficiary's health, safety, and well-being in the community. The case manager provides monthly and quarterly oversight to the waiver beneficiary to assure service provision, change in status and to mitigate risk of institutionalization.

The Four principal components of Case Management includes the following:

a. Assessing

The 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. Include early identification of conditions and needs for prevention and amelioration;
3. Involve consultation with other natural 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 including the comprehensive clinical assessment, medical assessments, and any other appropriate assessments; and
5. Periodic reassessment to determine whether a beneficiary's needs or preferences have changed.

Core Skills and Competencies

The case manager or care advisor must possess the following core skills and abilities in assessing:

1. Apply interviewing skills such as active listening, supportive responses, asking open and closed-ended questions, summarizing, and giving options;
2. Develop a trusting relationship to engage beneficiary and naturals supports;
3. Engage beneficiary and families to elicit, gather, evaluate, analyze and integrate pertinent information, and form assessment conclusions;

4. Recognize indicators of risk (health, safety, mental health or substance abuse);
5. Gather and review information through a holistic approach, giving balanced attention to individuals, family, community, educational, work, leisure, cultural, contextual factors, and beneficiary preferences;
6. Consult other professional and formal and natural supports in the assessment process; and
7. Discuss findings and recommendations with the beneficiary in a clear and understandable manner.

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

Core Skills and Competencies
1. The case manager or care advisor shall possess the following knowledge of care planning:
A. Values that underline a person-centered approach to providing service to improve beneficiary functioning within the context of the beneficiary's culture and community.
B. Models of wellness-management and recovery.
C. Biopsychosocial theories of practice, evidenced-based standards of care and practice guidelines.
D. Processes used in a variety of models for group meetings to promote beneficiary and family involvement in case planning and decision-making.
E. Services and intervention appropriate for assessed needs.
2. The case manager or care advisor shall possess the core skills and abilities of care planning to include:
A. Evaluative reasoning of the accessibility and reliability of resources and support systems.
B. Critical Analysis of assessment that yield measurable goals and outcomes.

c. Referral/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 entities to maximize risk stratification.

Core Skills and Competencies
1. To facilitate and maintain healthy, safe community inclusion, the case manager or care advisor shall have knowledge of:
A. Community resources such as medical and behavioral health programs, formal and informal supports, and social services, educational, employment, recreation, and housing resources.
B. Current laws, regulations, and policies surrounding medical and behavioral healthcare.
2. The case manager or care advisor shall possess the core skills and abilities of referral and linkage to include:
A. Research, develop, maintain, and share information on community and other resources relevant to the needs of beneficiaries.
B. Maintain consistent, collaborative contact with other health care providers and community resources.
C. Initiate services in the care plan in order to achieve the outcomes derived for the beneficiary's goals.

d. Monitoring & Follow-up
Monitoring and follow up includes activities and contacts with beneficiary, responsible party, and service providers that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the beneficiary.

Core Skills and Competencies
1. To assure the health, safety and well-being of beneficiaries, the case manager and care advisor shall have knowledge of:
A. Outcome monitoring and quality management;
B. Wellness-management, recovery, and self-management; and
C. Community beneficiary-advocacy and peer support groups.
2. To assure monitoring and follow-up, the case manager or care advisor shall possess the core skills and abilities to include:
A. Collect, compile and evaluate data from multiple sources;
B. Modify care plans as needed with the input of beneficiary, professionals, and natural supports;
C. Discuss quality-of-care and treatment concerns with the beneficiary, professionals, formal and natural supports;
D. Assess the motivation and engagement of the beneficiary and his or her supports;
E. Encourage and assist beneficiary to be a self-advocate for quality care; and

F. Conduct an annual reassessment to determine if the participant continues to meet the CAP/DA program eligibility and level of care criteria of need.

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 personal care aid or personal assistant is unavailable during regularly scheduled work hours and when the unpaid informal support is unavailable for the balance of the remaining 24-hour coverage period. The emergency back-up plan must address emergency preparedness.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
An annual calendar allotment of case management is set at 42hours/168units from January1st -December 31st. In 2009, legislation limited case management,the above referenced service is in compliance with the legislated limits.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	CAP/DA Lead Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Case Management

Provider Category:
Agency
Provider Type:
CAP/DA Lead Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and

statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

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 (1) years 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.
The case manager or care advisor shall complete (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); and
c. Completion of the following DMA program-specific training modules within (1) year of implementation of this clinical coverage policy and within (1) of a newly hired case manager or care advisor:
1. Introduction to Community Alternative Program for Disabled Adults (CAP/DA);
2. Case Management 101 for HCBS providers;
3. Person-Centered planning;
4. Prior approval policies and procedures;
5. Health, Safety and Well-being and Individual Risk Agreement;
6. Consumer-Direction;
7. Medicaid Due Process Appeal Rights;
8. EPSDT;
9. Money Follows the Person Transition Coordination;
10. Improving the Quality of Home and Community Based Waiver Services located at http://www.hcbsassurances.org;
11. PI;
12. Quality Assurance and Performance Outcomes, and
13. Critical Incident Reporting.

Verification of Provider Qualifications

Entity Responsible for Verification:

NC Division of Medical Assistance by designated appointment.

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

Institutional Respite Services

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

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

Service Definition *(Scope):*

Institutional Respite Care is the provision of temporary support to the primary caregiver(s) of the CAP/DA Beneficiary by taking over care of the CAP/DA 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/special occasions when the caregiver needs to be away from town for some extended period of time. 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. Edits/audits in the Medicaid management system will not deny claims for dates of admission or discharge in a facility or hospital if the participant receives in-home services prior to admission or after discharge.

Institutional respite services shall 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.

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

Not to exceed 30 days or 720 hours in one year for combined use of both Institutional Respite Care and Non-Institutional Respite Care.The services described in the definition refered above do not exist in state plan other than in the waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Facility

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Institutional Respite Services

Provider Category:
Agency
Provider Type:
Nursing Facility
Provider Qualifications
License *(specify)*:
TITLE 10: CH22, 0.0100
10 NCAC 06B .0101
Certificate *(specify)*:

Other Standard *(specify)*:

Verification of Provider Qualifications
Entity Responsible for Verification:
1.NC Division of Health Service Regulation
2.DHHS fiscal agent (CSC/NCTracks).
Frequency of Verification:
Every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Statutory Service
Service:
Personal Care
Alternate Service Title (if any):
Personal Care Aide

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

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

Service Definition *(Scope)*:
Personal Care Aide 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. Personal Care Aide 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 under its consumer

directed care waiver.
Personal Care Aides are provided by Homecare Agencies licensed by the State of North Carolina who comply with NC General Statute 131E-135 through 142 and 21 NCAC 36.0403 (a) and 21 NCAC 36.0403 (b). Workers providing Level III – Personal Care tasks must be certified as a Nurse Aide I.

Level I tasks, which consists entirely of home management tasks, are covered only when provided in conjunction with Level II or Level III Personal Care tasks. Typical Level I tasks include paying bills as directed by the participant; essential shopping, cleaning and caring for clothing; performing basic housekeeping tasks such as sweeping, vacuuming, dusting, mopping and washing dishes; identifying medications for the participant; providing companionship and emotional support; preparing simple meals; and shopping for food, clothes, and other essential items. Since many of these tasks are essential to the physical well-being of the participant, the case manager or care advisor is responsible for ensuring that an adequate back-up plan is in place for times when key direct care providers cannot provide services. The home care agency is immediately responsible for finding back-up staff to meet the participant's needs. However, it is not always possible to supply an aide, especially with very short notice. If the the in-home aide and back-up staff are not available, any family or friends (informal supports) will serve as back-up. The back-up plan is detailed in the participant's plan of care. Individuals deemed as having a need for 24-hour care are required to have a 24-Hour Coverage Plan. If this plan cannot be met adequately, the individual cannot be served through CAP/Choice or CAP/DA. The case manager or care advisor is available during regular business hours to assist the participant in emergency situations. After regular business hours, assistance is available through the toll-free hotline, CARELINE.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The services described in the above referenced definition exceed state plan Personal Care Services. The exceptions are:
The employment of a spouse, parent, child or sibling of the CAP/DA-CHOICE participant shall 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.110; and
c. Any employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the CAP/DA-CHOICE OPTION participant.
This restriction also applies to other relatives and hired personnel.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Homecare Agency Licensed by the State of North Carolina

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care Aide

Provider Category:
Agency
Provider Type:
Homecare Agency Licensed by the State of North Carolina
Provider Qualifications

License *(specify)*:
NC General Statute 131E-135 through 142 in accordance with Title 10 of the North Carolina Administrative Code
(10 NCAC 31.0900 - .1400)
Certificate *(specify)*:

Other Standard *(specify)*:
Workers providing Level III – Personal Care tasks must be certified as a Nurse Aide I by the NC Board of Nursing. Staff performing Level II tasks are required to be trained to provide in-home aide services. There are no requirements for licensing or certification for Level II staff.
Currently, DMA only reimburses Personal Care Aide Services at one rate, regardless of Level.

Verification of Provider Qualifications

Entity Responsible for Verification:
1.NC Board of Nursing
2.NC Division of Medical Assistance.

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Supports for Participant Direction

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

Support for Participant Direction:
Information and Assistance in Support of Participant Direction

Alternate Service Title (if any):
Care Advisor

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

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

Service Definition *(Scope)*:
The care advisor is a specialized case manager from a CAP/DA local lead agency with an understanding of consumer-directed care. The care advisor focuses on empowering consumers to define and direct their 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, monitoring/follow-up) however these functions are done under the guidance and direction of the Choice Beneficiary.

The Care Advisor provides the information and skills training needed to manage one's own care in the following areas:

1) The rights and responsibilities of both the participant and the employee;
2) Recruiting and hiring employees;
3) Negotiating hourly pay rates and benefits;

4) Developing schedules and outlining duties;
5) Supervising and evaluating employees;
6) Reporting on personal assistance expenditures; and,
7) Other relevant information and training.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
42 hours or 168 units allowed per calendar year (January1st -December 31st)

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	CAP/DA Lead Agency
Individual	Social Worker or Registered Nurse

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Care Advisor

Provider Category:
Agency
Provider Type:
CAP/DA Lead Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
Appointed and approved by CAPDA Unit at DMA and enrolled as a Lead Agecy by Fiscal Contractor (CSC/NCTracks)
A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;

• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

The CAP/DA Lead Agency that is designated as the FMS will also meet statutory guidelines to include:
Automated standard application of payment;
Check Claims;
Electronic Fund Transfer;
Electronic Fund Account;
International Treasury Service;
Invoice processing platform;
Judgment Fund;
Payment Application Modernization;
Prompt Payment;
Automated Clearing House;
Cash Management Improvement Act;
GFRS/FACTS I;
Government wide Accounting;
Intergovernmental Reconciliation;
Standard General Ledger;
Tax Payer Identification Number

Verification of Provider Qualifications

Entity Responsible for Verification:
DMA's Fiscal Contractor (CSC/NCTracks)
Frequency of Verification:
Every three years or as warranted

Appendix C: Participant Services

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

Service Type: Supports for Participant Direction
Service Name: Care Advisor

Provider Category:
Individual
Provider Type:
Social Worker or Registered Nurse
Provider Qualifications

License *(specify)*:
Registered Nurse must have a license to practice nurse in North Carolina
Certificate *(specify)*:

Other Standard *(specify)*:
must meet the basic staff qualification as listed:
The care advisor shall meet one of the following qualifications:
1. Bachelor's degree in social work from an accredited school of social work, and (1) years 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.

The care advisor shall complete (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); and
c. Completion of the following DMA program-specific training modules within (1) year of implementation of this clinical coverage policy and within (1) of a newly hired case manager or care advisor:
1. Introduction to Community Alternative Program for Disabled Adults (CAP/DA);
2. Case Management 101 for HCBS providers;
3. Person-Centered planning;
4. Prior approval policies and procedures;
5. Health, Safety and Well-being and Individual Risk Agreement;
6. Consumer-Direction;
7. Medicaid Due Process Appeal Rights;
8. EPSDT;
9. Money Follows the Person Transition Coordination;
10. Improving the Quality of Home and Community Based Waiver Services located at http://www.hcbsassurances.org;
11. PI;
12. Quality Assurance and Performance Outcomes, and
13. Critical Incident Reporting.

Verification of Provider Qualifications

Entity Responsible for Verification:
CWE
Frequency of Verification:
upon hire

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Supports for Participant Direction

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

Support for Participant Direction:
Financial Management Services

Alternate Service Title (if any):
Financial Management Services

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

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

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

Service Definition *(Scope)*:
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 the State of North Carolina designated Medicaid Management Information System (MMIS) 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). The FI conducts necessary background checks and age verification on personal assistants.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Financial Intermediary (FI) is billed through a vendor contract. The rate is $75 start-up fee and $75 per Beneficiary per month. Unlike other services, this service should not be included in the cost summary of the Plan of Care.

Financial Management services is also a waiver service that will only be utlized in the event of the lost of a vendor contractor. The waiver service and the administrative activity of FMS will not overlap or be a duplicative service.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FMS

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
FMS
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
The FMS must meet statutory guidelines to include:
Automated standard application of payment;
Check Claims;

Electronic Fund Transfer;
Electronic Fund Account;
International Treasury Service;
Invoice processing platform;
Judgment Fund;
Payment Application Modernization;
Prompt Payment;
Automated Clearing House;
Cash Management Improvement Act;
GFRS/FACTS I;
Government wide Accounting;
Intergovernmental Reconciliation;
Standard General Ledger;
Tax Payer Identification Number

The FMS shall have a minimum of (3) years experience in developing, implementing and maintaining a record management process that includes written policies and procedures for establishing and maintaining current and archived participant, attendant, service vendors and FMS files in a secure and confidential manner and for the prescribed period of time 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 will also have the capacity to provide Financial Management Services through both the Agency with Choice (AwC) and Fiscal/Employer Agent (F/EA) models. Be authorized to transact business in the State of North Carolina, pursuant to all State laws and regulations. Be approved as a Medicaid Provider for Financial Management Services (or in the process of applying for such approval).

A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

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 (1) years 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.
The case manager or care advisor shall complete (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); and
c. Completion of the following DMA program-specific training modules within (1) year of implementation of this clinical coverage policy and within (1) of a newly hired case manager or care advisor:
1. Introduction to Community Alternative Program for Disabled Adults (CAP/DA);
2. Case Management 101 for HCBS providers;
3. Person-Centered planning;
4. Prior approval policies and procedures;
5. Health, Safety and Well-being and Individual Risk Agreement;
6. Consumer-Direction;
7. Medicaid Due Process Appeal Rights;
8. EPSDT;
9. Money Follows the Person Transition Coordination;
10. Improving the Quality of Home and Community Based Waiver Services located at http://www.hcbsassurances.org;
11. PI;
12. Quality Assurance and Performance Outcomes, and
13. Critical Incident Reporting.

Verification of Provider Qualifications

Entity Responsible for Verification:
DMA and DHHS fiscal agent
Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Supports for Participant Direction

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

Support for Participant Direction:
Other Supports for Participant Direction

Alternate Service Title (if any):
Personal Assistance Services

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

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

Service Definition *(Scope):*
Personal assistance services are available only for those beneficiaries who have elected consumer-directed care under the CAP/DA waiver. The personal assistance is hired by the beneficiary to provide help with personal and home maintenence tasks for beneficiaries who are unable to meet these needs independently due to physical or

mental impairments. Personal maintenence tasks are basic activities of daily living that must be performed to assure or support one's physical well-being.

Personal Assistant Services is personal care attendant under participant-directed care option of the waiver. Participant-directed care allows eligible beneficiaries to hire the provider of their preference. The eligible beneficiary is the employer of record, hence requiring an FI to file Medicaid claims on their behalf. The FMS is credentialed by DMA to file claims on behalf of the eligible beneficiary and then reimburse the hired personal assistant.

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

Tasks, amount, frequency and duration must be clearly outlined in job duites.

A personal assistant is restricted for hire when:

The following findings on their background check:

1. Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
2. Felony health care fraud;
3. More than one felony conviction;
4. Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
5. Felony or misdemeanor patient abuse;
6. Felony or misdemeanor involving cruelty or torture;
7. Misdemeanor healthcare fraud;
8. Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
9. Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
10. Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	FMS
Individual	Personal aids

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

FMS

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify):*
The FMS must meet statutory guidelines to include:
Automated standard application of payment;
Check Claims;
Electronic Fund Transfer;
Electronic Fund Account;
International Treasury Service;
Invoice processing platform;
Judgment Fund;
Payment Application Modernization;
Prompt Payment;
Automated Clearing House;
Cash Management Improvement Act;
GFRS/FACTS I;
Government wide Accounting;
Intergovernmental Reconciliation;
Standard General Ledger;
Tax Payer Identification Number

The FMS shall have a minimum of (3) years experience in developing, implementing and maintaining a record management process that includes written policies and procedures for establishing and maintaining current and archived participant, attendant, service vendors and FMS files in a secure and confidential manner and for the prescribed period of time 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 will also have the capacity to provide Financial Management Services through both the Agency with Choice (AwC) and Fiscal/Employer Agent (F/EA) models. Be authorized to transact business in the State of North Carolina, pursuant to all State laws and regulations. Be approved as a Medicaid Provider for Financial Management Services (or in the process of applying for such approval).

The FMS will also meet statutory guidelines to include:
Automated standard application of payment;
Check Claims;
Electronic Fund Transfer;
Electronic Fund Account;
International Treasury Service;
Invoice processing platform;
Judgment Fund;
Payment Application Modernization;
Prompt Payment;
Automated Clearing House;
Cash Management Improvement Act;
GFRS/FACTS I;
Government wide Accounting;
Intergovernmental Reconciliation;
Standard General Ledger;
Tax Payer Identification Number

Verification of Provider Qualifications

Entity Responsible for Verification:
DMA, FMS, CWE

Frequency of Verification:
Initially and Annually

Appendix C: Participant Services

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

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

Provider Category:
Individual
Provider Type:
Personal aids
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
succesfully passes a background check to include criminal, check and registry. Must be 18 years old and older; can not be the legal representative appointed to direct own care. Can not be the legal guardian or POA.
Verification of Provider Qualifications
Entity Responsible for Verification:
FMS
Frequency of Verification:
Initial

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Assistive Technology

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

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

Service Definition *(Scope)*:
Assistive Technology includes 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 24/7 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 Beneficiaries 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 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.

The Beneficiary's service plan must clearly indicate a plan for training the Beneficiary, family, primary caregiver, personal aides or assistants who will 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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The following limitations apply to this service:
a. The cost of assistive technology is limited to $3,000 per Beneficiary per the life of the waiver, which is renewed every five 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 Durable Medical Equipment (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 home are excluded from this service.
Items not covered by this service include: computer desks and other furniture, heating, ventilation, air conditioning, plumbing, swimming pools, spas, hot tubs, saunas, service and maintenance contracts, and extended warranties.
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 experience working with assistive technology.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agencies provisioned to provide Assistive Technology Equipment and CAP/DA Lead Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:
Agency
Provider Type:
Agencies provisioned to provide Assistive Technology Equipment and CAP/DA Lead Agencies
Provider Qualifications
License *(specify)*:
A State Licensed Occupational Therapist, Physical Therapist, or Speech Language Pathologist (Licensure includes Certification of Clinical Competency which is required for augmentative communication evaluations)
Certificate *(specify)*:

An Assistive Technology Practitioner (ATP) or Assistive Technology Supplier (ATS) certified by RESNA
Other Standard *(specify):*
An Assistive Technologist with a bachelor's degree in a human services field, special education, or related degree, and two years of experience working with assistive technology

CAP/DA lead agencies can provide a service authorization for this service to an authorized provider, as listed above, and submit claims to Medicaid to reimburse the authorized provider. A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications
Entity Responsible for Verification:
CAP/DA Lead Agency/CWE
DHHS fiscal agent (CSC/NCTracks)
Frequency of Verification:
Prior to delivery of services

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Community Transition Services

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

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

Service Definition *(Scope):*
Transitions services are available to cover one-time expenses, not to exceed $2500 per participant. These expenditures are for initial set-up expenses for individuals who make the transition from an institution to their

own home or apartment in the community. The funds may be used to pay the necessary expenses for an individual to establish his or her basic living arrangement and to move home. This service may not include ongoing payment for rent.
Such items include:
• Equipment, essential furnishings, and household products
• Moving expenses
• Security deposits or other such payments (e.g., first month's rent) required to obtain a lease on an apartment or home
• Set-up fees or deposits for utility or service access (e.g., telephone, electricity, heating)
• Environmental health and safety assurances, such as pest eradication, allergen control, one time cleaning prior to occupancy
• Personal hygiene supplies
• First week supply of groceries
• Up to a one month supply of medication in instances when the participant is not provided with medication upon discharge from the nursing facility and/or when Medicaid coverage lapses during the transition process.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
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 their 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.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Services, Equipment or Supplies, CAP/DA Lead Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition Services

Provider Category:
Agency
Provider Type:
Services, Equipment or Supplies, CAP/DA Lead Agencies
Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
1. Medicaid providers who have the capacity as verified by the case manager/care advisor to provide items and services of sufficient quality to meet the need for which they are intended.
2. Items/services (including rental housing) must be of sufficient quality and appropriate to the needs of the participant. The participant must provide a receipt for each purchase or invoice for each payment.
3. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service definition.

The CAP/DA lead agency shall authorize this service. A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications

Entity Responsible for Verification:
1. CAP/DA Lead Agency
2. CWE
3. DHHS fiscal agent (CSC/NCTracks)

Frequency of Verification:
Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Home Accessibility and Adaptation

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

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

Service Definition *(Scope):*
Include equipment and physical adaptations or minor renovations to the beneficiary's home that are required to meet their needs and are documented in the approved plan of care. These services are provided to enhance the beneficiary's mobility, safety, and independence in the home. This service often plays a key role in preventing institutionalization. This service is not to exceed the limit of over the lifetime of the waiver, which is renewed every five years.
Home modification and mobility aids shall be provided by a durable medical equipment company or local lead agency through contract who are qualified as enrolled Medicaid providers and who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer's specifications and requirements.
1) Installation, maintenance, and repairs of ramps, grab bars, and handrails
2) Widening of doorways/passages for wheelchair or walker accessibility
3) Modification of bathroom facilities to improve accessibility for a disabled individual, including toilet, shower/tub (including hand-held showers), and sink fixtures or modifications; water faucet controls; floor urinal adaptations; plumbing modifications; and modification for turnaround space
4) Bedroom modifications to accommodate hospital beds and/or wheelchairs and Kitchen Modifications to improve accessibility for an individual with a disability including cabinets, sink fixtures or modifications, water faucet controls, related plumbing modifications, and modification for turnaround;
5) Floor coverings for ease of ambulation
6) Hydraulic, manual, or electronic lifts, including portable lifts or lift systems that can be removed and taken to a new location and are used primarily inside the participant's home
7) Non-skid surfaces
8) Lift chairs
9) Other modifications outside of these general categories must be approved by the Division of Medical Assistance
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
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 lifetime 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, in order to avoid exceeding the $10,000 limit over the lifetime of the waiver (five years).

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable medical equipment company or Local Lead Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Accessibility and Adaptation

Provider Category:
Agency
Provider Type:
Durable medical equipment company or Local Lead Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
1. Enrolled Medicaid providers who have demonstrated the capacity to make the needed modifications and install equipment according to applicable local and state building codes. Providers must install items according to the manufacturer's specifications and requirements.
2. DMA places a limitation of $10,000 on the total amount that may be spent for all home modifications and aids over the life of this waiver.

The CAP/DA lead agency shall authorize this services.A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications
Entity Responsible for Verification:
1. CAP/DA Lead Ageny
2. DHHS Fiscal Agent
3. CWE
Frequency of Verification:
Prior to service delivery

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Meal Preparation and Delivery

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

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

Service Definition *(Scope):*

This service is often referred to as "Meals on Wheels" and provides for the preparation and delivery to the beneficiary's home of nutritious meal.

Agencies and organizations providing nutrition services shall meet Division of Aging Services requirements for home delivered meals in compliance with 10A NCAC 06K.0101

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

The services described in the definition refered above do not exist in state plan other than in the waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nutrition

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Nutrition

Provider Qualifications

License *(specify):*

10A NCAC 06K.0101

Certificate *(specify):*

Other Standard *(specify):*
Agencies/organizations that meet Division of Aging and Adult Services requirements for home delivered meals.

Verification of Provider Qualifications

Entity Responsible for Verification:
1. NC Division of Aging and Adult Services
2. NC Division of Medical Assistance

Frequency of Verification:
Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Non-Institutional Respite Services

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

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

Service Definition *(Scope):*
Non-Institutional Respite Care is the provision of temporary support to the primary unpaid caregiver(s) of the CAP/DA Beneficiary by taking over the tasks of primary caregiver for a limited period of time. These services are provided in the CAP/DA Beneficiary's home and are provided by a Personal Care 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. 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 shall 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 plan of care requires the personal care aide provide extensive assistance which includes substantial hands-on care to a Beneficiary who is only able to perform part of the activity, the personal care aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-256. This applies to provider-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

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

Not to exceed 30 days or 720 hours in one year for combined use of both Institutional Respite Care and Non-Institutional Respite Care.The services described in the definition refered above do not exist in state plan other than in the waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Consumer Directed or Provider Managed
Agency	In-Home Aide Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Institutional Respite Services

Provider Category:
Individual

Provider Type:
Consumer Directed or Provider Managed

Provider Qualifications

License *(specify)*:
10A NCAC 13J .1107 IN-HOME AIDE SERVICES
If the beneficiary's plan of care requires the personal care aide to provide extensive assistance to the beneficiary which includes substantial hands-on care to the client who is able only to perform part of the activity, the personal care aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-256. This applies to provider-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.

Certificate *(specify)*:

Other Standard *(specify)*:
A participant-directed Personal Assistant providing Non-Institutional Repite requires on-the-job training based on the needs identified in the plan of care. Training will be provided by the participant. The participant-directed provider of this service can be a relative of the participant but not the legal representative or legal guardian.

Verification of Provider Qualifications

Entity Responsible for Verification:
1. Division of Health Service Regulation
2. Care Advisor / Fiscal Manager
3. Division of Medical Assistance

Frequency of Verification:
Nurse Aide I Verification:
Initially, the expiration date is 24 months from the date the individual successfully completed a competency evaluation. After the initial listing, the expiration date is 24 months from the last date the individual was employed as a nurse aide for monetary compensation under the direct supervision of a registered nurse as reported by the employer.

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Non-Institutional Respite Services

Provider Category:
Agency
Provider Type:
In-Home Aide Agency
Provider Qualifications
License *(specify):*
10A NCAC 13J .1107 IN-HOME AIDE SERVICES
If the beneficiary's plan of care requires the personal care aide to provide extensive assistance to the beneficiary which includes substantial hands-on care to the client who is able only to perform part of the activity, the personal care aide shall be listed on the Nurse Aide Registry pursuant to G.S. 131E-256. This applies to provider-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.
Certificate *(specify):*

Other Standard *(specify):*
Service authorization by the CAP/DA Lead Agency
Verification of Provider Qualifications
Entity Responsible for Verification:
CAP/DA Lead Agency
CWE
DHHS fiscal agent (CSC/NCTracks)
Frequency of Verification:
every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Participant Goods and Services

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

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

Service Definition *(Scope):*

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. Consumer-directed Beneficiaries may direct the Financial Manager (through the approved plan of care) to save a portion of their monthly Beneficiary-directed budget for these items and services.

The item or service would increase the individual's ability to perform ADLs or IADLs; decrease dependence on Personal Assistant Services or other Medicaid-funded services; and assist the waiver participant who does not have the funds to purchase the item/service.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The cost of participant goods and services for each Beneficiary must not exceed a limit of $800.00 annually. Any item over $200.00 must be approved by a DMA consultant. These services, equipment, and/or supplies are purchased through the lead agency. Medicaid providers who have the capacity as verified by the case manager 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

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Services, equipment, and/or supplies purchased through FM or Lead Agency

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Services, equipment, and/or supplies purchased through FM or Lead Agency
Provider Qualifications
License *(specify)*:

Certificate *(specify)*:

Other Standard *(specify)*:
1. Medicaid providers, including the Financial Manager, who have the capacity as verified by the care advisor to provide items and services of sufficient quality to meet the need for which they are intended.
2. Items/services must be of sufficient quality and appropriate to the needs of the participant. The participant must provide a receipt for each purchase.

3. Some items may be purchased directly through a retailer as long as the item meets the specifications of this service's service definition.

The CAP/DA lead agency shall authorize this services. A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications

Entity Responsible for Verification:

1.CAP/DA Lead Agency
2.DHHS Fiscal Agent
3. NC Division of Medical Assistance for items over $200
4. CWE

Frequency of Verification:

Prior to service delivery.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Personal Emergency Response Services

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

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

Service Definition *(Scope):*

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. PERS does not cover the purchase and installation of equipment in the Beneficiary's home.

The emergency response provider must have the capability to provide a 24-hour monitoring system in accordance with the service definition.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
Personal Emergency Response Services does not cover the purchase and installation of equipment in the participant's home.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Emergency Response

Appendix C: Participant Services

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

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

Provider Category:
Agency
Provider Type:
Emergency Response
Provider Qualifications
License *(specify)*:
UL/ETL Approved Devices
Emergency care providers
Alarm system contractor
Certificate *(specify)*:

Other Standard *(specify)*:
Provider must have the capability to provide a 24-hour monitoring system in accordance with service definition.
Verification of Provider Qualifications
Entity Responsible for Verification:
1. CAP/DA Lead Agency
2. DHHS Fiscal Agent
3. CWE
Frequency of Verification:
Prior to enrollment and annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Medical Equipment and Supplies- Nutritional Supplements

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

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

Service Definition *(Scope):*

Nutritional supplements are multi-nutrient liquid, semi-solid or powder products that provide macronutrients and micronutrients with the aim of increasing oral nutritional intake that improve dietary intake and weight, as well as benefiting the clinical outcome of underlying diseases. Nutritional supplements are taken by mouth when ordered by a physician.

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

The services referenced in the above definitions are limited to Medicaid beneficiaries under age 21 yrs. This waiver provides access to specialized medical equipment and supplies-nutritional supplements to eligible beneficiaries over age 21 yrs.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Specialized Medical Goods Supplies or Lead Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies- Nutritional Supplements

Provider Category:

Agency

Provider Type:

Specialized Medical Goods Supplies or Lead Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Must be a Medicaid-enrolled provider capable of providing supplies of sufficient quality and verified by the case manager/care advisor.

Other Standard *(specify)*:
The CAP/DA lead agency shall authorize these services. A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications

Entity Responsible for Verification:
1. CAP/DA Lead Agency
2. DHHS Fiscal Agent
3. CWE

Frequency of Verification:
Prior to provision of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Specialized Medical Equipment and Supplies- Reusable Incontinence supplies

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

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

Service Definition *(Scope)*:
Reusable Incontinence supplies are incontinence products that can be washed and used multiple times by the waiver participant. These supplies include underwear, panties and diaper covers. These reusable incontinence supplies assist with skin integrity. These supplies are provided to the waiver beneficiary to promote health and well-being.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The services referenced in the above definition is not covered in state plan outside this waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	CAP/DA Lead Agency, DME or Medical suppliers

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies- Reusable Incontinence supplies

Provider Category:
Agency

Provider Type:
CAP/DA Lead Agency, DME or Medical suppliers

Provider Qualifications

License *(specify)*:
Must be a Medicaid-enrolled provider capable of providing supplies of sufficient quality and verified by the case manager/care advisor.

Certificate *(specify)*:

Other Standard *(specify)*:
The CAP/DA lead agency shall authorize these services. A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications

Entity Responsible for Verification:

1. CAP/DA Lead Agency
2. DHHS Fiscal Agent
3. CWE

Frequency of Verification:
Prior to provision of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:
Other Service

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

Service Title:
Specialized Medical Equipment and Supplies-Disposable liners

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

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

Service Definition *(Scope):*
Disposable liners are incontinence products that are used independently or with reusable incontinence products for the protection of light bladder leakage. These supplies are provided to the waiver beneficiary to promote health and well-being. Disposal liners are not covered under the State Medicaid Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The services referenced in the above definitions are not in state plan outside this waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME, Medical suppliers and CAP/DA Lead Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies-Disposable liners

Provider Category:
Agency
Provider Type:
DME, Medical suppliers and CAP/DA Lead Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Must be a Medicaid-enrolled provider capable of providing supplies of sufficient quality and verified by the case manager/care advisor.
Other Standard *(specify):*
The CAP/DA lead agency shall authorize these services. A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications
Entity Responsible for Verification:
1. CAP/DA Lead Agency
2. Fiscal Agent
2. NC Division of Medical Assistance
Frequency of Verification:
Prior to provision of service

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).
Service Type:
Other Service
As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.
Service Title:
Specialized Medical Equipment and Supplies-Medication Dispensing Boxes

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

Service is included in approved waiver. There is no change in service specifications.

- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*
Medication boxes with compartments that can be pre-filled to apportion doses of medication for specific times and days so that the participant can independently take the medication or an aide can safely assist the participant in the taking of the medication.
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.
Specify applicable (if any) limits on the amount, frequency, or duration of this service:
The service describe in the above definitions exceed services in state plan.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	DME, Medical suppliers, and CAP/DA Lead Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Medical Equipment and Supplies-Medication Dispensing Boxes

Provider Category:
Agency
Provider Type:
DME, Medical suppliers, and CAP/DA Lead Agency
Provider Qualifications
License *(specify):*

Certificate *(specify):*
Must be a Medicaid-enrolled provider capable of providing supplies of sufficient quality and verified by the case manager/care advisor.
Other Standard *(specify):*
The CAP/DA lead agency shall authorize these services. A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;

• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications

Entity Responsible for Verification:

1. CAP/DA Lead Agency
2. DHHS Fiscal Agent
2. CWE

Frequency of Verification:

Prior to provision of service

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Training/Education and Consultative Services

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

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

Service Definition *(Scope):*

Training and education includes training for the Beneficiary, a family member who is the primary caregiver, or the Personal Assistant for CAP/DA 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 care plan as a goal with the expected outcomes. This service includes conference registration and enrollment fees for classes.

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

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

An organization with a training or class curriculum approved by the Division of Medical Assistance including Universities, Colleges and Community Colleges shall provide training and education services.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Trainers and Educators

Appendix C: Participant Services

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

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

Provider Category:
Individual

Provider Type:
Trainers and Educators

Provider Qualifications

License *(specify)*:

Certificate *(specify)*:
1) Universities, Colleges, and Community Colleges
2) An organization with a training/class curriculum approved by the Division of Medical Assistance.

Other Standard *(specify)*:
The CAP/DA lead agency shall authorize these services. A CAP/DA lead agency must be an organization with three or more years of direct service providing case management to individuals at risk of institutionalization and receiving home and community-based services. Each case management agency must enroll as a NC Medicaid provider and be credential to provide lead agency waiver services. At every three years, the case managements must be recertified as a Medicaid provider.
Qualified Case Management Providers must have:

• A resource connection of the service area as to provide continuity and appropriateness of care;
• Experience in Geriatric and physical disabilities;
• Polices/procedures in place that aligns with the governance of the state and federal laws and statues;
• 3 years of progressive and consistent home and community base experience;
• Ability to provide case management by both social worker and Nurse;
• Physical location;
• Computer technology/IT web-base connectivity to support the requirement of current and future automated programs;
• Meet the regulatory criteria under DHHS/DHRS
• Staff to participant ratio (appropriate case mix);
• Implementation of services within 30 days of POC approval;

Verification of Provider Qualifications

Entity Responsible for Verification:
1)CAP/DA Lead Agency
2)CWE

Frequency of Verification:
Prior to class or training

Appendix C: Participant Services

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

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

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

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

Appendix C: Participant Services

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

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

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

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

All providers are subjected to criminal background checks. The state has a fiscal agent, Computer Science Corporation (CSC) to conduct criminal background checks on all providers requesting to enroll as a Medicaid provider. The Department of Health Services Regulation also conducts background checks on organizations licensed to provide personal care services, skilled nursing services and durable medical equipment.

Under participant-directed care, hired personal care assistants do not have to be a nurse aide nor seek employment through an In-Home Aide Agency. To assure the health, safety and welfare of participant-directed waiver participants, the FMS conducts the background checks on all applicants applying to be the personal care assistants. Each applicant is presented a criminal record check consent form to complete. This consent form identifies the name, DOB, social security number, street address, city, state, driver's license information, gender, previous names used, length of stay in the NC, city and state of residence within last five years. The criminal background check consists of criminal history, driving record and fair credit reporting. The criminal background check includes a nationwide search.

The lifetime hiring ban is placed on all applicants who have any of the following findings on their background check:
• Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
• Felony health care fraud;
• More than one felony conviction;
• Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;

• Felony or misdemeanor patient abuse;
• Felony or misdemeanor involving cruelty or torture;
• Misdemeanor healthcare fraud;
• Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
• Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
• 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.

The North Carolina Division of Health Services Regulation (DHSR) performs a criminal background check at hire and annually for direct care providers who work for home care agencies. In addition to the DHRS regulations, an organization requesting to enroll as a Medicaid provider must complete a Medicaid Provider Enrollment application. A section within the application, Exclusion Sanction Information, must be completed by each provider to attest to any applicable criminal complaint, licensure action, suspension, penalty or recoupment notice, and final disposition. The provider application will be deemed incomplete and voided if not satisfactorily completed. Specific areas the Exclusion Sanction addresses:
• criminal convictions,
• disciplinary action taken against any business or professional license held in this or any other state;
• restricted, reduced or revoked license to practice in this state or any other state as a result of violating the standards or conditions relating to licensure, certification or the quality of service provided
• denial of enrollment, suspended, excluded, terminated or involuntarily withdrawn from Medicare or Medicaid or other insurance in any state;
• suspension of Medicaid or Medicare payment in any state
• received civil monetary penalties levied by Medicare or Medicaid including NC Department of Health Services Regulations;
• Medicare or Medicaid recoupment actions against in any state;
• money owed to Medicare or Medicaid not paid in full;
• conviction under federal or state law of criminal offenses related to neglect or abuse of a patient in connection with delivery of any health care goods or services;
• conviction under federal or state law of criminal offenses related to unlawful manufacture, distribution, prescription or dispensing of controlled substances;
• conviction under federal or state law of criminal offenses relating to fraud, theft embezzlement breach of fiduciary responsibility or other financial misconduct;
• found to have violated federal or state laws rules or regulations governed by NC Medicaid program or any state's Medicaid program

Each provider seeking NC Medicaid Provider enrollment must agree to and sign a Provider Administrative Participation Agreement. Within this agreement the following areas are addressed:
Governing Law and Venue
• XIX of Social Security Act
• HIPAA
• Family Education Rights and Privacy Act
• N.C.G.S. 108A-80
• Maintenance of License
• Billing and Payment
• Disclosure
• Inspections; Maintenance of Records; filling reports
• Termination
• Assignment
• Release of Liability
• Severability
• Independent Contractor
• Discrimination
• Waiver
• Survival
• Effective Date.

A provider will not obtain Medicaid enrollment status until the official completion of the credentialing process is validated by state Medicaid fiscal agent. An enrolled Medicaid provider must be credentialed every three years.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (select one):

- ○ **No. The State does not conduct abuse registry screening.**
- ◉ **Yes. The State maintains an abuse registry and requires the screening of individuals through this registry.**

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

The Division of Health Services Regulation (DHSR) is responsible for maintaining the nurse aide registry. DHSR requires direct care staff to be screened through the Nurse Aide Registry at hire and at least annually thereafter.
All direct care staff are not nurse's aides, the DHSR conducts a criminal background check on entities monitored by that division. The licensed entities monitored by DHRS are mandated to conduct criminal backgrounds and registry checks on all hired employees to assure health, safety and well-being of all individuals to mitigate risk.

For participant-directed waiver participants, FMS conducts a criminal background check, driving record check, adult registry and fair credit check on all applicants applying to be the personal care assistant referred by the participant-directed beneficiary prior to hire.

Beneficiaries participating in the traditional option of the waiver, the In-Home Aide Agencies are responsible for screening against the nurse aide registry. For beneficiaries participating in the participant-directed option, the FMS is responsible for screening against the nurse aide registry.

The state has a fiscal agent, Computer Science Corporation, to manage all NC Medicaid enrolled providers. The fiscal agent carefully reviews the completed provider application to assure the accuracy and completeness of the application by correlating each corresponding sections, verifying compliance with other regulatory agencies and validating the responses to the Exclusion Sanction section of the application.

Through a procured FMS contract for participant-directed services, the FMS is mandated to conduct an initial background check on all hired personal care assistants prior to Medicaid reimbursement. The FMS obtains a completed application from all personal care assistants requesting employment. The application is processed by the FMS to assure age requirements are met; the applicant is made aware of the mandatory criminal background and registry check. The FMS must provide a copy of the criminal background to the beneficiary for review. The criminal background and registry check are provided to the care advisor for review and filed in the beneficiary's record as well as in the files of the FMS. Upon request by DMA, the FMS must provide a copy of criminal background and registry checks.

Appendix C: Participant Services

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

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

- ◉ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

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

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

- ○ **No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- ◉ **Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

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

Personal Care Aide, Non-institutional Respite, and Personal Assistant Services may be provided by a relative and/or legally responsible person who is an employee of an In-Home Care Agency. The only exception is the Personal Care Assistant under participant-directed can not provide Non-institutional Respite Services, and may NOT also be the legally responsible person or the legal guardian. The Case Manager / Care Advisor plays a major role, along with the participant and/or representative in assessing and determining need for personal care. The Case Manager / Care Advisor also assists in monitoring the plans of care, tasks and time records to assure appropriate provision and utilization of these services. Additional safeguards include post-payment reviews conducted by DMA consultants.

The employment of a spouse, parent, child or sibling of the CAP/DA participant is able to provide personal care services only if the person:
a. Is at least 18 years of age;
b. Meets the aide qualifications; or deemed competent by the appropriate licensed supervisory professional of the In-Home Care agency to provide the personal care task at that level as defined in 10A NCAC 13J.110; and
c. Any employment cannot interfere with or negatively impact the provision of services; nor supersede the identified care needs of the CAP/DA participant.
This restriction also applies to other relatives and hired personnel.
A comprehensive interdisciplinary assessment is conducted to identify medical, functional, social and family support needs. The severity of these needs are identified in the assessment and carried over to the plan of care. The case manager or care advisor coordinates with the beneficiary and other care professionals to create a plan of care to meet the needs identified in the assessment. Take for example, if the beneficiary only needs cues and prompts assistance with ADLs, the hours authorized coincide with level of need consistent with cues and prompts. Each month, the case manager or care advisor corresponds with the beneficiary to assure that the services authorized on the POC are adequate in the amount, frequency and duration. Every three months, the case manager or care advisor is required to conduct a home visit to observe hands-on assistance to assure amount, frequency and duration are sufficient for needs. Adjustments are made upon discovery. Also, the case manager or care advisor is required to review supporting documentations to determine the need for a reassessment when the beneficiary is hospitalized or endures a significant change in status. Another monitoring task the case manager or care advisor performs to assure services are in the best interest of the individual is to hold a quarterly interdisciplinary monitoring team meeting with all services providers.

The case manager or care advisor closely monitors the provision of services through monthly contact with the beneficiary and quarterly observation of hands-on tasks performance.

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

- **The State does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The State makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

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

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

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

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

  The case manager or care advisor closely monitors the provision of services through monthly contact with the beneficiary and quarterly observation of hands-on tasks performance.

- **Other policy.**

  Specify:

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

Applicants must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once participation as a Medicaid provider has been approved, providers are assigned an NPI with an effective date. Each provider is notified by mail of their provider status. Providers may begin submitting claims to Medicaid upon receipt of their NPI.
DMA cannot provide special consideration for processing enrollment applications due to provider error, incomplete information, or a delay in obtaining credentialing, endorsement or licensure information from another agency.
Any provider who meets the qualifications specified by each service can apply and enroll to become a Medicaid provider. Information related to provider enrollment is available on the DMA website. Enrollment is based on meeting all stated qualifications. For participant-directed services, participants may choose their providers. The CWE will provide each beneficiary a freedom of choice policy which participants sign acknowledging their rights to choose any qualified provider eligible to provide a requested service.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. **Methods for Discovery: Qualified Providers**
   i. **Sub-Assurances:**

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

      Performance Measures

      For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

      Performance Measure:
      PM:Number/percent of new provider applications, by provider type, for which the provider obtained appropriate licensure/certification/enrolled with DMA prior to service provision. Numerator:New provider applications, by provider type, for which the provider obtained appropriate licensure/certification/enrolled with DMA prior to service provision Denominator:Total number provider applications

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of new provider applications for which appropriate background and registry checks, as required by the state/waiver, were conducted.
Numerator: Number of new provider applications for which appropriate background and registry checks, as required by the state/waiver, were conducted.
Denominator: Total number of applications

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

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

		☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: NCTracks/CSC	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment. Numerator: Number of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment Denominator: Total number of providers

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of agency providers whose direct support staff had timely criminal background and registry checks. Numerator: Number of agency providers whose direct support staff had timely criminal background and registry checks. Denominator: Total number of agency providers

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

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

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CWE, e-CAP FMS	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number/percent of direct support applicants screened by the FMS who passed background and registry checks and thus deemed eligible for hire
Numerator: Number of direct support applicants screened by the FMS who passed background and registry checks and thus deemed eligible for hire
Denominator: Total number of support applicants

Data Source (Select one):
Program logs
If 'Other' is selected, specify:

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

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of lead agencies meeting provider training requirements Numerator: Number of lead agencies meeting provider training requirements Denominator: Total Number of Lead Agencies

Data Source (Select one):
Training verification records
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Sub-Assurance A - DMA verifies all Medicaid providers are licensed or certified, as required, and properly enrolled as a Medicaid provider by DMA's fiscal agent for each type of service furnished. Through these rigorous state licensure/certification standards, providers must demonstrate competency to perform services. In addition to DMA''s credentialing requirements, each provider must be authorized by the CAP/DA lead agency for each county where services will be provided. The provider must receive an authorization notice initially, re-issued annually at continued need review and updated as needed. Medicaid beneficiaries have the freedom to choose to receive services from any licensed home care agency that serves their county. A waiver participant may switch agencies without any restrictions. Licensed home care agencies are required to perform the following activities to comply with state laws:
1. Complete background checks on all employees; 2. Conduct in-home aide competency evaluations and trainings; 3. Monitor quality of care; 4. Handle Workers Compensation; 5.Manage the payment of income and Social Security taxes; and 6.Ensure that in-home aides work under the supervision of a Registered Nurse.

Applicants must meet all program requirements and qualifications for which they are seeking enrollment before they can be enrolled as a Medicaid provider. Specific qualifications for each provider type are listed in the Provider Qualifications and Requirements Checklist. Once participation as a Medicaid provider has been approved, providers are assigned an NPI with an effective date and are notified by mail. Providers may begin submitting claims to Medicaid upon receipt of their NPI.
Sub-Assurance B - The applicant must attach or submit a complete copy of the applicable criminal complaint, Consent Order, documentation of licensure action, suspension, penalty or recoupment notice, and/or final disposition clearly indicating the final resolution. The provider application has the following questions that must be answered:
Have you ever been convicted of any criminal offense, had adjudication withheld on any criminal offense, pled no contest to any criminal offense or entered into a pre-trial agreement for any criminal offense? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had disciplinary action taken against any business or professional license held in this or any other state, including licenses

issued by the North Carolina Division of Health Service Regulation (NC DHSR) and endorsements issued by any Local Management Entity as that term is defined in N.C.G.S. 122C-115.4? Has your license to practice ever been restricted, reduced or revoked in this or any other state or been previously found by a licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided, or entered into a Consent Order issued by a licensing, certifying or professional standards board or agency? Have you or any entity you are or were either an agent, owner, or managing employee of, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had payments suspended by Medicare or Medicaid in any state? Have you or any entity you are or were either an agent, owner, or managing employee of, ever had civil monetary penalties levied by Medicare, Medicaid or other State or Federal agency or program, including NC DHSR, even if the fine(s) have been paid in full? Have Medicare or Medicaid in any state ever taken recoupment actions against you or any entity you are or were an agent, owner, or managing employee of? Do you or any entity you are or were either an agent, owner, or managing employee of, owe money to Medicare or Medicaid that has not been paid in full? Have you ever been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services? Have you ever been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? Have you ever been convicted under federal or state law of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct? Have you or any entity you are or were either an agent, owner, or managing employee of, ever been found to have violated federal or state laws, rules or regulations governing North Carolina's Medicaid program or any other state's Medicaid program or any other publicly funded federal or state health care or health insurance program?

NCTracks (on-line MMIS) will allow a provider time to submit the requirement documentation. On behalf of DMA, CSC must recredential active Medicaid Providers a minimum of every three years to ensure provider the provider's credentials and qualifications continue to meet N.C. Medicaid guidelines for provider enrollment. The credentialing process also includes a criminal background check. CSC will recredential providers in cycles. Providers will receive a Recredentialing Invitation via mail or e-mail when they are scheduled to begin the recredentialing process. FMS will conduct background and registry checks on all direct support staff.

Sub-Assurance C - The e-CAP system will provide training registration modules.

b. Methods for Remediation/Fixing Individual Problems

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

Sub-Assurance A -

Upon discovery of non-compliance, DMA's appointed fiscal agent notifies the provider via letter and electronically to inform the return of the provider application. The returned application will highlight the areas of non-compliance along with information in how to re-submit the application. The provider must comply with all required timelines. If the timeline is not met, the provider application will be voided.

A provider must document and provide a record of provision of services before seeking Medicaid payment. The record must provide an audit trail for services billed to Medicaid. Submitting a written explanation in lieu of supporting documentation may result in the denial of the application.

Each provider must notify the DMA's fiscal agent within thirty (30) calendar days of learning of any adverse action initiated against the license, certification, registration, accreditation and/or endorsement of the Provider or any of its officers, agents, or employees.

Sub-Assurance A -

Upon discovery of non-compliance, CWE/DMA notifies the FMS of the untimely criminal background and registry checks. CWE/DMA provides TA to the FMS, requires the FMS to conduct any outstanding background and registry checks. Persistent non-compliance may include sanctions up to termination of provider contract. Any direct support staff without a criminal background and registry check will not be allowed to provide services. If services are being rendered by the direct support staff without a background and registry check, services will immediately terminate.

Sub-Assurance B - Upon discovery of non-compliance, CWE/DMA notifies the FMA to immediately remediate cases of non-compliance. CWE/DMA requires the FMA to submit a corrective action plan.

Continuous failure to comply will result in termination of the provider contract.

Sub-Assurance C - DMA will ensure that provider training is conducted in accordance with state licensure/certification requirements, DMA clinical policy, and waiver requirements. DMA accepts DHSR's licensure of home care agencies and if any continuing education is required, DHSR conducts supplemental training. CAP/DA staff reviews training course materials and verifies that provider training programs meet the state administrative requirements, program policy, and waiver requirements.
Upon discovery of non-compliance, Lead Agencies will be required to attend a mandatory training session in this area. Persistent non-compliance may lead to sanctions to include revoking authority to serve as a Lead Agency.

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: CWE, e-CAP NCTracks/CSC	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

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

- ◉ **No**
- ○ **Yes**
  Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. **Additional Limits on Amount of Waiver Services.** Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ◉ **Applicable** - The State imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☐ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☑ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

An acuity level budgeting limit has been established based on the participant's level of care needs (low, intermediate (medium) and skilled (high)). All waiver services are to be included as part of the established monthly budget to assure the waiver participant is within their established budget limit. The assignment level of care/acuity level of support is derived from the completed assessment. A scoring logic based on clinical coverage indicators is integrated into the e-CAP assessment module. The scoring logic is tied to a set of assessment questions and responses that serve as indicators of the level of support the beneficiary requires.

Through e-CAP, case managers or care advisors conduct a comprehensive interdisciplinary assessment that reviews personal health information; caregiver information; medical diagnoses; medication and precautions; skin; neurological; sensory and communication; pain; musculoskeletal; cardio-respiratory; nutritional; elimination; mental health; informal support; and housing and finances to identify medical, functional and social needs that require formal and informal planning. Once the assessment is completed, pre-programmed algorithms derive level of acuity.

The acuity level is computed through e-CAP using the following logic: determine if beneficiary is eligible for Level 3 (high) acuity; if not, determine if the beneficiary meets the level 1 criteria (low acuity); if not, assign the beneficiary to Level 2 (intermediate/medium acuity).
The assignment of acuity level is performed based on a rule-out of high and low levels of acuity. The first step is to determine Level 3 acuity eligibility. The e-CAP system will follow the scoring logic listed below:
• e-CAP will determine if the beneficiary has a current treatment that alone signals high acuity or an interpersonal functioning behavior that signals high risk. These single indicators include ventilator, suctioning, pulse oximetry, non-vent., tracheostomy, nebulizer care, homicidal, combative/history of altercations, dangerous to others, physically abusive, suicide/ideation in varying degrees.
• For each single indicator, treatment must be indicated as being provided by frequency or type and meet a specified threshold.
• If a beneficiary is receiving any of the single-indicator treatments and meets the additional requirement listed, the beneficiary is automatically assigned to the high acuity category.
• If the beneficiary does not meet the single-indicator treatment criteria, then e-CAP will test to see if there is some combination of indicators that will result in level 3 (high) acuity. Combination indicators that will be used to reflect eligibility include: number of medications, number of PRN medications, number of prescribed treatment regiments, more than 5 mood and behavioral indicators, more than 5 interpersonal functioning indicators, more than 3 unplanned hospitalizations, current involvement with Adult Protective Services for safety and protection.
• If the beneficiary does not meet the Level 3 acuity scoring threshold, then e-CAP will evaluate to see if

the beneficiary falls into the Level 1 (low) acuity category. Level I will rule-out indicators from Level III algorithm. Indicators for Level I (low) acuity will include 3 or fewer diagnosis, medically stable, no PRN medications, fewer than 5 prescribed medication, two or fewer treatment indicators (example: cardiac monitoring, CAP/BiPAP), weight management, continence management), two or fewer mood and behavior indicators, no interpersonal or functioning indicators, no involvement with APS, and no unplanned hospitalizations.
• All beneficiaries that do not meet the high acuity or low acuity criteria are assigned to the intermediate acuity scoring category.

This scoring logic was generated from the current methodology that state Medicaid agency uses to establish LOC. This new method provides specificity to the HCBS population and achieves an accurate level of acuity of needs.

The e-CAP assessment functionality carries over service needs to the plan of care template. Individual service plans are entered responsive to the identified beneficiary needs. The case manager in combination with the beneficiary is responsible for entering the service(s) start date, service frequency, intensity and duration. Once the service plans are entered, e-CAP calculates the budget for the plan period for the beneficiary both in terms of units and dollar amounts. The individual budget (units and $) are identified by average week (for in-home aide/personal care services), by plan period and average monthly costs. All the budget calculations are performed by e-CAP based on built-in Medicaid current fee schedules and the negotiated rate for participant directed services. Once the plan of care is drafted, e-CAP compares the overall plan and service budgets to policy defined limits in force. In the case of CAP/DA, the case caps (plan of care limits) are based on the acuity level determined by e-CAP as part of the assessment process. The e-CAP system compares each draft plan of care to the applicable case cap. No plan is considered complete until the individual budget is equal to or less than the applicable case cap based on the beneficiary's acuity level.

Each month, the case manager or care advisor corresponds with the beneficiary to assure the services authorized on the POC are adequate in the amount, frequency and duration. Every three months, the case manager or care advisors is required to conduct a home visit to observe hands-on assistance to assure amount, frequency and duration are sufficient to needs. Adjustments to the POC or level of care are made upon discovery or through request by the beneficiary/primary caregiver. The case manager or care advisor must review supporting documentations to plan a reassessment to determine a change in the beneficiary's level of acuity. A reassessment is performed within 30 days of the request or discovery to review personal health information; caregiver information; medical diagnoses; medication and precautions; skin; neurological; sensory and communication; pain; musculoskeletal; cardio-respiratory; nutritional; elimination; mental health; informal support; and housing and finances to identify medical, functional and social needs. The new assessment is scored through the scoring algorithm that determines the level of acuity. The beneficiary's POC is planned based on the LOC identified in the reassessment. If beneficiary is not in agreement with the results of the reassessment, an appeal can be requested by the beneficiary/responsible care giver.

Once the assessment is entered, e-CAP determines the acuity level and displays in the e-CAP plan of care template. The beneficiary is the center for the development of their plan of care. The case managers or care advisors must inform the beneficiary/primary caregiver during the initial development of POC the level of care the beneficiary has been approved. The case manager or care advisor must inform of the budgetary limits of the approved acuity level. Once a plan is drafted, the case manager or care advisor generates a beneficiary plan summary that clearly lists what formal services are included and the corresponding monthly budget. This document is included in the POC package in which the beneficiary/primary caregiver signs. An approval letter is forwarded to the beneficiary that clearly identifies approved services, level of care and the budgetary limit.

The Division of Medical Assistance publishes the CAP/DA Clinical Coverage policies on its web-site for public inspection. The level of care and acuity of needs are included in the CAP/DA program descriptions and related coverage policies.

☐ **Other Type of Limit.** The State employs another type of limit.

Describe the limit and furnish the information specified above.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:
Participant Plan of Care

a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(select each that applies):*

- [x] **Registered nurse, licensed to practice in the State**
- [ ] **Licensed practical or vocational nurse, acting within the scope of practice under State law**
- [ ] **Licensed physician (M.D. or D.O)**
- [x] **Case Manager** (qualifications specified in Appendix C-1/C-3)
- [ ] **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

- [x] **Social Worker.**

Specify qualifications:

1. Bachelor's degree in social work from an accredited school of social work, and (1) years 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.

- [x] **Other**

Specify the individuals and their qualifications:

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.
a. 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.
Each individual who qualifies must complete a DMA certified training program within 90 days.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. **Service Plan Development Safeguards.** *Select one:*

- ( ) **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

- **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

The DMA and CWE are primarily responsible to educate the community about the waiver and services available through the waiver. When a referral is made for waiver participation, the beneficiary/responsible party is provided educational information about the waiver and the case management providers available to render the service in their community. The CWE and lead agency are responsible for providing additional education to the beneficiary/responsible party upon request and dissemination of these materials. When the beneficiary has met basic eligibility to participate in the waiver and is ready to establish the functioning LOC, a comprehensive interdisciplinary assessment is conducted by the case manager entity selected by the beneficiary through freedom of choice. The e-CAP assessment functionality carries over service needs to the plan of care template. Prior to the POC development, the beneficiary/responsible caregiver is provided additional information about their right to select among enrolled Medicaid providers and waiver services. Each beneficiary's record must contain a copy of the signed and dated freedom of choice document, prior to the approval and initiation of waivers services. The information and check points the CWE will assure as safeguard include the signatures and filing of the following:
• The beneficiary/responsible party original freedom of choice document detailing their choice of providers and waiver services and steps the CWE/DMA will take to mitigate influence of providers.
• The documentation listing all the known enrolled providers of Medicaid CAP/DA and regular Medicaid services working in, or available to work, in the county where the beneficiary/ responsible party resides.
• The beneficiary/responsible party choices of providers, in order of preference, within categories, if there are multiple choices available.

In addition, the beneficiary/responsible party also receives information pertaining to:
• All providers on the list must have met specific DMA criteria for enrollment to provide the particular service.
• The lead agency can be requested by the beneficiary/responsible party to explore the possibility that a provider not listed, yet desired by the beneficiary/responsible party may be enrolled with DMA.
• A statement to inform the beneficiary/responsible party that a provider not currently enrolled with DMA would need to meet specific criteria to be enrolled with DMA before the provider could be authorized to provide service and be reimbursed by Medicaid for services rendered.
• The document will inform the beneficiary/responsible party how to contact the CAP/DA consultant in DMA assigned to their county if their problems are not resolved at the local level or by CWE.
• The beneficiary/ responsible party will be informed how to change agencies or lodge a complaint if they are unhappy about the care provided or the person rendering the care.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Each participant chooses a CAP/DA Lead Agency responsible for facilitating the person centered planning process. The process emphasizes a strength based approach, collaborative problem-solving and decision-making with the participant and those persons that are most important in his/her life. The participant guides the plan and chooses participants to assist. Family members and friends are frequent contributors and professional service providers are included as deemed relevant by the participant in consultation with the case manager or care advisor.

The CWE and the Lead Agency are primarily responsible to educate the beneficiary/responsible party about person-centered planning. When a referral is made for waiver participation, the beneficiary/responsible party is provided educational information about the waiver and the services available under the waiver. The educational material includes waiver service definitions, limitations, LOC budget limits and other Medicaid services. The beneficiary is provided educational materials that describe what person-centered planning is and how to identify the services that are consistent with currently assessed needs. The beneficiary is also provided information on how to appeal an adverse decision when a service request is denied, reduced or terminated. The CWE is responsible for providing additional education when a referral is made and the individual meets the basic eligibility criteria. Upon the assignment to the case management entity, the case manager or care advisor provide additional education about the assessment and person-centered POC process. During the assessment process, the case manager or care advisor

conducts an assessment of needs. Upon the completion of the assessment, the case manager or care advisor reviews the information with the beneficiary to assist in highlighting needs for planning. The person-centered plan of care identifies preferences and individuals the beneficiary would like to be included in the plan of care development. The assessment and POC are performed in an interdisciplinary format where the beneficiary/responsible party is at the core of the decisions.

For beneficiaries selecting participant-directed services, they are provided self-assessment tools to assist with identifying their care needs and strategies they can use in directing their plan of care.

A future functionality of e-CAP will include a consumer interface to allow beneficiaries/responsible parties with internet service to access a variety of self-help and self-management tips and guides. These educational materials will include information on how to actively engage in the plan development process.

The participant guides the plan. Family members and friends are frequent contributors and professional service providers are included as deemed relevant by the participant in consultation with the case manager or care advisor.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Person Centered Plan will be developed in conjunction with the waiver participant and the case manager or care advisor. The participant chooses individuals to help them in the planning process. This may include friends, family members, service providers, teachers, and other professionals. The person centered plan is updated at least annually. If the participant's provider changes or if their needs change and requires services to be added, increased, decreased or terminated, a revision to the plan shall be completed within 30 days. The results from the assessments should be considered and incorporated within the person centered plan.

The lead agency social worker and registered nurse are responsible for developing the plan of care.

Services and supports for participants should be planned as well as implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community. The following must be considered in the process:
Comprehensive information regarding the participant or family's preferences and personal goals, needs and abilities, health status as well as other available supports is gathered with the participant or family and used in the development of a person centered plan. Information and support is available to assist participant and families to make informed choices regarding service options as well as providers. Information and support are available to assist participants to freely choose among qualified providers.

Each participant's PCP comprehensively addresses his/her identified need for supports, health care and other services in accordance with expressed personal preferences and goals.
Participants and families have continuous access to assistance as needed to obtain and coordinate services and quickly address issues encountered in community living.
All services and supports are provided in accordance with the person centered plan.
Regular, systematic and objective methods, including participant or family feedback, are used to monitor the participant's well being, health status, and the effectiveness of supports and services in enabling the participant to achieve personal goals.
Significant changes in the participant or family's circumstances promptly trigger consideration of modifications to the person centered plan.

An initial and annual interdisciplinary comprehensive needs assessment is conducted on each beneficiary to determine medical, functional and social acuity level to plan for all the beneficiary's needs. The initial interdisciplinary comprehensive assessment is conducted after the determination of basic level of care derived from the approved Service Request Form. The completed assessment must be approved by designated personnel by the Lead Agency within 45-calendar days of the approved waiver slot.
The annual re-assessment is called a Continued Need Review (CNR) assessment. The CNR assessment includes 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 POC as evidence of completed assessment.

A CNR assessment must be completed every 12 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 of the CAP effective month. The POC must not be initiated prior to the completion of the interdisciplinary comprehensive assessment. The medical, functional and social information collected through the interdisciplinary comprehensive needs assessment are documented in a POC. The POC specifies the person-centered goals, objectives and formal and informal services to address the identified medical and functional care needs of an approved CAP/DA beneficiary. The services documented on the POC effectively meet the needs identified in the assessment. Case managers and Care Advisors use the POC to achieve the following:
h. Summarize the evaluation and assessment information to highlight the beneficiary's strengths and needs;
i. Outline person-centered goals and objectives based on the assessment and identified needs;
j. Develop a comprehensive list of waiver services, medical supplies and durable medical equipment (DME), including provider name, amount, frequency and duration of each service;
k. Calculate the monthly beneficiary cost of care;
l. Ensure the beneficiary's right to choose among providers as evidence by a signed provider freedom of choice form;
m. Assure the beneficiary's right to choose between CAP/DA and institutionalization and from among Medicaid-enrolled providers by signature of the POC; and
n. To provide on an annual basis and updated when warranted due to status changes in the waiver participant's condition, a document that dictates the waiver participant's care needs.

The person-centered planning process enables and assists the participant to identify and access a personalized mix of non-paid and paid services that will assist in achieving personally defined outcomes in the most inclusive community setting. The participant identifies planning goals to achieve these personal outcomes in collaboration with those that the participant has identified, including medical and professional staff. The case manager is responsible for informing the participant of the services that are available under the waiver. Information on the services is also available on DMA's and CWE's websites.

The Person Centered Plan is expected to address how the provider will ensure back up staff are available (if the staff regularly assigned to provide services are unavailable). The back-up staff must be trained to meet the specific needs of the participant, as detailed in the Person Centered Plan, including health, mobility, communication, risks behavioral issues, and skill training. All participants are informed of and provided information related to back-up staff at the time of identification of provider and during the PCP process.

POC 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 POC changes for waiver services.

The Lead Agency shall send a written adverse notice in accordance with DMA's beneficiary notices to the beneficiary or responsible party if a service is denied, reduced or terminated.
c. Documenting a change in services: The CAP/DA case manager or 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-days of identified needs for Lead Agency approval within five (5) business days.
d. 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.
Focus is on the ability to meet the identified needs of the participant within the budget limitations while maintaining the participant's health, safety, and well-being. For those choosing consumer-directed care a participant-directed budget is developed. The CWE and case manager and care advisor provides orientation and training on participation in the waiver. Those electing consumer-directed care, orientation and training are provided to the participant, participant's representative, and/or family members, as appropriate about directing one's care. The CWE monitors

the case manager/care advisor to assure the provision of care and expenditures and maintains contact with the participant to assure that needed care is being provided. If necessary, under consumer-directed care, the care advisor is also responsible for identifying the need for a representative and assuring that representatives are capable of meeting the needs of the participant.
The CWE reviews 100% cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from failure to complete the care planning assessment tool accurately.
The CWE places prior approval limits on all service plans to identify deviations of approved services. If there are consistent deviations and the services are authorized on the POC, the case manager or care advisor must review these with the beneficiary and discuss a possible change of providers. If the beneficiary can be maintained at the deviated service level(s), a POC revision must be completed.
Each county lead agency has access to QI reports and can contact the CWE or DMA for clarification of the quality measures and to verify the accuracy of the assessment question/answer. The case managers and care advisors can also access the Q and A section from the e-cap system.
In addition to the activities described above, DMA utilizes desktop reviews and on-site reviews (audits), CME reports, and special reviews to assure program accountability for POC development and implementation. These desktop reviews and on-site reviews occur annually and as needed.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The state has procedures to promote individual and family preferences and selections for care and services. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences and goals of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts) to ensure that family or individual decisions are honored.

An Individual Risk Agreement (IRA) outlines the risks and benefits to the beneficiary of a particular course of action that might involve risk to the beneficiary, the conditions under which the beneficiary assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement permits individuals to assume responsibility for their choices personally, through surrogate decision makers, or through planning team consensus.
The state has procedures to promote individual and family preferences and selections for care and services. These are appropriately balanced with accepted standards of practice. This balance requires deference to the preferences and goals of the individual whenever possible. Procedures may include individual risk management planning (e.g., risk agreements or informed consent contracts). To ensure that family or individual decisions are honored an individual risk assessment tool is used to help provide a framework for supporting individuals to remain in their homes despite identified risk of health, safety and well-being. This tool helps the case manager, care advisor or the participant to think through risks and identify ways to minimize them. Risk and outcomes are identified to develop a risk plan and service plan to monitor and control the probability and/or effects of unfortunate events or to maximize the realization of opportunities for ongoing community living.

The individual risk assessment tool:
Ensures full understanding through:
• Written and Signed Statement to Negotiate Risks
• Process Balances of Autonomy & Safety
• Degree of Specialization of Service Plan
The tool identifies real or potential risks by:
• Fostering communication, discussing and setting expectations
• Describing service delivery plan
• Acknowledging participant's right to make choices involving risks
• Assigning responsibilities
This tool on an ongoing basis:
• Addresses changing risks over time;
• Evaluates how things are going;
• Adjusts the outcomes; and

• Provides Remediation.

The primary consideration underlying the provision of services and assistance for disabled and elderly adults is their desire to reside in a community setting. Enrollment and continuous participation in CAP/DA waiver may be denied based upon the inability of the program to ensure the health, safety, and well-being of the beneficiary despite the implementation of an individual risk agreement. Based on the evaluation of the risk agreement and the assessment of the beneficiary's medical, mental, psychosocial and physical condition and functional capabilities, conditions may warrant inability to participate in the waiver when the following considerations cannot be mitigated:
a. The beneficiary is considered to be at risk of health, safety and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a Personal Emergency Response System;
b. The beneficiary lacks the emotional, physical and protective support of a willing and capable caregiver who must provide adequate care to oversee required 24-hour hands-on support or supervision to ensure the health, safety, and well-being of the individual with debilitating medical and functional needs; or
c. The beneficiary's needs cannot be risk stratified and maintained by the system of services that is currently available to ensure the health, safety, and well-being.
d. The beneficiary's primary private residence is not reasonably considered safe to meet the health, safety and well-being in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the beneficiary's safety, and these issues cannot be resolved;
e. The beneficiary's residential environment would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager or care advisor; presents a physical or health threat due to the proven evidence of unlawful activity conducted in the primary private residence; threatening or physically or verbally abusive behavior by the beneficiary or family member exhibited on more than two incidences; physically and verbally abusive behavior or threatening language; or present of a health hazard due to pest infestation.
f. The beneficiary's continuous intrusive behavior impedes the safety of self and others by attempts of suicide, injurious to self or others, verbally abusive, destructive of physical environment, or repeated noncompliance of POC and written or verbal directives; or
g. The beneficiary's primary caregiver or responsible party continuously impedes the health, safety and well-being of the beneficiary by refusing to comply with the terms of the plan of care, refusal to sign a plan and other required documents of when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal) and refusal to keep the care manager or care advisor informed of changes in the status of the beneficiary.
h. 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 assessment or care plan.

The case manager or care advisor will review all critical incident reports to identify and address risk and to assist in preventing future instances of abuse, neglect and exploitation. Case managers will be required to report monthly on substantiations of abuse and neglect of all waiver participants to assure health, safety and well-being is maintained.

As another safety precaution and risk mitigation, each waiver beneficiary must have an emergency back-up plan with adequate formal and informal supports to meet the basic needs outlined in the CAP/DA assessment and plan of care (POC) to maintain their health, safety and well-being. 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 personal care aid or personal assistant is unavailable during regularly scheduled work hours and when the unpaid informal support is unavailable for the balance of the remaining planned services of the POC coverage period. The emergency back-up plan must also address emergency preparedness.

The emergency back-up plan is created by the 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.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

During the referral and basic eligibility process, the CWE provides the beneficiary with information about freedom of choice. This information informs of their right to choose institutional care or the waiver and the ability to select

any provider to provide their care as listed on the plan of care. When the beneficiary meets the basis criteria for waiver participation and is at the point to be assessed, a freedom of choice form is signed by the beneficiary to identify the agencies of choice.

Prior to the approval and initiation of waivers services, the information and check points the CWE will assure as safeguard include the signatures and filing of the following:
• The beneficiary/responsible party original freedom of choice document detailing their choice of providers and waiver services and steps the CWE/DMA will take to mitigate influence of providers.
• Documentation that lists all the known enrolled providers of Medicaid CAP/DA and regular Medicaid services working in or available to work in the county where the beneficiary/ responsible party resides.
• The beneficiary/responsible party choices of providers, in order of preference within categories, if there are multiple choices available.

In addition, the beneficiary/responsible party also receives information informing them that:
• All providers on the list have met specific DMA criteria for enrollment to provide the particular service.
• The lead agency can be requested by the beneficiary responsible party to explore the possibility that a provider not listed, yet desired by the beneficiary/ responsible party may, in fact, be enrolled with DMA.
• A statement to inform the beneficiary/ responsible party that a provider not currently enrolled with DMA would need to meet specific criteria to be enrolled with DMA before the provider could be authorized to provide service and be reimbursed by Medicaid for services rendered.
• The beneficiary/ responsible party will be informed how to change agencies or lodge a complaint if they are unhappy about the care provided or the person rendering the care.

The document will inform the beneficiary/responsible party how to contact the CAP/DA consultant in DMA assigned to their county if their problems are not resolved at the local level or by CWE.
Each selected Medicaid provider is evaluated to assure that the basis requirement to be a Medicaid provider is met.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The Medicaid agency will subject the approval of service plans when a CAP/DA lead agency and the CWE has two consecutive quarters with less than 100% compliance of service plan development as per waiver policies and procedures. Safeguards DMA has implemented for accurate development of service plan include:

The process for review and approval/authorization of Person Centered Plans is a primary function of the CAP/DA lead agency and the CWE. Plans and accompanying documentation are reviewed by the CWE monthly to ensure that all waiver requirements are met and that services are appropriate in type and frequency to meet the needs of the participant. A quarterly report is provided to DMA for review of waiver compliance.

The CWE conducts quality assurance reviews that include a review of the Person Centered Plan and service documentation for each waiver participant. The reviewer reviews the current service request form, the assessment and the approved Person Centered Plan, agency service documentation, and paid claims to insure that services are appropriate to the needs of the participant, are provided appropriately, are billed appropriate, and that the participant's health, safety and well being continue to be assured.

Annually the DMA's Accountability Team conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of enrolled providers. This review includes monitoring of requirements that address staff qualifications, service authorizations, Person Centered Plans, service documentation, and billing protocol.

For Medicaid audit purposes, a valid plan must:
1. Have the required signatures on or before services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person’s needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and

7. Include a 24 hour schedule of coverage, if warranted.

The e-CAP system reviews 100% of cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from consistent failure to complete the care planning assessment tool accurately.

The CWE will conduct the e-CAP reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, or different LOC and appeals on a monthly basis to assure accuracy and 100% compliance of the wavier QIS. The Division of Medical Assistance will review this information quarterly to assure compliance of waiver assurances.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

CWE/e-CAP

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

Monitoring and follow-up include activities and contacts with beneficiary, responsible party, and service providers who are necessary to ensure the care plan is effectively implemented and adequately addresses the needs of the Beneficiary.
The CWE ensures that waiver services managed by the case manager/care advisor are furnished in accordance with the plan of care by maintaining and providing a quality framework of QAQI reports regularly. Monthly reports and alerts are provided to the case manager/care advisor to assure appropriate implementation of the service plan as per policy. The case manager/care advisor monitors the waiver beneficiary monthly and quarterly by telephone and/or in the home to assure the provision of waiver services, assess a change in status, and every 90-day observe the provision of services.

(b) & (c) Method and Frequency of Oversight/Monitoring:
The CWE provides monthly oversight and monitoring of all documents submitted via the e-cap system. QAQI

reports are run monthly to identify waiver corrective actions and remediation. The CWE and the Waiver Program Consultants from the State Medicaid agency conduct annual desktop and on-site program reviews and assist/advise local Lead Agencies in the operation of the waiver program as needed. Performance audits occur every 12 months.

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant**

The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

(a)The State has established standards for all types of providers that furnish services under the waiver.

(b)The State requires that applicable state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements will be met on the date that the services are furnished.

(c)The State assures that all facilities covered by Section 1616(e) of the Social Security Act, in which Home and Community-Based Services will be provided, are in compliance with applicable State standards for board and care facilities. Participants are provided the freedom of choice amongst providers and are educated on all due process rights. DMA and CWE consultants provide technical assistance and review this information on request and/or at program site visits.

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

i. Sub-Assurances:

a. *Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of participants whose service plans have adequate and appropriate strategies to address their health and safety risks Numerator: Number of participants whose service plans have adequate and appropriate strategies to address their health and safety risks Denominator: Total number of service plans

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

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

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

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

☑ **Other** Specify: CWE, e-CAP	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: CWE, e-Cap	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM: Number and percent of participants' service plans that address personal goals Numerator: Number of participant's service plans that address personal goals Denominator: Total number of service plans

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

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CWE, e-CAP	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of participants' service plans that are adequate and appropriate to the waiver participant's needs, as identified in the assessment.
Numerator: Number of participants' service plans that are adequate and appropriate to the waiver participant's needs, as identified in the assessment
Denominator: Total number of service plans

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

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

☑ **Other** Specify: CWE, e-CAP	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CWE,e-CAP	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of participants' service plan that were signed by the waiver participant/responsible party, case manager, and approved by the local approval authority. Numerator: Number of participants' service plan that were signed by the waiver/responsible party, case manger and approved by the local approval authority Denominator: Total number of service plans

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

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

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

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

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of service plans that are updated on or by the person's annual renewal date Numerator: Number of service plans updated on or by the person's annual renewal date Denominator: Total number of service plans

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of waiver participants whose service plans were revised, as needed, to address changing needs Numerator: Number of waiver participants whose service plans were revised, as needed, to address changing needs Denominator: Number of participants reviewed who needed a revision to their service plan to address changing need

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

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: CWE, e-CAP	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of participants who received services in the type, amount, frequency and duration specified in the service plan. Numerator: Number of participants who received services in the type, amount, frequency and duration specified in the service Denominator: Total number of service plans

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

☑ **Other** Specify: CWE, e-CAP	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

collection/generation *(check each that applies):*		
☑ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CWE, e-CAP	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.***

Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of wavier participants whose records contained a completed and signed POC that specifies choice was offered between institutional care and waiver services Numerator: wavier participants whose records contained a completed and signed POC that specifies choice was offered between institutional care and waiver services Denominator: Total number of participant's records

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

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

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
PM: Number and percent of waiver participants whose records contain a completed and signed Freedom of Choice form that specifies choice offered among waiver services and providers Numerator:waiver participants whose records contain a completed and signed Freedom of Choice form that specifies choice offered among waiver services and providers Denominator:Totalnumberof participant's records

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

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

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

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
SAa:
All assessment data information entered in e-CAP automatically corresponds to critical components of the service plan. The assessment will identify plan of care needs and auto-populate the POC to match needs as identified in the assessment. Individual service needs are triggered by various assessment questions/answer combinations. The POC template in turn will require each identified service need to be addressed in terms of waiver services or other means. The e-CAP system will not allow a POC to be completed until there is a plan for each identified service need.
Each approved CAP/DA beneficiary is provided a "Welcome Letter" within 30 days of the service plan. The contents in the welcome letter will address this performance measure as listed:
"While participating in the CAP/DA waiver, you are entitled to receive services that are assessed to meet your care needs as approved within an approved cost limit. These services can include: adult day health, personal care services, home accessibility and adaptation, respite services, home delivered meals, emergency response services, reusable incontinence supplies, liners, medication box, participant goods and services, training/education and consultative services, assistive technology, oral nutritional supplements and case management. In addition, you are allowed the freedom to choose any provider within your community to provide these services and to assist you with your care needs. What this means is that you have the freedom to select any Medicaid approved agency in your community to provide the services listed above."

Provisions are made for identification of personal goals in the assessment. These are automatically transferred to the POC template to ensure an activity/task plan for each goal is developed. The e-CAP system will not allow a POC to be completed until there is a plan for each identified service need.
The e-CAP system allows the CWE and State Medicaid Agency to review an individual service plan in order to evaluate if the selected services and proposed service interventions are adequate (proposed hours, schedule and skilled level). The service plan can also be reviewed by type and can be reviewed for adequacy and appropriateness by structured query reports.
SAb:
In the e-CAP system, the signed service plan is uploaded as a supporting document and integrated into the beneficiary's record. The service plan is not considered complete until the signature form is uploaded to e-CAP.
SAc:
The e-CAP system tracks all Continued Need Review and reassessments. The e-CAP system provides monthly alerts to all case managers of when these annual reassessments are due.
The e-CAP system captures all assessment information and automatically generates a service plan revision recommendation.

SAd:
The e-CAP system has a functionality to prior approve all services to providers as identified in the amount, frequency and duration specified on the service plan. A selected provider will receive a service authorization with the amount, frequency and duration of the service. NC Medicaid fiscal agent (CSC/NCTracks) will only reimburse the prior approved limits and deny any claims over the prior approved limits.
SA-e:
In the e-CAP system, upon the completed service request form and approval of basic LOC determination, the beneficiary is required to sign a document that specifies choice was offered between institutional care and wavier services. After the completion of the assessment and service plan, the beneficiary signs the service plan acknowledging choice to participate in the waiver program. The signed service plan is uploaded as a supporting document and integrated into the beneficiary's record. The record is not considered complete until the signature form is uploaded.
Each approved CAP/DA beneficiary is provided a "Welcome Letter" within 30 days of the completion of the service plan. The contents of the welcome letter that address freedom of choice are listed as:

"You also have the freedom to select the CAP/DA program you would like to provide your care needs. The CAP/DA program has two service options: CAP/DA and CAP/Choice. CAP/DA is the traditional program under the CAP/DA wavier. In this program you are assigned a case manager who assists you with assessing and identifying the services that you need to keep you safe in your home. Under the CAP/Choice program, you are in charge of making your own decisions that best meet your health care needs. This program is called consumer-direction. This program allows you to select and hire your own workers, determine how much to pay your worker and identify the tasks you would like your worker to do to meet your health care needs. Under the CAP/Choice program, you are assigned a Care Advisor who helps guide you through your decisions."

The e-CAP system has a functionality to assure in the service plan development stage a Freedom of Choice form is completed and uploaded to the beneficiary's electronic file. The record is not considered complete until the signature form is uploaded.
In addition, CAP/DA participants sign a Freedom of Choice form that verifies that they had a choice among waiver services and providers available through NC Medicaid list of providers authorized to provide that service. The Freedom of Choice form is updated annually, or as warranted by need.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
SA a:
Upon discovery of non-compliance, CWE notifies the responsible Lead Agency. The Lead Agency develops an action plan and submits to CWE/DMA within 30 days. CWE/DMA reviews the action plan, makes a final decision, and issue directives for the Lead Agency to follow. Repeated findings of non-compliance by a Lead Agency may result in DMA issuing a corrective action plan, staff training and/or recoupment of payment.
If there are repeated and consistent deviations, and the service is authorized on the POC, the case manager or care advisor must review with the beneficiary to discuss a possible change in providers or revision to the service plan.
If the beneficiary's needs are consistent with the deviated service(s), a POC revision must be completed.
Each county lead agency has access to the QI reports and can freely contacts CWE or DMA for technical assistant or clarification of the report and to verify the accuracy of the report.

SA b:
Upon discovery of non-compliance, CWE notifies the responsible Lead Agency. The Lead Agency develops an action plan and submits to CWE/DMA within 30 days. CWE/DMA reviews the action plan, makes a final decision, and issues directives for the Lead Agency to follow. Repeated findings of non-compliance by a Lead Agency may result in DMA issuing a corrective action plan, staff training and/or recoupment of Medicaid payment.

SA c:
When it is discovered that a service plan was not completed timely, CWE/DMA contacts the responsible Lead Agency and issues a directive providing technical guidance to the agency. Repeated findings of non-compliance by a Lead Agency may result in DMA issuing a corrective action plan, staff training and/or recoupment of payment.
Upon discovery of non-compliance, CWE notifies the responsible Lead Agency. The Lead Agency develops an action plan to revise/update the individual's service plan to meet the changing needs to the individual and submits to CWE/DMA within 30 days. The CWE/DMA reviews the action plan, makes a final decision, and issues directives for the Lead Agency to follow. Repeated findings of non-compliance by a Lead Agency may result in DMA issuing a corrective action plan, staff training and/or recoupment of Medicaid payment.

SAe:
Upon discovery of non-compliance, CWE notifies the responsible Lead Agency to ask for an office visit to evaluate the circumstances that contributed to the findings of non-compliance. The Lead Agency develops an action plan to revise/update the individual's plan of care/contract as necessary and submits to CWE/DMA within 30 days. The CWE/DMA reviews the action plan, makes a final decision, and issues directives for the Lead Agency to follow. Repeated findings of non-compliance by a Lead Agency may result in DMA issuing a corrective action plan, staff training and/or recoupment of Medicaid payment.
Upon discovery of non-compliance, CWE notifies the responsible Lead Agency. The Lead Agency develops an action plan and obtains the waiver participant's signature within 5 days of notification by DMA. The

CWE/DMA reviews the action plan, makes a final decision, and issues directives for the Lead Agency to follow. Repeated findings of non-compliance by a Lead Agency may result in DMA issuing a corrective action plan, staff training and/or recoupment of Medicaid payment.

The State will use quarterly QI monitoring reports and correction action plans to document these remediation issues.

ii. Remediation Data Aggregation

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

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

c. Timelines

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- (●) **Yes. The State requests that this waiver be considered for Independence Plus designation.**
- ( ) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. **Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

This waiver provides participant direction opportunities. The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services. Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant.
Description of Participant Direction: (a) Under the Choice Option, participants will be able to:
• Choose (hire) the personal assistant who will provide their care;
• Train, supervise, and evaluate the worker;
• Negotiate the rate of pay and other benefits;
• Release the worker should this become necessary;
• Select individual providers and direct reimbursement for several other waiver services (identified previously in Appendix C-1/C-3); and,
• Engage in a cooperative working arrangement with a financial manager who will pay the beneficiary's worker, handle federal/state taxes and other payroll or benefits related to the employment of the worker, and reimburse other service providers under the direction of the participant.
(b)The program affords increased participant choice and independence in meeting home care needs and increasing satisfaction with long term supports. To be eligible for CAP/Choice an individual must:
• Meet basic criteria to be assessed for HCBS waiver participation e.g., at risk of institutional care;
• Be eligible for Medicaid; and
• Understand the rights and responsibilities of directing one's own plan of care and be willing and able to self-direct or select a representative who is willing and capable of assuming this responsibility
(c) DMA, Local Lead Agencies, Financial Management Agencies, Waiver Service Providers and other providers interact with and participate in the participant's plan of care.
Availability of Participant Direction by Type of Living Arrangement: Participant direction opportunities are available to participants who live in their own private residence or the home of a family member

The Lead Agency provides care advisement to the beneficiary on a monthly and quarterly basis. The care advisor is a specialized case manager from a CAP/DA local lead agency with an understanding of consumer-directed care. The care advisor focuses on empowering consumers to define, and direct their 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, monitoring/follow-up) however these functions are done under the guidance and direction of the participant-directed beneficiary.

The FMS provides financial services to the beneficiary. Financial management services are provided to ensure that participant-directed funds outlined in individual plans of care are managed and distributed as intended. The 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.

The CWE provides education and resource materials about participant-directed services.

An In-Home Aide agency provides non-institutional respite. 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.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☑ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☐ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**
- ☐ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ○ **The waiver is designed to afford every participant (or the participants representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ◉ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

The CAP/DA waiver has two options, CAP/DA (traditional option) and CAP/Choice (participant-directed option). A waiver beneficiary can select either option during the initial or annual assessment. An approved waiver participant can also elect participant-directed during any time of his approved waiver coverage. To be eligible for participant-directed care, a waiver participant must meet all of the following criteria:
1. Understands the rights and responsibilities of directing one's own care;
2. Willing and capable to assume the responsibilities for beneficiary (self)-directed care, or selects a representative who is willing and capable to assume the responsibilities to direct the beneficiary's care; and
3. Complete a self-assessment questionnaire to determine ability to direct care or identify training opportunities to build competencies to aid in self-direction.

At any given time, a waiver participant directing his own care can request to return to the traditional option of waiver participation. The care advisor will work with the participant for a smooth transition to the traditional option.

DMA will impose a careful review of appropriateness to participant in participant-directed care when:
1. Decline in mental or physical health and/or loss of informal support that would affect the ability of the participant to self-direct. If this occurs, Care Advisors will reassess the participant's situation to determine whether the participant-directed option continues to be appropriate for the individual. Personal Care Assistants and other direct care workers, who are in touch with the participant on a daily or regular basis, are instructed to report problems in these areas to the care advisor;
2. Consistent misappropriation of self-directed services;
3. Criminal involvement; and
4. Continuous violation of the Participant-directed Bill of Rights, signed by the waiver participant.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. **Information Furnished to Participant.** Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

Information Furnished to Participant:

The CAP/DA Lead Agency is responsible for providing individuals/primary caregivers sufficient information to assure informed decision-making and understanding of the participant-directed services option and of the traditional provider-managed service delivery option. The information includes the responsibilities and choices individuals can make with the election of the participant-directed service option. The Lead Agency case managers review the participant-directed services option at program enrollment, at least annually, or upon request.

Information provided orally and in writing to the individual and the legally authorized representative by the CWE and Lead Agency case manager includes:
1. An overview of the participant-directed services option;
2. Explanation of responsibilities of the individual or individual's legally authorized representative and the consumer directed services agency in the participant-directed services option;
3. Explanation of benefits and risks of participating in the consumer directed services option;
4. Self-assessment for participation in the consumer directed services option;
5. Explanation of required minimum qualifications of service providers through the participant-directed services option; and
6. Explanation of employee/employer relationships that prohibit employment under the participant-directed services option.

The CWE will monitor the compliance of all self-assessment tools to assure appropriateness of directing care.

The Care advisors will inform participants and families of the option to self direct during the assessment and person centered planning process. Participants and/or family members will be informed of all of the roles and responsibilities associated with a self directed model, explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual/representative to modify their individual budget. The care advisor will also provide:
• Assessment of individual risk;
• Assessment of health, safety, and well being of the person as well as the continued appropriateness of services and supports;
• Identification of the need for a representative for the participate who desires to direct his/her own services and supports, and assure that the representative meets established criteria to assist the participant to self-direct their supports/services;
• Assurance that the Person Centered Plan identifies how emergency back-up services will be furnished for workers employed by the individual, and authorizes the provision of on-call emergency back-up services;
• Reorganization and report critical incidents; and
• Assistance with grievances and appeals.

The CWE will give each HCBS waiver applicant a choice between the traditional program and the new participant-directed model. In making this decision a participant/representative will be educated on the benefits and responsibilities of the participant-directed model.
The care advisor provides orientation and training on participant-directed care to the participant and/or participant's representative or family members as appropriate, prior to implementation of participant-directed services. The advisor monitors the provision of care and expenditures and maintains contact with the participant to assure that the needed care is being provided on a continuous basis. Care Advisors will participate in training and have access to materials with a participant-directed focus.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. **Participant Direction by a Representative.** Specify the State's policy concerning the direction of waiver services by a representative *(select one):*

- ○ **The State does not provide for the direction of waiver services by a representative.**
- ◉ **The State provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

- ☑ **Waiver services may be directed by a legal representative of the participant.**
- ☑ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**

Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

The representative may NOT also be the paid caregiver (i.e. personal assistant) for the participant. The representative cannot be paid for the service and must meet the following requirements:
• demonstrate knowledge and understanding of the participant's needs and preferences;
• agree to a predetermined level of contact with the participant;
• be willing to comply with program requirements;
• be at least 18 years of age; and,
• be approved by the participant to act in this capacity.
The Care Advisor plays a significant role in identifying the need for a representative and assuring that the representative meets the criteria outlined above. Additionally, the care advisor, as part of ongoing monitoring activities, assures that the representative continues to act in the best interest of the participant.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-1/C-3.

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Specialized Medical Equipment and Supplies-Medication Dispensing Boxes	☑	☑
Participant Goods and Services	☑	☑
Community Transition Services	☑	☑
Home Accessibility and Adaptation	☑	☑
Specialized Medical Equipment and Supplies- Reusable Incontinence supplies	☑	☑
Specialized Medical Equipment and Supplies-Disposable liners	☑	☑
Assistive Technology	☑	☑

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Training/Education and Consultative Services	☑	☑
Specialized Medical Equipment and Supplies- Nutritional Supplements	☑	☑
Financial Management Services	☑	☑
Non-Institutional Respite Services	☑	☑
Personal Assistance Services	☑	☑

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i)*.

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**
☑ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C1/C3**

The waiver service entitled:
Financial Management Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

The DHHS may elect to procure an FMS vendor to provide FMS service as an administrative activity to provide consistency among CAP/DA lead agency and other state agencies within DHHS. The administrative activities provided by an FMS vendor will not duplicate the FMS services covered as a waiver service and will not be used in conjunction of each other.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

Payment for FMS- Payment for FMS Services is paid on a Per Member Per Month arrangement under direct contract with the Department of Health and Human Services.

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

☑ **Assists participant in verifying support worker citizenship status**

- [x] **Collects and processes timesheets of support workers**
- [x] **Processes payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- [x] **Other**

Specify:

The FMS provider also provides training to the participant employer on proper hiring practices and technical assistance as needed.

Supports furnished when the participant exercises budget authority:

- [x] **Maintains a separate account for each participant's participant-directed budget**
- [x] **Tracks and reports participant funds, disbursements and the balance of participant funds**
- [x] **Processes and pays invoices for goods and services approved in the service plan**
- [x] **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- [x] **Other services and supports**

Specify:

Monthly reports of expenditures and the status of the participant budget are available to the participant through the Care Advisor.

Additional functions/activities:

- [ ] **Executes and holds Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- [x] **Receives and disburses funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- [x] **Provides other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget**
- [ ] **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The DMA will contact with a vendor to perform the duties of FMS. The FMS provider must provide reports that include the elements listed below:
a) provide a detailed payroll budget utilization report per participant at least monthly that includes:
• Vendor name
• Vendor number
• payroll date: From ___ To ___
• participant's total payroll expenditure for pay period
participant name
• participant's authorization #
• participant identification #
• service code(s)
• budget code
• approved personal assistant hours per week
• level of care identification
• name of PAS office serving the participant,
• care advisor identification
• caseload code

• authorization date: From___ To____ for participant
• annual authorization $ amount for participant
• authorization budget balance carried forward for participant
• amount remaining on annual authorization for participant
• goods and services annual authorized amount for participant
• goods and services budget balance carried forward for participant
• goods and services expenditure amount for pay period for participant
• WCI policy date: From_____ To_____ for participant
• WCI annual policy premium rate for participant
• WCI bi-weekly amount for participant
• name, number of hours worked and rate of pay for each participant's personal assistant
• amount of gross wage, FICA, FUTA and SUTA deductions, and net wage for each assistant
• total hours, gross wage, FICA, FUTA & SUTA deductions, and net wage for all of the participant's assistants
b) FMS must provide a detailed cumulative bi-weekly summary report of all participants per PAS office
This report must include:
• name of PAS office
• total annual payroll budget per PAS office
• payroll budget balance carried forward
• total payroll expenditures for the pay period
• remaining payroll budget
• total annual budget for purchase of goods and services
• goods and services budget balance carried forward
• total expenditures for purchase of goods and services, per pay period
• remaining budget for goods and services
• total FI processing fee for pay period
• total WCI expenditures per pay period
These reports are reviewed for accuracy and compliance with FMS services by Contracted Waiver Entity and local lead agency staff. DMA will review FMS invoices monthly to assure accuracy of scope of work.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. **Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☑ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

The participant directed waiver managed by the State is provided through case management activities. Care advisors will inform participants and families of the option to self-direct during the assessment and person centered planning process. Participants and/or family members will be informed of all of the roles and responsibilities associated with a self directed model.
The case management activities will include:
• Explanation of the methodology for resource allocation, total dollar value of the allocation and mechanisms available to the individual/representative to modify their individual budget.
• Assessments of individual risks.
• Assessment of health, safety, and well being of the person as well as the continued appropriateness of services and supports.
• Identification of the need for a representative for the participant who desires to direct his/her own services and supports, and assure that the representative meets established criteria to assist the participant to self-direct their supports/services
• Assurance that the Person Centered Plan identifies how emergency back-up services will be furnished for workers employed by the individual, and authorizes the provision of on-call emergency back-up services.

• Reorganization and report critical incidents
• Assistance with grievances and appeals
• Assist and support the participant/family in transitioning to the provider directed model of the Supports waiver if the participant/family decides that they no longer desire to continue to self direct their supports/services or for those participants who have been unable to maintain budget authority.
• Notification of any concerns with implementation and on-going utilization of the self-direction option.

This waiver will provide financial management services as a waiver service for a participant choosing to direct their care. This service will be included in the waiver benefit packet as a fee-for-service item on the Medicaid Fee Schedule. Although financial management services will be included in the waiver as a service, the state Medicaid agency will procure a contract with a financial intermediary for financial management services for the purpose of consistency and efficiency across all CAP/DA Lead Agencies. Within the scope of the FMS contractor, the contractor will be mandated to provide administrative financial management services during initial enrollment and monthly thereafter. The waiver service in the benefit package and the administrative activity service provided by the FMS aren't duplicative services, nor will these two services be utilized simultaneously.
During the initial enrollment, the FMS will be responsible for providing the following:
• Information, training and outreach;
• Information in completing and filing IRS tax forms;
• What are the roles and responsibilities of FI?;
• What are the roles and responsibilities of the waiver participant?;
• conducting criminal background checks and explaining the criminal background that is identified during the check;
• Processing referral applications;
• How applicants must complete the employment application;
• How to submit Medicaid personal care claims for reimbursement;
• An explanation of Bill of Rights;
• How to contact a representative of the FI contractor; and
• Access to customer services to submit claims and guidance for technical problems or concerns.

On an ongoing monthly basis, the FMS is responsible for the following:
• Filing Medicaid claims for reimbursement of personal care claims;
• Managing and paying payroll;
• Arranging to reimburse hired assistants when payroll is missed;
• Trouble shooting concerns or problems;
• Conducting criminal background checks on newly hired personal care assistants;
• Maintaining monthly contact with the care advisor; and
• Assuring accessibility to customer service for waiver participants to submit claims and seek guidance for technical problems or concerns.
The CAP/DA Lead Agency in conjunction with the CWE is responsible for assuring that the assessment for waiver eligibility and for level of need is complete, assuring the identified budget amount does not exceed the monthly budget limits, informing the individual/family of their budget, reviewing and approving the service plan, and assuring that health and safety factors have been considered.

☑ **Waiver Service Coverage.** Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Specialized Medical Equipment and Supplies-Medication Dispensing Boxes	☑
Participant Goods and Services	☑
Community Transition Services	☑
Institutional Respite Services	☑
Home Accessibility and Adaptation	☑
Specialized Medical Equipment and Supplies- Reusable Incontinence supplies	☑
Specialized Medical Equipment and Supplies-Disposable liners	☑

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Assistive Technology	☑
Care Advisor	☑
Training/Education and Consultative Services	☑
Specialized Medical Equipment and Supplies- Nutritional Supplements	☑
Financial Management Services	☑
Adult Day Health	☑
Meal Preparation and Delivery	☑
Non-Institutional Respite Services	☑
Personal Care Aide	☑
Personal Emergency Response Services	☑
Case Management	☑
Personal Assistance Services	☑

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one)*.

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Waiver participants choosing participant-directed care are provided information on opportunities to access independent advocacy. This information is provided during screening and referral for support planning and during the enrollment process for ongoing support. Independent Advocacy is provided by multiple disabled and aging advocacy programs. Through the Community Resource Connection program sponsored by the Division of Aging and Adult Services, individuals are provided option counseling, training and technical assistance in how to live independently and how to arrange and access resources in their community. The Division of Vocational Rehabilitation Services provides education, information and training in self-direction and how to efficiently arrange and access services in community. The Department of Health and Human Services (DHHS) has a Customer Service Center to provide information, referrals, education and outreach to individuals choosing to direct their own care. The DHHS Customer Service Center can be reached by dialing 1-800-662-7030.
All waiver participants as well as disabled and aged Medicaid beneficiaries are eligible to receive services from Division of Aging and Adults Services, DHHS Customer Service Center and the Division of Vocational Rehabilitation Services.
The DHHS Customer Service Center is available 24-hours, 7-days per week and includes interpretive services for non-English speaking callers. The Division of Aging and Adults Services as well as Division of Vocational

Rehabilitation Services are available Monday-Friday from 8am -5pm for direct assistance in person, in writing or by telephone. Offices for option counseling sponsored by DAAS are available throughout North Carolina and accommodate walk-ins. There is no fee for accessing and using these advocacy programs.

Waiver participants seeking legal guidance are able to access services from NC Legal Aide Services.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. **Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

A Care advisor works with the participant to transfer to regular CAP/DA waiver services or other state plan service (s) and monitors health and safety until the new service is fully implemented.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provide-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

Any time utilization of funds exceeds planned expenditure levels for participant-directed care during the lifetime of the approved waiver, the state Medicaid agency will notify the Financial Manager, the individual, legally responsible person, and the case manager. If involuntary termination is imposed, the state Medicaid agency will assure a smooth transition to the traditional option of the waiver. The beneficiary will be given the choice to transition to the traditional program of the waiver or to another comparable service in the community.

The State will coordinate with the CWE, Lead Agency and FMS to identify a timeline for the transition. Each waiver participant electing to direct their own care will receive written guidance on the involuntary termination of the participant-directed program and the plans of transition. Prior to and during the transition, each participant will continue to receive the services listed in their service plan. Each beneficiary will be given an opportunity to select enrolled Medicaid providers to meet their identified needs. The hired care givers under participant-directed care will be provided information by the FMS on the transition schedule and how this transition will impact their employment.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. **Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		1379
Year 2		1408
Year 3		1438
Year 4		1468

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5		1500

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. **Participant - Employer Authority** *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. **Participant Employer Status.** Specify the participant's employer status under the waiver. *Select one or both*:

☐ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

☑ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. **Participant Decision Making Authority.** The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☑ **Recruit staff**
☑ **Refer staff to agency for hiring (co-employer)**
☑ **Select staff from worker registry**
☑ **Hire staff common law employer**
☑ **Verify staff qualifications**
☑ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Reimbursed to financial management entity by Medicaid.

☑ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**
☑ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**
☑ **Determine staff wages and benefits subject to State limits**
☑ **Schedule staff**
☑ **Orient and instruct staff in duties**
☑ **Supervise staff**
☑ **Evaluate staff performance**
☑ **Verify time worked by staff and approve time sheets**
☑ **Discharge staff (common law employer)**
☑ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

- ☑ **Reallocate funds among services included in the budget**
- ☑ **Determine the amount paid for services within the State's established limits**
- ☑ **Substitute service providers**
- ☑ **Schedule the provision of services**
- ☑ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**
- ☑ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**
- ☑ **Identify service providers and refer for provider enrollment**
- ☑ **Authorize payment for waiver goods and services**
- ☑ **Review and approve provider invoices for services rendered**
- ☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Methodology for Calculation of Individual/Participant-Directed Budget:
Budgets will be calculated based on the methodology currently in place for the CAP/DA waiver. The process involves an assessment to identify needs; development of goals based on identified needs; and agreement on the type and amount of services needed to meet the goals. The estimated monthly cost of each waiver service is calculated. The cost of all services cannot exceed the average per capita cost to Medicaid of nursing facility care. Additionally, there is a monthly individual budget limit, designated by the acuity of care needs, which cannot be exceeded.
It is recognized that actual utilization of services authorized does not equate to 100% - for example, participants are hospitalized, aides miss visits and substitutes are not available. (*NC DMA requires a minimum of monthly monitoring of all waiver services, including the participant's emergency back-up plan. If it is determined the participant's needs are not being met the plan of care is modified to address these needs. New supports and services are identified and put in place to meet these needs. If these needs continue

to go unmet or the participant's health and well-being are at risk other programs may be identified that better serve the participant.) Based on findings of the National Cash & Counseling Demonstration, at least 10 to 20% of personal care services authorized in the traditional delivery system is not used. In addition, many of the indirect costs which are built into the payment rates such as professional supervision and training of workers, office space, equipment, supplies, etc., are not applicable to the participant-directed model. Therefore, the maximum hourly rate for personal assistant services will be 10 to 20 percent lower than the current Medicaid personal care rate. Individuals may negotiate personal assistant payment rates lower than the maximum, thereby enabling them to set aside a portion of their budget for other services such as participant-designated goods and services, which would increase independence.
Participants will have considerable flexibility in using funds designated as participant-directed. They will be able to substitute services and/or reschedule services within the budget without agency approval in certain cases.
The methodology will be explained to the participant/representative by the care advisor. The care advisor will point out both the added responsibilities if this model is selected and its benefits. The Individual/Participant-Directed Budget will be re-determined at least annually and more frequently depending on changes in the participant's situation. The methodology will be published in the operations manual for this program. All Medicaid policy and program manuals are available for public inspection.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The budgetary limits are set at three levels: high (skilled), medium (intermediate) and low. A completed assessment identifies the acuity level of each beneficiary and automatically assigns the level of care and the monthly budget limits. A change to the participant's status may warrant a change in the level of care, thus changing the maximum monthly budgetary limit. The beneficiary, the care advisors, physician or provider agency can request a change in status assessment to identify an adjustment in the budget. Medicaid beneficiaries or their personal representatives have the right to appeal adverse decisions of the State Medicaid agency and receive a fair hearing pursuant to the Social Security Act, 42 C.F.R. 431.200 et seq. and N.C.G.S. §108A-70.9. If a service is reduced, terminated or denied, a beneficiary has the right to a hearing. The care advisor will provide the beneficiary a trackable adverse notice of the decision to reduce or deny their request for an adjustment. This adverse notice will cite the reason for the denial or reduction, provide policy citations and provide guidance on how to file an appeal to this adverse decision. The beneficiary will have 10-calendar days to file the appeal to allow maintenance of services until the appeal is resolved. The beneficiary has a total of 30-calendar days to request an appeal to assure maintenance of services is activated on the date of the request. An unbiased second party mediates the adverse decision based on the facts of the case and the information provided by the beneficiary. If the adverse decision cannot be resolved in mediation, the beneficiary is entitled to a hearing in front of an Administrative Law Judge (ALJ). The beneficiary or the initiator of the adverse decision must adhere to the final decision of the ALJ.

The participant must be informed of the amount of the individual budget during and after the service plan development process. Participants may inquire about the balance of their account throughout waiver enrollment from his/her care advisor in addition to an annual evaluation. The participant acknowledges this responsibility by signing his/her plan of care.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Participants have the authority to modify the timing of service delivery (ex. personal assistant hours). Otherwise, modifications to the participant-directed budget must be preceded by a change in the service plan after discussion with the care advisor.
Although the participant can exercise budget flexibility, a maximum hourly wage amount is imposed by DMA to assure cost limits of the personal budget. However, the maximum wage rate can be contested and a final decision will be made by DMA.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. **Expenditure Safeguards.** Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

At the local level, plans of care and service provision will be continually monitored by the Care Advisor, the contracted FMS and the CWE are to see that needs are met and funds are utilized according to program criteria. If problems in these areas are identified, the Care Advisor will work with the participant to resolve them. If the problem is not resolved, the care advisor and Local Lead Agency will consult with DMA Program Consultants prior to taking any adverse action towards a participant.
Also, post-approval and post-payment reviews are conducted by CWE, FMS contractor, PI and fiscal contractor as well as DMA consultants.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice (s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The following describes the process for informing eligible individuals of their right to request a fair hearing under 42 CFR Part 431, Subpart E: at 42 CFR Part 431, Subpart EA

Waiver participation and services are not covered by Medicaid for any one of the following:
a. The Community Alternatives Program (CAP) indicator code has not been entered or has been removed from eligibility information system (EIS);
b. The HCBS Service Request Form is incomplete or has been denied;
c. The required annual LOC determination was not approved;
d. An assessment of medical and functional needs has not been completed by an RN or social worker to determine risk of institutionalization, as defined by DMA;
e. 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 into 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;
f. 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);
g. The beneficiary resides in an unsafe home environment placing the eligible beneficiary's health, safety and well-being at risk, as defined by DMA;
h. 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, as defined by DMA; or
i. The CAP/DA case manager or CAP/Choice care advisor has been unable to establish contact for the provision of care with the beneficiary or his or her responsible party for more than 60-calendar days despite more than two verbal and written attempts;
j. The beneficiary Medicaid eligibility is terminated;
k. The beneficiary is in a Medicaid sanction period;
l. The beneficiary's Medicaid coverage is in deductible status; or
m. The beneficiary does not reside in a primary private residence as defined by DMA;

Medicaid shall not cover CAP/Choice participation and services for any one of the above items or following:
a. The beneficiary is not willing or capable to assume the responsibilities of participant-directed care and does not have an approved representative who is willing and capable to assume the responsibilities to direct the beneficiary's care;
b. The beneficiary does not have an emergency back-up plan with adequate social support to meet the basic needs outlined in the CAP/Choice assessment to maintain his or her health, safety and well-being; or
c. The beneficiary demonstrates a continued inability or unwillingness to adhere to the rights and responsibilities of the CAP/Choice program as outlined in the "Beneficiary Rights and Responsibilities" form, and signed during the admission process.

An approved waiver participant will be granted a fair hearing for any waiver service that is denied, reduced, terminated or suspended. DMA will waive the opportunity for a fair hearing when:
The Community Alternatives Program (CAP) indicator code has not been entered or has been removed from eligibility information system (EIS) which indicates the individual was not approved or is no longer approved for waiver participation;
The HCBS Service Request Form is incomplete or has been denied;
The beneficiary Medicaid eligibility is terminated (a hearing will be offered to the participant by the Medicaid eligibility department);
The beneficiary is in a Medicaid sanction period; and
The beneficiary's Medicaid coverage is in deductible status.

The CWE and the Lead Agency are primarily responsible to educate the beneficiary about their right to appeal an adverse decision. When an adverse decision is made, the Lead Agency will provide the beneficiary a trackable adverse notice of the decision to deny a requested provider. This adverse notice will cite the reason for the denial, provide policy citations and provide guidance on how to file an appeal to this adverse decision. The beneficiary will have 10-calendar days to file the appeal to allow maintenance of services until the appeal is resolved. The beneficiary has a total of 30- calendar days to request an appeal to assure maintenance of services is activated on the date of the request. An unbiased second party mediates the adverse decision based on the facts of the case and the information provided by the beneficiary. If the adverse decision cannot be resolved in mediation, the beneficiary is entitled to a hearing in front of Administrative Law Judge (ALJ). The beneficiary or the initiator of the adverse decision must adhere to the final decision of the ALJ. The beneficiary or the initiator of the adverse decision must adhere to the final decision of the ALJ.

The case advisor will generate the adverse decision templates through e-CAP. The CWE will manage all adverse decisions to assure accuracy of notice dates, appropriateness of maintenance of service and compliance to the final decision. The lead agency uploads the adverse notice in the state's data warehouse (Public Consulting Group). The Office of Administrative Hearing will monitor this data bank to initiate and follow through with all appeal requests.

When a referral is made for waiver participation under the participant-directed option, the beneficiary/responsible party is provided educational information about the participant directed care and their right to request a fair hearing when a choice of provider is denied. The Lead Agency and FMS are responsible for explaining to the beneficiary the reason that a selected provider will be denied. The CWE and Lead Agency are responsible for providing additional education to the beneficiary/responsible party regarding the procedures once a request for a hearing is made. When the beneficiary has met basic eligibility to participate in the waiver and is ready to participate in the waiver, the CWE assures that each beneficiary's record contains a copy of the signed and dated self-assessment survey that describes participant directed services and their

roles and responsibilities. Prior to the approval and initiation of waiver services, the CWE validates the file as complete to assure self-assessment survey and a freedom of choice is exercised by the beneficiary. The information and check points the CWE will assure as safeguard, include the signatures and filing of the following:
• The beneficiary/responsible party original self-assessment survey and freedom of choice document detailing their choice of providers and waiver services;
• The documentation lists all the known enrolled providers of Medicaid CAP/DA and regular Medicaid services working in or available to work in the county where the beneficiary/ responsible party resides; and
• The beneficiary/ responsible party choices of providers, in order of preference within categories, if there are multiple choices available.

In addition, the beneficiary/responsible party also receives information pertaining to:
• All providers on the list have met specific DMA criteria for enrollment to provide the particular service;
• The lead agency can be requested by the beneficiary/ responsible party to explore the possibility that a provider not listed, yet desired by the beneficiary/ responsible party may, in fact, be enrolled with DMA;
• A statement to inform the beneficiary/ responsible party that a provider not currently enrolled with DMA would need to meet specific criteria to be enrolled with DMA before the provider could be authorized to provide service and be reimbursed by Medicaid for services rendered;
• The document will inform the beneficiary/ responsible party how to contact the CAP/DA consultant in DMA assigned to their county if their problems are not resolved at the local level or by CWE; and
• The beneficiary/ responsible party will be informed how to change agencies or lodge a complaint if they are unhappy about the care provided or the person rendering the care.

The beneficiary will also be informed that if the requested provider met any one of the lifetime ban, the state will not allow an appeal. The lifetime ban includes:

• Felonies related to manufacture, distribution, prescription or dispensing of a controlled substance;
• Felony health care fraud;
• More than one felony conviction;
• Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd or 3rd degree), fraud or theft against a minor or vulnerable adult;
• Felony or misdemeanor patient abuse;
• Felony or misdemeanor involving cruelty or torture;
• Misdemeanor healthcare fraud;
• Misdemeanor for abuse, neglect, or exploitation of a minor or disabled adult;
• Substantiated allegation of abuse, neglect or exploitation listed with the NC Health Care Registry; or
• Any substantiated allegation listed with the NC Health Care Registry that would prohibit an individual from working in the health care field in the state of NC.

A beneficiary will not be given the opportunity to a fair hearing by DMA when basic LOC is not recommended by a clinician. Establishing LOC is a prior approved service for the state Medicaid agency. The state Medicaid agency has a rule of prior approved Medicaid services; it must be fully documented by the treating clinician to demonstrate medical necessity. When the physician is not able to document medical necessity to make a level of care recommendation, the individual must dispute that decision directly with the clinician/physician. The individual will have the opportunity to present additional information directly to the clinician/physician that supports institutional level of care. The clinical/physician's decision will impact initial level of care determination as the CWE and Lead Agency will not be able to process the assessment without an established LOC recommendation. The individual is provided a referral list of other community resources that are available to meet needs.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

   - (●) **No. This Appendix does not apply**
   - ( ) **Yes. The State operates an additional dispute resolution process**

b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and

timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. **Operation of Grievance/Complaint System.** *Select one:*

- (●) **No. This Appendix does not apply**
- ( ) **Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

b. **Operational Responsibility.** Specify the State agency that is responsible for the operation of the grievance/complaint system:

c. **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The State operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*
  If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.

b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

To safeguard the health and welfare of each approved waiver participant, DMA, on an ongoing basis, identifies addresses and seeks to prevent the occurrence of abuse, neglect and exploitation. In assuring the health, safety and well-being of each CAP/DA participant, the Lead Agency shall address remediation efforts that mitigate the participant's health and welfare when a critical incident occurs. A critical incident report shall be completed each time a CAP/DA participant has been involved in a critical incident that jeopardizes his or her health, safety and well-

being. Upon knowledge of the critical incident, a report must be completed within 5 days. Each lead agency is provided a copy of the critical incident report developed by the state Medicaid agency. The form has automatic fill-in responses through drop-down box options. The form is accessible through the e-CAP system. The CWE will track receipt of all critical incident reports to assure timeline is adhered. The CWE will also follow-up to assure the identified waiver participant is receiving the necessary services as identified through the recommendation of the incident report.
The types of critical incidences that must be reported include: death, missing person, use of restraints or seclusions, thefts, injury, abuse, neglect and exploitation, hospital admission, ER visits, concerns of health, safety and well-being, and medication error. Incidences of abuse, neglect and exploitation must be carefully followed to assure services are adequately met to keep the waiver participant safe in the community.
Level of reporting is managed by two incident levels: Level I and Level II. Level I incidences must be reported within 5 days in the e-CAP system. These incidences include, hospitalizations, ER visits, falls, death by natural causes, failure to take medication as ordered. Level II incidences must be reported within 5 days to DMA. These incidences include, APS referrals, death other than expected or natural causes, restraints and seclusions, misappropriation of consumer-directed funds, falls requiring hospitalization or results in death, traumatic injury, medication administration that results in injury or hospitalization, wandering away from home, homicide/suicide and media related events.

The critical incident report has fields that identify the participant demographic information, description of the incident, participant's response, action taken/prevention/disposition, notification/reported to other authority, recommendation by the case manager or care advisor of how to mitigate future incidences and the recommendation by the State against the data report and action taken.
Each lead agency is provided annual training in critical incident reporting approved by the state Medicaid agency. The lead agency is responsible to education and inform waiver beneficiaries/responsible parties and service providers on types of critical incidences, how to make a report, and the timeframe to make a report. The lead agency must provide training and education initially, quarterly, annually and as needed to all waiver participants.
For incidences of abuse, neglect and exploitation, the state has prescribed guideline to react to a report and create an action plan.

To assure the health, safety and well-being of waiver beneficiaries, the goal is to report a critical incident immediately when it happens. However, for incidences that the lead agencies are not immediately aware, upon of the knowledge of the incident the lead agency is expected to file a report and follow through to assure the health, safety and well-being of the beneficiary. The report must be submitted through e-CAP within 5-business day. When the lead agency is notified of an incident, notification or report to other providers or entities must occur within 5-days of the reported incident.

The types of events that warrant notification to state Medicaid agency is reports of abuse, neglect and exploitation that are referred to the local DSS Adult Protective Services.

Article 6, Chapter 108A of the North Carolina General Statutes requires that county departments of social services perform certain activities for disabled adults alleged to be abused, neglected, or exploited and in need of protective services. In accordance with its authority under N.C.G.S. 143B-153, the North Carolina Social Services Commission has established rules and regulations for the provision of Protective Services for Adults.
The Counties Department of Social Services must accept all reports alleging abuse, neglect, or exploitation of a disabled adult who is in need of protective services. This includes anonymous reports.

North Carolina has a mandatory reporting law. Any person having reasonable cause to believe that a disabled adult is in need of protective services shall report such information to the director of the county Department of Social Services, or his representatives, where the disabled adult resides or is present. The report may be made orally or in writing. The report shall include the name and address of the disabled adult; the name and address of the disabled adult's caretaker; the age of the disabled adult; the nature and extent of the disabled adult's injury or condition resulting from abuse or neglect; and other pertinent information. (G.S. 108A-102)

North Carolina conducts a comprehensive functional assessment (evaluation) to determine whether there is a need for protective services in situations where it is alleged that a disabled adult has been abused, neglected, or exploited. Protective Services are those services provided by the State or other government or private organizations or individuals that are necessary to protect the disabled adult from abuse, neglect, or exploitation. (G.S. 108A-101)

North Carolina General Statutes require that any director receiving a report that a disabled adult is in need of protective services shall make a prompt and thorough evaluation to determine whether the disabled adult is in need

of protective services and what services are needed. The evaluation shall include a visit to the disabled adult and consultation with others having knowledge of the facts of the particular situation. A thorough evaluation of a protective service report shall include identifying indicators of abuse, neglect, or exploitation and the disabled adult's strengths and limitations by assessing physical health, mental health, social support, activities of daily living, and instrumental activities of daily living, financial support, and physical environment.

A memorandum of agreement has been implement between Division of Aging and Adult Services and Division of Medical Assistance (Waiver Administrator) to share "need to know information:" to assure the appropriate planning of all waiver participants. Through this memorandum of agreement, the case manager /care advisor and the APS workers have an agreement to consult with one another about the facts of a particular situation for appropriate care planning and referrals.

Natural disasters such as hurricanes are considered critical events. Every locality/county must have a disaster plan in place and shelters available that can provide care for individuals and families, including those with special needs, who must evacuate their homes. Each waiver participant is required to have an emergency plan that covers disaster planning.

c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Initially an annually each waiver participant is provided information about abuse, neglect and exploitation and how to make a report when concerns arise. The service request form generally addresses potential abuse to assure comprehensive assessment of the waiver participant. The interdisciplinary assessment captures information about informal support systems and their burden of care giving that identifies potential risk factors for abuse, neglect and exploitation. Additional information is provided when requested or when the case manager and care advisor is concerned of abuse, neglect and exploitation.

After waiver approval, each beneficiary is provided a Welcome Letter. Some of the contents within the letter address ANE: "As a condition for participating in this waiver, your case manager must plan for your health, safety and well-being. He or she must ensure that you are safe at all times and that you are not abused, neglected or exploited. The case manager or care advisor will talk with you monthly and make a home visit with you every 90 days to monitor your care needs, to ensure services are provided as planned, and to ensure that your health, safety and well-being is intact. If you think that you are not safe or have any concerns about abuse, neglect or exploitation you can call your local Department of Social Services for assistance with Adult Protective Services. You can also call your case manager or care advisor."

Each case manager or care advisor is required to have annual mandatory training that includes abuse, neglect and exploitation and how to complete, assess, report and mitigate critical incidences of waiver participants.

The state will make available and provide services such as assistance in locating and selecting qualified workers, training in managing the workers, completing and submitting paperwork associated with billing, payment and taxation.

In addition, providers are required to provide on-going training to direct service staff in how to recognize abuse, neglect and exploitation, and where to go for help. During the review of participant rights and responsibilities, the CWE, case manager and care advisors educate and provide information to participants, families and legal representatives. Participants sign a form indicating that they have received information about incident reporting. A criminal background check is performed on all personal care assistants under participant-direction as an addition safety precaution.

d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Diagnoses and symptoms that pose a significant risk to health, safety, and well-being of each CAP/DA participant are identified as part of the intake and assessment process. These items are entered into the e-CAP assessment tool along with the service plan which is completed using the e-CAP plan of care tool. The e-CAP system has the capacity to compare identified risk factors with elements of the plan to ensure these risks are adequately addressed

for all CAP/DA participants. Each risk identified by the assessment process must be addressed in the waiver participant's service plan or through an individual risk agreement.
A critical event is any incident that puts or has put a participant at-risk of harm which jeopardizes their health, safety and well-being to live safely in their home community. When a beneficiary experiences any one of the following, each lead agency must complete a critical incident report:
• deaths
• thefts
• Injuries
• abuse, neglect or exploitation
• admission to a facility
• health, safety and well-being
• medication errors
• unplanned hospitalizations
• Missing person
• Restraints or seclusions
• other
The Administrative Authority and the CWE actively seek to ensure participant's safeguards while participating in the waiver. During enrollment and during continuous participation in CAP/DA waiver, a beneficiary may be denied based upon the inability of the program to ensure the health, safety, and well-being. Based on assessments of the beneficiary's medical, mental, psychosocial and physical condition and functional capabilities, conditions my warrant inability to participate in the waiver if the following areas cannot be mitigated:
• a. The beneficiary is considered to be at risk of health , safety and well-being when they cannot cognitively and physically devise and execute a plan to safety if left alone, with or without a personal emergency response system;
b. The beneficiary lacks the emotional, physical and protective support of a willing and capable caregiver who must provide adequate care to oversee 24-hour hands-on support or supervision to ensure the health, safety, and well-being of the individual with debilitating medical and functional needs;
c. The beneficiary's needs cannot be risk stratified and maintained by the system of services that is currently available to ensure the health, safety, and well-being;
d. The beneficiary's primary private residence is not reasonably considered safe to meet the health, safety and well-being in that the primary private residence lacks adequate heating and cooling system; storage and refrigeration; plumbing and water supply; electrical service; cooking appliance; garbage disposal; or is determined to be a fire hazard which does not provide for the beneficiary's safety, and these issues cannot be resolved;
e. The beneficiary's primary private residence presents a physical or health threat due to the proven evidence of unlawful activity conducted; threatening or physically or verbally abusive behavior by the beneficiary or family member exhibited on more than two incidences physically and verbally abusive behavior or threatening language; or present of a health hazard due to pest infestation. These conditions would reasonably be expected to endanger the health and safety of the individual, paid providers or the case manager or care advisor;
f. 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 of POC and written or verbal directives;
g. The beneficiary's primary caregiver or responsible party continuously impedes the health, safety and well-being of the beneficiary by refusing to comply with the terms of the plan of care, refusal to sign a plan and other required documents of when designated responsible party (Power of Attorney, Health Care Power of Attorney, or Legal) refuse to keep the care manager or care advisor informed of changes in the status of the beneficiary; or
h. 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 APS assessment or care plan.

When health, safety and well-being issues are identified, a participant has the discretion to enter into an Individual Risk Agreement (IRA). This agreement 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 permits individuals to assume responsibility for their choices personally, through surrogate decision makers, or through planning team consensus.

Each participant will be required to have an emergency back-up plan. The emergency back-up plan is created by the CAP/DA beneficiary with the assistance of the case manager or care advisor. This plan specifies who will provide care when key direct care staff cannot provide services or tasks as indicated in the current plan of care. Because both personal and home maintenance tasks are essential to the well-being of the participant, the case manager or care advisor is responsible for ensuring that an adequate emergency back-up plan is in place. In the event of an emergency or an unplanned occurrence, the plan will include family, friends, neighbors, community volunteers and licensed home care agencies to assist with care needs. An emergency back-up plan is necessary for times when the

Personal care aide or Personal Care Assistant is unavailable during regularly scheduled work hours and when the unpaid informal support is unavailable for the balance of the remaining 24-hour coverage period.
Additionally, the CWE in conjunction with the case managers and care advisors monitor service plans with special consideration given to diagnoses and symptoms where risk is more inherent and evaluate if these risks are addressed adequately on at least a monthly basis.
Assessments are completed at intake, during continued need reviews, or as needed, when the health of the participant changes. Every time the assessment (initial, CNR, or a change in status) is completed, a plan of care is completed or amended based upon the most current assessment.
The e-CAP system generates reports of service plans to address risk factors identified in the assessment. These reports are provided to the lead agency for continuous care planning as well as to make revisions to the care plan, when needed. The interventions, as set forth in the individual's service plan, designed to minimize risk will be assessed during site reviews to assure they are functioning and are being implemented as designed and intended.

When an event/issue is observed by or reported to a waiver provider, the provider has the responsibility to notify the local lead agency, and if applicable, other agencies (CPS, APS, DMA or law enforcement). When an event/issue is identified by, or reported to the local lead agency, an event/issue (report) form is completed. The report is designed to document: who the report is from; the type of event or issue; the date and time of the event/issue, if applicable; the location of the incident (participant's home, etc.); details of the event; involved parties; the source of the information; individuals who have first-hand knowledge of the event; whether the attending physician was notified; and the name, address and phone number of the physician and any other agencies or individuals that were also notified. The specific nature of an event or issue will determine if notification to others is warranted, e.g., CPS, APS, DMA, law enforcement, etc.
Any contact made with other agencies or individuals will be kept confidential. The local lead agency will develop a plan of resolution. All plans developed to resolve identified problems are thoroughly evaluated by local lead agency managers to ensure that they are appropriate, will result in a resolution, which is amenable to the participant and/or his/her legal guardian.

Reports of neglect, abuse and exploitation are reported to the local DSS to the Adult Protective Services Department.
Reports pertaining to inappropriate care by the In-Home Aide Agency, the assigned CNA or personal care aide are reported to the Division of Health Services Regulations to the Home Care compliant section and Health Care Personnel registry
Reports that pertain to skilled nursing care are reported to the Board of Nursing.
Reports pertaining to mismanagement of services or misappropriation of Medicaid dollars are reported to Medicaid Program Integrity Section.
Reports pertaining to violations against the law are reported to law enforcement.

The Department of Social Service, APS section is responsible for evaluating all cases of abuse, neglect and exploitation. The Adult Protective Services unit has a prescribed timeframe of 24, 48 and 72 hours to investigate a case. The beneficiary is provided a disposition of the case within 30- days of the initial home visit. APS have specific guidelines of evaluating a case to determine if a beneficiary is at risk and needs protection. The assigned Adult Protective Service Worker evaluates the beneficiary cognitive skills to determine capacity to make decision and the need for supportive care. If beneficiary is deemed not to be able to make appropriate cognitive decision, APS will provide an order of protection.
The lead agency is responsible for evaluating all other reports, other than law enforcement matters. An evaluation of the report is made against the clinical coverage policy to assure appropriateness of the waiver performances. The lead agency is at liberty to seek guidance from the CWE and state Medicaid agency.

The Department of Social Service, APS section is responsible to investigate all cases of abuse, neglect and exploitation. The Adult Protective Services unit has a prescribed timeframe to conduct a timely investigation to assure the health, safety and well-being of waiver participants. The beneficiary is provided a disposition of the case within 30-days of the initial home visit.

The lead agency is responsible for investigating all other reports expect for criminal involvement to assure the health, safety and well-being of all waiver participants. The lead agency is at liberty to seek guidance from the CWE and state Medicaid agency.

The waiver participant must be notified of the recommendation of the investigations within 30-days of the incident.

e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Critical Incident Reports are filed through the case management IT system, e-CAP. The CWE aggregates the data on the critical incident report and sends alerts regarding needs and recommendations to the lead agency and the waiver authority. The Local Lead Agencies are responsible for completing a critical incident report within 5 days of the occurrence. The lead agency will identify a remediation plan for the beneficiary to mitigate the situation. The CWE will review the remediation plan to assure appropriateness and facilitation of the outcome. The provider and local lead agency shall act immediately on any report of incidents placing the waiver participant in immediate or imminent danger; including contacting local law enforcement when the event/issue consist of abuse, neglect, and/or exploitation.

The state has an agreement with the state aging and adult agency (Division of Aging and Adults Services-DAAS) to provide quarterly data query of waiver participants reported to be abused, neglected or exploited. The data query provides the date of the report, the alleged perpetrator, and the disposition of the case, confirmed or substantiated. The report is compiled by county, the waiver program, type of report, disposition decision, and the number of reports received on a given waiver participant. The local DSS trains the APS workers on how to captured and complete the needed information on the report. A planning meeting is scheduled quarterly with the DMA staff and the DAAS staff to review and analyze the data query to identify trends and implement strategies to mitigate future occurrences.
The state has trained each lead agency on how to detect and accept critical incident reports (CIR). Upon the knowledge of an incident, each lead agency is required to submit a CIR via e-CAP within 5-days. The e-CAP system will compile all critical incident reports to assure accuracy of policy compliance and that the incident was clearly followed-up. Each incident is placed in a data query to track the frequency of each incident to identify trends. The data query generated by the e-CAP is reviewed by DMA on a quarterly basis and compared against the data query generated by DAAS. These two reports are used to identify trends and strategies to mitigate future occurrences.

If the CWE disapproves the lead agency's remediation plan, the CWE will seek guidance from state Medicaid agency. The state Medicaid agency will make the final remediation plan recommendation based on the nature of the incident and in combination of the policy guidelines.

The waiver participant must be notified of the recommendation of the investigations within 30- days of the incident.

An incident/death committee meets quarterly to track and trend level II incidences. The committee will review summary of care history, age and gender of the participant, date of enrollment in the program, the significant diagnosis, participant's extent on formal and informal supports, summary of events, contributing factors, participants enrollment/action surrounding the event, immediate action taken, participant status, identification of risk points and their potential contribution to the event. An analysis of the following will be assessed to trend occurrences for quality improvement:
Human factor (staffing levels, knowledge, training and competency)
Prior addressed risk factors
Equipment-related factors (maintenance)
Environmental factors (lighting, noise clutter)
communication factors (training and adequate tools)

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 2)

a. **Use of Restraints or Seclusion.** *(Select one)*:

◉ **The State does not permit or prohibits the use of restraints or seclusion**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:

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. CAP/DA does not permit the use of restraints or seclusion, including personal restraints, drugs used

as restraints, mechanical restraints, or seclusion.

The CAP/DA waiver 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. Refer to: http://www.cms.gov/surveycertificationgeninfo/downloads/SCletter07-22.pdf

If DMA determines that use of the restraints or seclusion is used on waiver participant law enforcement and/or adult protective services will be contacted immediately to report the event. Any known or observed use of restraints is referred to APS and DHSR, to investigate and report on their findings. DMA is responsible for monitoring investigation and findings to assure the health, safety and well-being of the waiver participant. The use of authorized restraints or seclusion on the participant indicates a need to reassess the participant's to review current medical and functional needs, caregiver's ability and stress level to determine appropriateness of CAP services (safety and well-being, ability to self-direct).

If a waiver provider or CAP Program consultant observes or learns that restraints or seclusion are being used, an event/issue report must be completed the date of discovery and submitted to DMA on same date. DMA will initiate referrals and investigatory steps within 2-days of notification.

○ **The use of restraints or seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. **Safeguards Concerning the Use of Restraints or Seclusion.** Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 2)

b. Use of Restrictive Interventions. *(Select one)*:

◉ **The State does not permit or prohibits the use of restrictive interventions**

Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

CAP/DA does not permit the use of restrictive interventions that restrict participant movement; participant access to other individuals, locations, or activities; restrict participant rights; or that employ aversive methods to modify behavior, unless provided for a waiver participant for whom it is not used as a restraint, but for safety - such as bed rails, Gerri chair, lift chair, safety straps on wheelchairs.

If DMA determines unauthorized use of restrictive interventions, or the use of the restrictive interventions is not in compliance with the plan of care and physician orders (bed rails, Gerri chairs, lift chairs, or safety straps on wheelchairs as a safety precaution), the appropriate law enforcement and/or adult protective services be will contacted on the day of discovery to report the event. Unauthorized use of restrictive interventions is referred to law enforcement and APS, for investigation and report on their findings. DMA is responsible for monitoring investigations and findings to assure the health, safety and well-being of the waiver participant. The use of authorized restrictive interventions on the participant indicates a need to reassess the participant's needs, caregiver's ability and stress level to determine appropriateness for CAP services (safety and well-being, ability

to self-direct).

If a waiver provider or CAP Program consultant observes or learns restrictive interventions are being used, an event/issue report must be completed on the date of discovery and submitted to DMA on the same date. DMA will initiate referrals and investigatory steps within 2-days of notification.

- **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

  i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

  ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. **Applicability.** Select one:

- **No. This Appendix is not applicable** *(do not complete the remaining items)*
- **Yes. This Appendix applies** *(complete the remaining items)*

b. **Medication Management and Follow-Up**

  i. **Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

  ii. **Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. **Medication Administration by Waiver Providers**

Answers provided in G-3-a indicate you do not need to complete this section

i. **Provider Administration of Medications.** *Select one:*

- **Not applicable.** *(do not complete the remaining items)*
- **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

ii. **State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

iii. **Medication Error Reporting.** *Select one of the following:*

- **Providers that are responsible for medication administration are required to both record and report medication errors to a State agency (or agencies).**
  Complete the following three items:

  (a) Specify State agency (or agencies) to which errors are reported:

  (b) Specify the types of medication errors that providers are required to *record:*

  (c) Specify the types of medication errors that providers must *report* to the State:

- **Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the State.**

  Specify the types of medication errors that providers are required to record:

iv. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare
The State, on an ongoing basis, identifies, addresses and seeks to prevent the occurrence of abuse, neglect and exploitation.

i. Performance Measures

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number/percent of participants who received information/education about how to report abuse, neglect, exploitation (ANE) and other critical incidents as specified in the approved waiver Numerator: participants who received information/education about how to report abuse, neglect, exploitation and other critical incidents as specified in the approved waiver Denominator: number participants

Data Source (Select one):
Provider performance monitoring
If 'Other' is selected, specify:

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of Critical Incident reports that were reported to DMA by the CM entity within required time frames as specified in the approved waiver Numerator: Number of CIs that were reported to DMA by the CM entity within required time frames as specified in the approved waiver Denominator:Total number of Critical Incident Reports

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

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

		Confidence Interval = +/-5 %
☑ **Other** Specify: CWE, e-CAP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of CIs that were responded and follow-up with to CI by the Lead Agency as specified in the approved waiver. Numerator: Number of CIs that were responded and follow-up with to CI by the Lead Agency as specified in the approved waiver Denominator: Total number of CI

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

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

Performance Measure:
PM: Number and percent of APS referrals that were reported to DMA by the Division of Aging and Adult Services within required time frames (30 days) as specified in the approved waiver. Numerator: Number of APS referral reports generated by the DAAS and sent to DMA within required time frames as specified in the approved waiver Denominator: Total number of APS referrals

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

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

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

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of reported cases of CI to APS where the POC was updated to provide needed services to address participant's needs identified in findings of the APS investigation. Numerator:reported cases of CI to APS where the POC was updated to provide needed services to address participant's needs identified the findings of the APS investigation Denominator:number of CI

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

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

		Confidence Interval =
☑ **Other** Specify: CWE, e-CAP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Number and percent of critical incident reviews/investigations (both APS and CI) that were confirmed within the timeframes as specified in State law. Numerator: Number of critical incident reviews/investigations (both APS and CI) that were confirmed within the timeframes as specified in State law Denominator: Total number of critical incident

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

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

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

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

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Specify: CWE, e-CAP	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM: Number and percent of participants who has an emergency plan to include information about emergency preparedness in the case file Numerator: Number of participants who has an emergency plan to include information about emergency preparedness plan in the case file Denominator: Total number of participants

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

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM: Mortality Review -Number and percent of deaths screened within the required timeframe to determine if further review or investigation was warranted. Numerator:

Number of deaths screened within the required timeframe to determine if further review or investigation was warranted Denominator: Total number of deaths

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

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

Data Source (Select one):
Mortality reviews
If 'Other' is selected, specify:

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

☑ **Other** Specify: CWE, e-CAP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
Participant health risk and safety considerations are assessed, and potential interventions are identified that promote health, independence and safety with the informed involvement of the participant. Local Lead Agencies assure that services and supports are included in the POC to address risk and safety issues identified in the assessment. Case managers monitor specific triggers in the assessment that should have corresponding POC inclusions. Each approved CAP/DA beneficiary is provided information about ANE at the waiver screening and during the assessment process. Upon waiver approval, each beneficiary is provided a Welcome Letter. Some of the content within the letter that address ANE includes: "As a condition for participating in this waiver, your case manager must plan for your health, safety and well-being. He or she must ensure that you are safe at all times and that you are not abused, neglected or exploited. The case manager or care advisor will talk with you monthly and make a home visit with you every 90 days to monitor your care needs, to ensure services are provided as planned, and to ensure that your health, safety and well-being is intact. If you think that you are not safe or have any concerns about abuse, neglect or exploitation you can call your local Department of Social Services for assistance with Adult Protective Services or you can also call your case manager or care advisor." The e-CAP system provides incident and compliant reporting for use by the Lead Agency. This information can be analyzed through reports on the timeliness of the compliant or incident reporting. The e-CAP system has the capacity to document responses and follow-up

to any compliant or incident entered into e-CAP.
DMA has a collaborative working relationship with DAAS. A planning and discussion meeting is scheduled quarterly to track and trend all APS CI reports. DMA and DAAS will use the quarterly meeting to discuss and implement work plan for tracking of CI reviews/investigations to obtain individual level data on the status/disposition of the CI report.
An IMOU has been implemented between DMA and DAAS to include the following language: The DAAS agrees to:
1. Include a response question on the Adult Services Referral form to identify 1915 (c) and other HCBS beneficiaries, i.e. CAP/DA, CAP-Choice, CAP/C, CAP/IDD, & PACE.
2. Train local DSS-APS workers on how to complete the HCBS response question on the APS referral form.
3. Run a CSDW query monthly that identifies all APS referrals made against an HCBS beneficiary, reason for the referral, the action taken by APS and the final resolution of the referral.
4. By the 5th day of each month, DAAS will forward a CSDW query report by encrypted e-mail to the CAP/DA & PACE Program Manager at Division of Medical Assistant that is no more than 30 days old of each APS referral date.

The DMA agrees to:
1. Use the CSDW report from DAAS for the sole purpose of assuring the health, safety and well-being of each HCBS beneficiary
2. Disclosure contents of the CSDW query report conditioned to the federal regulations under HIPAA.
3. Use the data from the CSDW query to track and trend patterns of abuse, neglect and exploitation to identify gaps in service provisions or system barriers.
4. Use the data to train and educate service providers and caregivers about abuse, neglect and exploitation.
5. Use the data to identify strategies to support caregivers and to empower the beneficiary.
6. Use the data to identify root causes of beneficiaries whom receive multiple APS referrals.
7. Use the date of the query CSDW report to assure that confirmed beneficiary's care plan is reflective of current needs identified in the APS report and disposition of APS findings.
8. Use the data of CSDW query report to assure substantiated beneficiary assessed needs are appropriately planned to maintain health and safety while participating in HCBS programs.
The e-CAP system will document and classify all incidents that results in an APS referral.
The e-CAP system will capture all assessment information and automatically generate a service plan revision recommendation. The e-CAP system allows the CWE and State Medicaid Agency to review an individual service plan in order to evaluate if the selected services and proposed service interventions are adequate (proposed hours, schedule and skilled level). The service plan can also be reviewed by type and can be reviewed for adequacy and appropriateness by these of structured query reports. The e-CAP system can document when CI and APS referrals were confirmed.
The e-CAP system will not allow the case file to be completed without an emergency plan that includes emergency preparedness. The e-CAP system allows the CWE and State Medicaid Agency to review an individual service plan in order to evaluate if the emergency plan is adequate. The e-CAP system identifies and documents all mortalities that result from a critical incident/APS event.
The NC Division of Health Services Regulation, houses a Complaint Intake Unit which investigates complaints regarding the care and services provided to patients/residents/consumers by health care facilities, provider agencies, and group homes. A Complaint Form is available for written complaints but is not required to be used. Each complaint is prioritized for investigation according to the seriousness of the situation. North Carolina statutes require any person having reasonable cause to believe that a disabled adult is in need of protective services shall report (either orally or in writing) such information to the county director of DSS. DSS must accept all reports alleging an abused, neglected or exploited disabled adult is in need of protective services.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
The case manager must ensure that the POC is kept current and updated on a continuous basis with the participant's changing needs. When the case manager discovers that a participant is at risk, the potential risk must be addressed immediately or in a timely fashion as required. This may include calling a team meeting to address the issue, getting medical advice for the participant, or seeing that the participant is removed immediately from the risky, unsafe environment. If the case manager or care advisor discovers that the participant has had multiple incident reports submitted for the same or different incidents, the case manager or care advisor must address this with the team an address as necessitated by the severity of the incident.
If it is found that the critical incident was not reported to APS, the case manager or care advisor must

immediately submit a report to APS. If it is found that the critical incident was not reported timely, technical assistance will be provided by DMA and the Lead Agency will submit an action plan to reduce future occurrences of untimely critical incident reports to APS.
Upon discovery of non-compliance, CWE notifies the responsible Lead Agency. The Lead Agency develops an action plan and obtains the waiver participant's signature within 5 days of notification by CWE/DMA. The CWE/DMA reviews the action plan, makes a final decision, and issues directives for the Lead Agency to follow. Repeated findings of non-compliance by a Lead Agency may result in DMA issuing a corrective action plan, staff training and/or recoupment of Medicaid payment.

Upon discovery of non-compliance, CWE/DMA notifies the responsible Lead Agency. The Lead Agency develops an action plan to revise/update the individual's plan of care in response to the APS investigation findings and submits to DMA within 30 days. DMA reviews the action plan, makes a final decision, and issues directives for the Lead Agency to follow.
Upon discovery of non-compliance, all outstanding critical incident reviews/investigations that have exceed the timeframes to confirm the case will be discussed at the quarterly meeting of DAAS and DMA to discuss and develop options to resolve individual critical incidents.

Technical assistance will be provided by CWE/DMA to the Div. of Aging and Adult Services to review timeframes for submitting APS referrals reports as outlined in the Memorandum of Understanding.

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

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

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

- ◉ **No**
- ○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State

specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

DMA has developed a quality management plan that integrates, analyzes and responds to information from multiple sources across functions within the state system. The plan also involves partners and stakeholders including participants/families, Contracted Waiver Entity, CAP/DA Lead Agencies, provider agencies, as well as representatives from various stae agencies.
The overall purpose of the Quality Improvement Strategy (QIS) for CAP/DA is to design, develop, implement, and manage a Quality Assessment and Quality Improvement Program for CAP/DA waiver that:
1. Ensures that the Division of Medical Assistance meets the Centers for Medicare and Medicaid Services' (CMS) through monitoring of the 6 waiver assurances;

2. Designs and implements the Quality Framework that will discover, remediate and improve assurances for waiver services;
3. Establishes a systematic approach to monitor, evaluate, and continuously improve the quality of CAP/DA services;
4. Identifies and sets appropriate performance and outcome measures to evaluate CAP/DA services; and
5. Implements a Quality Management (QM) Program for CAP/DA that focuses on participant-centered outcomes related to:
a. Participant access;
b. Participant-centered services planning and delivery;
c. Provider capacities and capabilities;
d. Participant safeguards;
e. Participant rights and responsibilities;
f. Participant outcomes and satisfaction; and
g. System performance.

The process for trending and prioritizing will be achieved through a quality management plan and the assembly of a QA/QI committee.
The quality management plan includes:
Provide training and technical assistance to the waiver community as needed; Analyze trended data and take action to remediate findings; Review and prioritize recommendations from all stakeholders and make changes as deemed appropriate; Disseminate information compiled from analysis of QA/QI data to appropriate stakeholders, including participants, family members and system advocates.

A QI/QA committee will be assembled that is comprised of participants/families, VieBridge, Inc., CAP/DA Lead Agencies, provider agencies, and representatives from various agencies of the State system. This committee convenes quarterly. This committee works to support and encourage systematic quality management activities and improvements. The responsibilities of this committee consist of: Reviewing QA/QI system data; Analyzing data to determine patterns, trends, problems, and issues relative to all assurances; Making recommendations to DMA for changes in policies and procedures based on analysis of compiled QA/QI data; Making recommendations to DMA regarding the provision of training, technical assistance and other activities, based on analysis of QA/QI data and conducting follow-up monitoring of the activity to assure remediation and statewideness; continuing to develop and refine the QA/QI quality indicators to be monitored; Reviewing the QA/QI plan at least annually and making changes as needed to assure that the data gathered is generating useful information to improve quality of service delivery; Reviewing the QA/QI policies and procedures at least annually and modifying as needed; and Disseminating information compiled from analysis of QA/QI data to appropriate stakeholders, including participants, family members and system advocates.
In addition to the activities described above, each QM performance indicator written into the waiver includes the type and frequency of activity in gathering data specific to the indicator, the sampling methods for each indicator, how data will be collected, and who will collect the data.

System improvement will be achieved through the following:
Data gathered during the first waiver year will be used to establish baseline performance levels and will be the basis for setting acceptable thresholds for each indicator for the following waiver years. Through the analysis and review process, indicators that reflect changes from expected trends will be identified for further analysis and study. If applicable, special studies will be undertaken on prioritized measures to understand changes in trends.
Method that will be utilized:
The Participants and their families will:
Contact their case managers or care advisors if they have concerns about their services or supports; Access grievance and complaint processes, with assistance from their case managers or care advisors, if needed, based on materials provided by the CWE/DMA; Provide feedback on state and local plans and budgets; and Participate in the monitoring of service development and delivery through participation in surveys and stakeholders meetings.

The CAP/DA Lead Agency and CWE will:
Help identify under-served populations and gaps in the service array; Review reports generated by DMA; Advise on the development of additional services and new models of service delivery; Participate in quality improvement projects at the provider; Facilitate the Person Centered Planning (PCP) process and ensure that the PCP includes all needed services and supports as well as all state and waiver requirements (including a Crisis Plan based on a risk assessment); Reasses each participant's needs at least annually and develop a

revised PCP based on that reassessment (Continued Need Review); Act on and remediate any issues related to the participant's health, safety, and welfare or service delivery. Unresolved issues will be brought to the attention of DMA/CWE. Revise the PCP as the participant's needs change; Conduct quarterly face-to-face visits with the participant to Oversee PCP implementation; monitor health safety and welfare; identify risk factors determine if the back-up plan remains effective and is implemented as written.

Other waiver service provider agencies are responsible for:
Maintaining licensure, certification and accreditation as required, including ensuring that staff are qualified to deliver services, criminal background/Healthcare Registry checks and staff receive required supervision; Monitoring the provision of services; contacting the case manager or care advisor if there are any concerns regarding the participant; Participate in the development of the PCP; Implementing the PCP including risk mitigation strategies and the back-up plan; Submitting Incident Reports and Quarterly Incident Reports as required by DHHS rules; Responding appropriately to all participant incidents; maintaining documentation of critical incidents; Reporting and remediating critical incidents to the CWE/DMA; Developing and implementing an internal quality improvement plan; Developing and convening an internal client rights committee; Participating in stakeholders' meetings.

The CWE is responsible for:
Reviewing and assuring plans completions monthly; contacting the case manager or care advisor to address any deficiencies prior to approval; following up to ensure that case managers or care advisors have corrected any deficiencies prior to approval.
The CWE is a non-governmental contracted entity that is responsible for the day-to-day operation of CAP/DA waiver. The functions of the CWE include:
Operating an uniform local access system; Monitoring, evaluating and conducting continuous quality improvement; Managing secure information systems with data on participants, Monitoring and overseeing services, including provider compliance with standards for state and waiver requirements, provider qualifications, and utilization; Providing technical assistance to providers; Providing information to waiver participants including their responsibilities, protections and rights, as well as grievance and complaint resolution processes; Resolving issues related to any participant's health, safety, welfare or service delivery that are unresolved by the case manager or care advisor; Ensuring that CAP/DA providers participate in the DHHS incident reporting system; Receiving, reviewing and following up on incident reports from CAP/DA Lead Agencies and other providers as required by DMA/DHHS rules; Ensuring that reporting is made to the County Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that a participant may be abused, neglected or exploited; Submitting Quarterly Incident Report and Quarterly Complaint Report to DMA; Submitting a Quarterly Provider Monitoring Report of monthly local monitoring activities to the DMA that identifies provider monitoring issues requiring correction and an explanation of uncorrected issues.
The CWE will also perform:
Yearly audits of paid claims to CAPDA providers, as well as record reviews and PCP reviews; Investigating incidents and complaints that are unresolved at the local level or that have the appearance of conflict of interest with the CAP/DA Lead Agency; Tracking, reviewing, analyzing and reporting on aggregated data reported on all waiver assurances; Tracking and reviewing incident reports and investigating as needed; Collecting, aggregating, analyzing and reporting quarterly and annually on statewide and sub-state incident and complaint data; Routinely monitoring the performance of CAP/DA Lead Agency; Conducting yearly accountability audits; Conducting surveys of individual and family outcomes; Meeting with DMA on at least a quarterly basis to review trends and issues and to communicate information on any needed changes to the waiver.
DMA will:
Conduct quarterly audits of Level of Care and PCPs for waiver participants; Conduct fiscal audits of the waiver programs; Review waiver data/evidence from CWE/CAPDA; Ensure remediation by DMA for any identified issues and conduct ad hoc reviews of the waiver program; Meet with CWE/CAPDA Lead Agencies on at least a quarterly basis to review trends and issues and to communicate information on any new CMS policies and procedures; Enroll qualified providers; and Oversee the performance of the Utilization Review vendor.

Remediation
Remediation is the action taken to remedy specific problems or concerns that arise. When an issue of weak performance is discovered, the CWE will notify the lead agency to make that entity aware of the issue, inform of the policy and assist with implementing an action plan to bring the weak performance to a level consistent with waiver compliance. Subsequently, a root cause analysis will be performed to identify the

problem to improve future performances and to prevent other problems in the future.
Continuous monitoring will be implemented to improve system design flaws that allowed for weak performance, but more importantly map out how both existing and improved data and quality information can lead to continuous improvement in the waiver program.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☑ **Other** Specify: CWE, e-CAP	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The North Carolina Division of Medical Assistance (DMA) is the state Medicaid agency responsible for the administration of the CAP/DA Program. Case management services and business processes are delivered through a network of county agencies called CAP/DA Lead Agencies (lead agencies). Several agencies play key roles in the CAP/DA service delivery system, as summarized below:
The Medicaid CAP/DA Unit – The CAP/DA unit is one of ten long-term care programs in DMA's Home and Community Care Section. The primary responsibilities of the CAP/DA Unit include providing overall management oversight of the program, developing and implementing program policies and procedures, conducting the CAP/DA quality management program, setting the county slot allocations, and providing training, consultation, providing oversight and monitoring of the Operating Waiver Agency, and technical assistance to the lead agencies and CAP/DA providers.
The Local CAP/DA Lead Agency – Local CAP/DA lead agencies are appointed in each county by the CAP/DA unit and may be a department of social services (DSS), local health department, area agency for the aged, a hospital, or an organization with proven substantial history in providing community long-term care. CAP/DA lead agencies perform the following duties: Develop referral procedures according to DMA standards and local policy and share these procedures with the appropriate providers and organizations; Educate the aging and disabled community about CAP/DA; Determine case management capacity, case mix and caseloads; Provide assistance in obtaining and verifying documentation from medical staff and other health care professional to determine support for level of care and other medical and functional needs; Complete comprehensive assessments to ascertain medical, psychosocial and functional needs for waiver participation; Coordinate and collaborate in an interdisciplinary team approach for the provision of waiver services that prevent institutionalization; Develop a person-centered service plans that identifies the amount, duration and frequency of each service and the responsible party to render the service; Assure cost neutrality of the CAP/DA waiver by budgeting the approved waiver resources allotted by DMA; Review all initial and revised service plans to provide written authorization for approval and participation in the waiver; Provide each beneficiary or primary caregiver freedom of choice between institutional care or waiver participation and choice among waiver services and providers; Provide monthly monitoring of the service plan with beneficiary and all approved services providers; Provide direct observation of hands-on personal care services performed with the beneficiary to include personal care and participation in adult day health quarterly; Initiate Due Process tasks when an adverse decision is made and coordinate with beneficiary, providers and due process management vendor; Provide assistance, when requested, in verifying whether medical documentation supports nursing facility level of care; Monitor and assess the CAP/DA beneficiary monthly to assure safe community living (health, safety and well-being criteria); concerns must be mitigated through referral to Adult Protective Services (APS) or a revision to the service plan; and provide monthly and

quarterly Case Management/Care Advisement to the CAP/DA beneficiary.
3. The Medicaid Fiscal Agent – The Medicaid Fiscal Agent, Computer Science Corporation (CSC)/NCTracks, provides the prior approval review for CAP/DA participants, processes and pays provider claims, allows provider enrollment in the Medicaid program, and provides training related to these activities to provider organizations.
4. CAP/DA Provider Organizations – Provider organizations are enrolled with Medicaid to provide certain defined services, as specified in their enrollment contracts. Provider qualifications are specified in the CAP/DA Clinical Coverage Policy and the Medicaid Provider Enrollment Agreement Packet/Handbook.
5. Contracted Waiver Entity – The CWE is a non-governmental contracted entity designated as the quality improvement organization. The CWE, under contract to DMA, conducts a comprehensive internet-based quality management program for the CAP/DA Program called e-CAP. This automated quality management system is described below under the heading of e-CAP. The CWE is responsible for:
The Contracted Waiver Entity (CWE) is the day-to-day administrator of the CAP/DA waiver to manage administrative tasks. The CWE shall: Assure participant waiver enrollment; Assure waiver enrollment against approved limits; Assure waiver expenditures managed against approved limits; Assure level of care evaluation; Review participant service plans; Perform prior authorization of waiver services; Perform utilization management; Perform quality assurance and quality improvement strategy (QIS Framework); Perform continuous quality improvement; Monitor randomly selected beneficiaries case files from the local Lead Agency to ensure compliance with the six waiver assurances according to all applicable state and federal laws, state and federal rules and regulations, and agency policy; maintain access to a web-based automation tool for case management and quality improvement activities; Monitor and review approved CAP/DA assessments and POCs for all waiver participants to assure compliance to Waiver Assurances; Track mediation and appeal for Due Process; Monitor the CAP/DA program through various audits and reports including on-site visits and desk reviews of selected Lead Agency and beneficiary record to ensure compliance with the intent of the waiver and with state policies and procedures; Establish ongoing communication mechanisms with CAP/DA providers to include: Posting Frequently Asked Questions (FAQs) to the DMA website (http://www.dhhs.state.nc.us/dma); Providing instructional memos to CAP/DA providers when changes occur to the program; Provide training and technical assistance to Lead Agency
The e-CAP system is a Web-based software application developed by VieBridge, Inc. to support the operation of HCBS waiver programs operated under the provisions of 1915(c)HCBS. The e-CAP system provides the means by which the waiver case management services can be organized, tracked and made more effective.
The e-CAP system refines the 1915 (c) HCBS waiver assessment process in order to consistently and accurately assess beneficiary's needs, determine beneficiary's eligibility, authorize service provision, make provider referrals, ensure beneficiary's due process and support HCBS level of care prior approval for waiver participation.
The e-CAP system, refines the provider-based services planning process for the 1915(c) HCBS Waiver to ensure that: 1) HCBS waiver assessments are the basis for services planning; 2) service plans can be reviewed by the waiver Administrative Authority entity quickly and effectively; 3) service plans are reflective of CMS guidelines for person-centered planning and the beneficiary's assessment; and 4) service plan data can be used for DMA utilization management reviews.
The e-CAP system, improves beneficiary monitoring to include outcomes definition and tracking.
The e-CAP system, refines the quality assurance reporting process, as described in the CMS QIS for the 1915 (c) HCBS Waiver, to ensure all core quality measure reporting is consistent and timely and that the quality assurance data will support DMA quality oversight of Medicaid waiver long term care services.
The e-CAP system, implements a continuous quality improvement process that encompasses direct service providers, case managers and DMA in concert with the beneficiaries and/or their informal caregivers or representatives.
The e-CAP system, retools the day-to-day waiver administration and oversight as one integrated process for the 1915(c) waivers to include: participant waiver enrollment; waiver enrollment managed against approved limits; waiver expenditures managed against approved limits; level of care evaluation; review of participant service plans; prior authorization of waiver services; utilization management; and quality assurance and quality improvement activities.
The e-CAP system arranges the following: On-line processes for service requests and level of care determination processes for both waiver programs and other HCBS services, as appropriate; Prior approval functionality; An e-CAP consumer interface for use by waiver beneficiaries or their informal caregivers; Quality assurance reporting system that meets CMS reporting guidelines; Web-based continuing education; Case management video conferencing capability with consumers/beneficiaries; Telehealth functionality to support case management and risk management; On-line mediation and appeals tracking for waiver programs.

The e-CAP system will: perform on-line workflow management processes and tools for the various administrative authority responsibilities related to waiver enrollment, monitoring waiver limits, level of care evaluations, review of service plans, prior authorization of waiver services, utilization management, and quality assurance/quality improvement; process on-line request for service/level of care determination that is standardized and computerized for both waiver programs and other HCBS services, as appropriate; generate module for electronically-generated prior approvals for the waiver program, including an interface to MMIS to transmit prior approvals for use in MMIS claims processing; generate quality assurance reporting system for the waiver programs that meets CMS reporting guidelines that can be implemented using e-CAP service provider interface, case management interface and administrative authority interface; refine reporting model for a continuous quality improvement program that allows DMA to analyze quality data state-wide and directly target, time-limited quality improvement initiatives state-wide in response to identified quality problems or best practices; implement Web based model for continuing education designed to support DMA implementation of a continuous quality improvement program.
The quality improvement system captures and assesses data in three areas to assure each individual beneficiary receives quality health care that is delivered cost effectively and in the appropriate setting:
1. Level of Care: Are enrollees categorized properly, and can this be compared across lead agencies?
2. Cost: Are we staying within the cost limits, both at the individual level and at the county and state levels?
3. Quality: Are there opportunities for systems improvement? Are there variations between counties that can help us identify ways to more effectively provide services? Are there individuals who need immediate attention? Are the six waiver assurances being adequately monitored and met?
The e-CAP system provides an automated assessment and plan of care tool that captures data on all CAP/DA beneficiaries. In addition to providing the automated assessment and plan of care tool, CWE provides the following services:
1. Customer service
2. Clinical staff support;
3. Web-based, HIPAA compliant, searchable database that contains data on all CAPDA beneficiaries;
4.24/7 on-line secure access and data entry support;
5. Automated system that accepts claims data from DMA and matches it to beneficiary data;
6. Links claims to the beneficiary by preparing cost summary reports for use by DMA in monitoring expenditures per beneficiary;
7. Assist DMA in implementing a quality measurement and improvement system which can identify both individual and systematic quality issues;
8. Provide training sessions on a quarterly basis for new users;
9. Establish, maintain, and monitor a standardized Waiting List;
10. Development of training videos

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

Quality Assurance is monitored by the Home and Community Care Section's Quality Management Committee. Home and Community Care Section QM, the CWE and CAP/DA Program staff monitor quality on an ongoing basis. Each year the QM Committee will conduct an annual evaluation of the QM Program and Develop an Annual QM Work Plan.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Financial Integrity and Accountability of the waiver is the primary responsibility of DMA. In conjunction with DMA, the CWE will provide oversight in financial integrity and accountability. The CWE will analyze each Person Centered Plan of Care initially and monthly thereafter to ensure that all waiver requirements are met. Then will also ensure services are appropriate in type and frequency to meet the needs of the participant. Financial integrity and accountability tasks are achieved by the CWE's review of current service request form, the assessment, the approved Person Centered Plan, agency service documentation, and paid claims. The CWE will assure that services are appropriate to the needs of the participant, are provided appropriately, are billed appropriately, and that the participant's health, safety and well being continue to be assured. A financial quarterly report is provided to DMA for review.

An additional accountability to assure the waiver beneficiary is aware of authorized waiver services, budgetary limits and waiver limits and waiver service that are available, the beneficiary is mailed an approval letter that identifies the approval to participate in the waiver and their budgetary limits. Further, within 30-days of waiver approval, the waiver participant is mailed a “Welcome Letter” that describes the waiver program and how to report program integrity concerns.

Each month, the case manager or care advisor corresponds with the beneficiary to assure that the services authorized on the POC are adequate in the amount, frequency and duration. Every three months, the case manager or care advisor conducts a home visit to observe the provision of services, and that the receipt of waiver services are received in the amount, frequency and duration as identified in the service plan.

Annually the DMA's Accountability Team conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of enrolled providers. This review includes monitoring of requirements that address staff qualifications, service authorizations, Person Centered Plans, service documentation, and billing protocol.

For Medicaid audit purposes, a valid plan must:
1. Include the required signatures on or before services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person’s needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and
7. Include a 24 hour schedule of coverage, if warranted.

The e-CAP system reviews 100% cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided. These reviews also determine deficiencies that result from consistent failure to complete the care planning assessment tool accurately.
The CWE will conduct the e-CAP reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, or different LOC and appeals on a monthly basis to assure accurate and 100% compliance of the wavier QIS. The Division of Medical Assistance will review this information quarterly to assure compliance of waiver assurances.

Post-payment reviews by DMA look at the complete audit trail including the approval of the plan of care, the case manager’s authorization to the provider to render approved services, service provision, service documentation and the case manager’s authorization for claims submission and actual claims data.

CAP/DA participant files are monitored as submitted and/or changed by DMA's Quality Assurance contractor. Quality assurance (QA) reviews determine participant's LOC is classified correctly. Results of monthly monitoring are reviewed by the CWE and DMA. The findings are shared with the lead agencies. The findings enable the agencies to improve the manner in which CAP/DA is operated. The QA review process is not a negative process, but one that leads to the continuous quality improvement. Additionally, QAQI places prior approval limits on services to assure claims data is billed as planned in the amount, frequency and duration. This process ensures compliance of monthly budget monitoring.

DMA’’s Program Integrity Section is tasked with multiple responsibilities. These include:
- coordinating provider fraud, abuse and administrative over-payments;
- determining the accuracy of Medicaid eligibility determinations;
- performing reviews of claims filed to identify problem areas;
- assisting in claim payment audits;
- conducts periodic reviews with providers who bill for payments; and
- referring cases of possible fraud to the Attorney General’s Medicaid Investigations unit.

The efforts of the Program Integrity Section promote program fiscal efficiency of Medicaid money spent and the services rendered.

North Carolina fiscal contractor monitors waiver providers for fiscal accountability through post payment audits of paid claims. The fiscal contractor has established edits in the claims payment system to ensure payment is made in accordance with the approved methodology.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. **Methods for Discovery: 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.

i. **Performance Measures**

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator. Each performance measure must be specific to this waiver (i.e., data presented must be waiver specific).

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

Performance Measure:
PM: Number and percent of claims coded and paid according to the waiver reimbursement methodology. Numerator: Number of claims paid according to waiver reimbursement methodology Denominator: Total number of waiver claims reviewed

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

	Specify:	

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: CWE, e-CAP CSC/NCTracks (OMMIS)	☐ **Annually**

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

Performance Measure:
PM: Number and percent of waiver claims reviewed where the paid claims are only for services specified in the individual's POC Numerator: Number of waiver claims paid only for services specified on the individual's POC Denominator: Total number of paid claims

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

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

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: CWE, e-CAP CSC/NCTracks (OMMIS)	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:

PM: Number and percent of waiver service claims that were submitted for participants who were enrolled in the waiver on the date that the service was delivered Numerator: Number of waiver service claims that were submitted for participants who were enrolled in the waiver on the date that the service was delivered Denominator: Total number of service claims

Data Source (Select one):
Financial records (including expenditures)
If 'Other' is selected, specify:

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

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

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

		☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: CWE, e-CAP CC/NCTracks	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: CWE, e-CAP CSC/NCTracks (OMMIS)	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.
The e-CAP system will place prior approval limits on service authorizations, which will prevent over payment in the amount, duration and frequency of approved Medicaid claims. The prior approval limits will also prevent providers from submitting Medicaid claims prior to the effective date of services implementation. The Medicaid Fiscal Agent, Computer Science Corporation is responsible for ensuring that CAP/DA claims are paid correctly. All services are appropriately coded and audits and edits within the system ensure claims are paid correctly. Audits have been tested to assure claims for the CAP/DA waiver services will process as per Medicaid guidelines.
The CWE monitors service authorization against paid claims to ensure that they are coded and paid correctly

and that they correspond with the approved services in each participant's POC. The CWE in conjunction with the Medicaid CAP/DA Unit monitors expenditures to ensure that monthly benefit limits are not exceeded and the program stays within its approved budget.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Upon discovery of non-compliance, a root cause analysis is completed to identify the source of the systems error. If a CSC/NCTracks (MMIS) issue is discovered, a Medicaid Policy Memo (Change Service Request-CSR) is generated to identify and resolve the issue.

Upon discovery of non-compliance, DMA contacts the provider to alert them of the paid claim error and requests proposal on repayment, which can include recoupment of payment and/or adjustment to future provider payments; if trends or patterns are revealed of continued non-compliance, an audit is conducted, which may result in further sanctions or disbarment as a Medicaid-enrolled provider.

ii. Remediation Data Aggregation

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: CWE, e-CAP CSC/NCTracks	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. Timelines

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

◉ **No**

○ **Yes**

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

DMA establishes the final reimbursement rate and has developed a process to ensure that rates for waiver services are adequate and appropriate.

Rates are set to reimburse reasonable cost as defined in section 1861(v) of the Social Security Act. Service rates are developed using various methodologies; Medicare, historical cost to providers, cost modeling and Medicare established fee schedules; and, in some cases, providers are invited to participate in forums related to rate setting

The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.

The waiver participant is provided information about the waiver and payments when a referral is made and during the initial assessment process and annually thereafter.

b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

CAP-DA Providers must obtain prior approval from one of the approved Utilization Review Vendors before performing any service to be billed to Medicaid.

The provider must identify and bill third party insurance and/or Medicare coverage prior to billing Medicaid because Medicaid is the payor of last resort.

Once the provider determines that the invoice is a Medicaid claim, the provider then bills CSC for payment.

CSC is the fiscal agent (FA) for Medicaid claim processing and payment. It is the FA's responsibility to process valid Medicaid claims from enrolled providers in accordance with NCDMA policies, edits, audits, guidelines, and reimbursement methodologies.

All CAP/DA services may be billed only by an agency enrolled with DMA and approved by the lead agency, when applicable, and must be provided to an enrolled CAP-DA participant.
CAP-DA Providers must obtain a service authorization from one of the authorized Lead Agency(s) before performing any service to be billed to Medicaid.
Once the provider determines that the invoice is a Medicaid claim, the provider then bills NCTracks (CSC) for payment.

CSC is the fiscal agent (FA) for Medicaid claim processing and payment. It is that contractor's responsibility to process valid Medicaid claims from enrolled providers in accordance with NCDMA policies, edits, audits, guidelines, and reimbursement methodologies.
Individuals who choose to direct their own services and supports must enter into a working arrangement with a Financial Management Provider, who will pay the participant's staff, and handle federal/state taxes and other payroll or benefits related to employment of the support person. The Financial Management Provider (FM) may submit claims on behalf of a participant for payment directly to the State's claims payment system for those services provided through an Individual Provider selected by the participant. If billing Medicaid services on behalf of participants, the Financial Management provider must enroll with the Division of Medical Assistance, sign a provider Participation Agreement, and receive a provider ID number. Subcontractors are subject to all rules and regulations, which govern Medicaid reviews/audits.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. **Certifying Public Expenditures** *(select one)*:

- (●) **No. State or local government agencies do not certify expenditures for waiver services.**
- ( ) **Yes. State or local government agencies directly expend funds for part or all of the cost of waiver services and certify their State government expenditures (CPE) in lieu of billing that amount to Medicaid.**

***Select at least one*:**

☐ **Certified Public Expenditures (CPE) of State Public Agencies.**

Specify: (a) the State government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b).*(Indicate source of revenue for CPEs in Item I-4-a.)*

☐ **Certified Public Expenditures (CPE) of Local Government Agencies.**

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). *(Indicate source of revenue for CPEs in Item I-4-b.)*

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Annually the DMA's Accountability Team conducts a Medicaid Compliance Audit that includes waiver services. Auditors review Medicaid billed events per a sample of enrolled providers. This review includes monitoring of requirements that address staff qualifications, service authorizations, Person Centered Plans, service documentation, and billing protocol.
For the CAP/DA waiver, a validation of the following is reviewed:
1. Have the required signatures on or before services begin;
2. Cover the dates of service;
3. Identify the services billed and the amount being billed;
4. Have measurable goals and appropriate interventions;
5. Be updated/revised based on a person's needs, provider changes and/or regulatory changes;
6. Include informal and formal support systems; and
7. Include a 24 hour schedule of coverage, if warranted.

During and prior to waiver participation DMA validates:
• The e-CAP system reviews 100% of its cases monthly to determine errors in services that were authorized but not provided, or unauthorized services that were provided.
• The reviews of assessment, plans of care, freedom of choice, monitoring, requests for additional service, different LOC and appeals on a monthly basis to assure accuracy and 100% compliance of authorized services.
• The CWE conducts quality assurance reviews that include a review of the Person Centered Plan and service documentation for each waiver participant. The reviewer reviews the current service request form, the assessment and the approved Person Centered Plan, agency service documentation, and paid claims to insure that services are appropriate to the needs of the participant, are provided appropriately, are billed appropriate, and the participant's health, safety and well being continue to be assured.
• The CWE places prior approval limits on all service plans to identify deviations from the providers and review provision of services monthly. If there are consistent deviations and the service is authorized on the POC, the case manager must review these with the beneficiary for further validation.

DMA/CWE will provide each lead agency with QI reports to validate all paid claims and authorized services. The Lead Agency will contact the CWE/DMA when program integrity concerns are present. DMA will arrange for a program integrity review of the concerns.

In addition to the activities described above, DMA utilizes desktop reviews and on-site reviews (audits), CME

reports, and special reviews to assure program accountability for POC development and implementation. These desktop reviews and on-site reviews occur annually and as needed.

Submitted claims are systematically reviewed by the fiscal agent to ensure that all required information is present. Completed claims processed through OMMIS are run against system edits verify:
• Services are prior authorized (i.e., level of care);
• Individual is a Medicaid beneficiary and is enrolled in the waiver (i.e. CAP indicator);
• Provider is an enrolled waiver provider;
• Claim is not a duplicate;
• Claim is paid per the published rates; and the participant was not institutionalized during the time covered.

Payments are made through CSC and are restricted to those coded on the correct program. Claims are subject to a complete series of edits to ensure that only valid claims for eligible beneficiaries and covered services are reimbursed to enrolled providers.

Validation that services have been provided as billed is a function of quality assurance conducted by the CWE. Audits include verification that the services were provided as billed. Additional validation that services were provided as billed is performed during lead agency and provider on-site compliance monitoring reviews, conducted by DMA's Program Integrity Unit. Validation will also be achieved through participant's surveys by mail or by telephone; education about fraud and abuse and how to report concerns of payment integrity and quality of care. During enrollment and annually thereafter, each waiver participant will be provided education and information regarding financial accountability. In addition, post payment reviews, review of provider records and claims will also be used for validation.

e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §92.42.

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. **Method of payments -- MMIS** (*select one*):

- (●) **Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).**
- ( ) **Payments for some, but not all, waiver services are made through an approved MMIS.**

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are not made through an approved MMIS.**

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ( ) **Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.**

  Describe how payments are made to the managed care entity or entities:

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

- [ ] **The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.**
- [x] **The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.**
- [x] **The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.**

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

The FMS contracted by DMA acts in a limited fiscal agency capacity to reimburse hired personal care assistants for participant-directed services. The FMS files a claim to Medicaid based on the approved POC for personal care services rendered by the hired employee of a participant-directed beneficiary. The Medicaid agency exercises oversight of the limited fiscal agent through the following:
• Payment: The respective participating Divisions will pay the Contractor within thirty (30) days following approval of the Contractor's monthly invoice for services.
• Consultation: Division Contract Administrators will be available for consultation with the Contractor during normal working hours (8:00 a.m. - 5:00 p.m.) at its offices in Raleigh, North Carolina for the purpose of discussing matters pertinent to the performance of the contract.
• Records/Files: The Division and the Division Local Entities will provide the Contractor the necessary records and files in order for the Scope of Work to be completed.
• Storage of Reviews: The respective participating Divisions will retrieve from the Contractor and store all reviews including supporting medical records, worksheets, justifications, faxes, correspondence, etc.
• Oversight of FMS Entity: The Division staff (combination of state and local staff representing funding agencies) is responsible for monitoring and maintenance of the contract with the FMS. Standard contract monitoring principles will apply including:
o On-site visits with the FMS to review the business flows and quality measures developed by the FMS to the standards of the Division programs
o Review of monthly Financial Participant statements
o Annual survey of Participants to ascertain issues, trends or areas needing improvement
o Review of FMS quality standards
o Monthly review of customer services calls/complaints

A quarterly report will be provided by participating Divisions indicating the results of the FMS reviews. If there are significant concerns of customer service or fiscal integrity, deficiency (ies) will be noted with an expected corrective action plan to be put in place. Sanctions may include monetary penalties or termination of contract if warranted.

- [ ] **Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity.**

Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

- (●) **No. The State does not make supplemental or enhanced payments for waiver services.**
- ( ) **Yes. The State makes supplemental or enhanced payments for waiver services.**

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the State to CMS. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. **Payments to State or Local Government Providers.** *Specify whether State or local government providers receive payment for the provision of waiver services.*

- ( ) **No. State or local government providers do not receive payment for waiver services.** Do not complete Item I -3-e.
- (●) **Yes. State or local government providers receive payment for waiver services.** Complete Item I-3-e.

Specify the types of State or local government providers that receive payment for waiver services and the services that the State or local government providers furnish: *Complete item I-3-e.*

Designated lead agencies of this waiver are authorized to furnish services. These governmental agencies are local departments of social services, public health departments and aging programs. These agencies are reimbursed to provide waiver services for case management, specialized medical equipment and supplies, home accessibility and adaptation, participant goods and services and assistive technology. The reimbursement rate for lead agencies does not differ from other Medicaid providers.

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. **Amount of Payment to State or Local Government Providers.**

Specify whether any State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

- (●) **The amount paid to State or local government providers is the same as the amount paid to private providers of the same service.**
- ( ) **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.**

- **The amount paid to State or local government providers differs from the amount paid to private providers of the same service. When a State or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.**

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

- **Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.**
- **Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.**

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. **Additional Payment Arrangements**

i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

- **No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.**
- **Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e).**

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. **Organized Health Care Delivery System.** *Select one:*

- **No. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.**
- **Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10.**

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver;

(e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. **Contracts with MCOs, PIHPs or PAHPs.** *Select one:*

- (●) **The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.**
- ( ) **The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency.**

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ( ) **This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.**

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Select at least one*:

- [x] **Appropriation of State Tax Revenues to the State Medicaid agency**
- [ ] **Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.**

  If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the State entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by State agencies as CPEs, as indicated in Item I -2-c:

- [ ] **Other State Level Source(s) of Funds.**

  Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by State agencies as CPEs, as indicated in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. **Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Select One*:

- (●) **Not Applicable**. There are no local government level sources of funds utilized as the non-federal share.
- ( ) **Applicable**

  Check each that applies:

  - [ ] **Appropriation of Local Government Revenues.**

    Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

  - [ ] **Other Local Government Level Source(s) of Funds.**

    Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2- c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. **Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. *Select one*:

- (●) **None of the specified sources of funds contribute to the non-federal share of computable waiver costs**
- ( ) **The following source(s) are used**

  Check each that applies:

  - [ ] **Health care-related taxes or fees**
  - [ ] **Provider-related donations**
  - [ ] **Federal funds**

  For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. **Services Furnished in Residential Settings.** *Select one:*

- (●) **No services under this waiver are furnished in residential settings other than the private residence of the individual.**

- **As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual.**

b. **Method for Excluding the Cost of Room and Board Furnished in Residential Settings.** The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:
Do not complete this item.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- **No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.**
- **Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C -3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.**

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

- **No. The State does not impose a co-payment or similar charge upon participants for waiver services.**
- **Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services.**

i. **Co-Pay Arrangement.**

Specify the types of co-pay arrangements that are imposed on waiver participants (*check each that applies*):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ **Nominal deductible**
- ☐ **Coinsurance**
- ☐ **Co-Payment**
- ☐ **Other charge**

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants. *Select one*:

- (●) **No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.**
- ( ) **Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement.**

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2d have been completed.

Level(s) of Care: Nursing Facility

Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Col 7 less Column4)
1	20248.43	5195.67	25444.10	22665.64	4285.63	26951.27	1507.17
2	19954.50	5414.93	25369.43	23345.61	4466.48	27812.09	2442.66
3	20251.81	5633.69	25885.50	24045.98	4646.93	28692.91	2807.41
4	20252.74	5860.16	26112.90	24767.36	4833.74	29601.10	3488.20
5	20254.34	6096.92	26351.26	25510.38	5029.02	30539.40	4188.14

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. **Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table: J-2-a: Unduplicated Participants

Waiver Year	Total Number Unduplicated Number of Participants (from Item B -3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)
		Level of Care:
		Nursing Facility
Year 1	13363	13363
Year 2	13647	13647
Year 3	13936	13936
Year 4	14231	14231
Year 5	14533	14533

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. **Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.

The average length of stay was calculated based on claims/eligibility data provided by the state's fiscal intermediary for waiver year 10/1/10-9/30/11 as this is the most recent completed waiver year. Total number of enrolled days (in waiver as well as in Medicaid) was divided by the number of unduplicated waiver recipients during that time period.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. **Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

i. **Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Year 1 Factor D Derivations are estimated based on North Carolina's experience in it's current CAP/DA and CAP/Choice waivers. Claims data was run to factor actual utilization (users and units) of current services in the most recently completed waiver year (7/1/11-6/30/12). Utilization was then trended forward to the first year of the waiver using historic utilization trends. Current service rates are utilized.

ii. **Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Year 1 Factor D' Derivation is estimated based on actual Medicaid expenditures for all non-waiver services for CAP/DA and CAP/Choice recipients in the most recently completed waiver year (7/1/11-6/30/12).

iii. **Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Year 1 Factor G Derivation is estimated based on actual Medicaid expenditure data for Medicaid recipients in nursing facilities. The data was run for the most recently completed waiver year of 7/1/11-6/30/12, the data was trended forward to the first year of the waiver using historic trends.

iv. **Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The Year 1 Factor G' Derivation is estimated based on actual Medicaid expenditure data for Medicaid recipients in nursing facilities. These are the non-facility expenditures for these recipients. The data was run for the most recently completed waiver year of 7/1/11-6/30/12, the data was trended forward to the first year of the waiver using historic trends.
DMA based our assumptions regarding cost and utilization on data extracted from the DMA claims warehouse. The claims warehouse does not contain any Part D claims data; therefore, it was not necessary to make an explicit adjustment in order to remove the impact of Part D data.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "*manage components*" to add these components.

Waiver Services	
Adult Day Health	
Case Management	
Institutional Respite Services	
Personal Care Aide	
Care Advisor	
Financial Management Services	
Personal Assistance Services	
Assistive Technology	
Community Transition Services	
Home Accessibility and Adaptation	
Meal Preparation and Delivery	
Non-Institutional Respite Services	

Waiver Services	
Participant Goods and Services	
Personal Emergency Response Services	
Specialized Medical Equipment and Supplies- Nutritional Supplements	
Specialized Medical Equipment and Supplies- Reusable Incontinence supplies	
Specialized Medical Equipment and Supplies-Disposable liners	
Specialized Medical Equipment and Supplies-Medication Dispensing Boxes	
Training/Education and Consultative Services	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 1

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**2072297.52**
Adult Day Health	per diem	324	166.00	38.53	**2072297.52**	
Case Management Total:						**18497029.18**
Case Management	15 minutes	10763	121.54	14.14	**18497029.18**	
Institutional Respite Services Total:						**25036.30**
Institutional Respite Services	per diem	18	6.72	206.98	**25036.30**	
Personal Care Aide Total:						**187522408.80**
Personal Care Aide	15 minutes	10638	5080.00	3.47	**187522408.80**	
Care Advisor Total:						**2194995.19**
Care Advisor	per diem	1399	110.96	14.14	**2194995.19**	
Financial Management Services Total:						**1333596.75**
Financial Management Services	15 minutes	1399	41.00	23.25	**1333596.75**	
Personal Assistance Services Total:						**46400250.10**
Personal Assistance Services	15 iminutes	1270	10529.00	3.47	**46400250.10**	
				GRAND TOTAL:		**270579776.85**
				Total Estimated Unduplicated Participants:		**13363**
				Factor D (Divide total by number of participants):		**20248.43**
				Average Length of Stay on the Waiver:		297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Assistive Technology Total:						**506478.00**
Assistive Technology	Instance	300	1.00	1688.26	**506478.00**	
Community Transition Services Total:						**48000.00**
Community Transition Services	Instance	96	1.00	500.00	**48000.00**	
Home Accessibility and Adaptation Total:						**3178000.00**
Home Accessibility and Adaptation	Event	1589	1.00	2000.00	**3178000.00**	
Meal Preparation and Delivery Total:						**304159.60**
Meal Preparation and Delivery	Instance	551	184.62	2.99	**304159.60**	
Non-Institutional Respite Services Total:						**899885.51**
Non-Institutional Respite Services	15 minutes	740	350.45	3.47	**899885.51**	
Participant Goods and Services Total:						**28800.00**
Participant Goods and Services	Event	36	1.00	800.00	**28800.00**	
Personal Emergency Response Services Total:						**1958893.20**
Personal Emergency Response Services	per month	5996	11.00	29.70	**1958893.20**	
Specialized Medical Equipment and Supplies - Nutritional Supplements Total:						**844272.00**
Specialized Medical Equipment and Supplies-Nutritional Supplements	Instance	99	410.00	20.80	**844272.00**	
Specialized Medical Equipment and Supplies - Reusable Incontinence supplies Total:						**3928500.73**
Specialized Medical Equipment and Supplies-Reusable Incontinence supplies	Instance	5309	1.00	739.97	**3928500.73**	
Specialized Medical Equipment and Supplies -Disposable liners Total:						**652550.41**
Specialized Medical Equipment and Supplies-Disposable liners	Instance	2288	838.84	0.34	**652550.41**	
Specialized Medical Equipment and Supplies -Medication Dispensing Boxes Total:						**2123.55**
Specialized Medical Equipment and Supplies-	Instance	195	1.00	10.89	**2123.55**	

GRAND TOTAL:	**270579776.85**
Total Estimated Unduplicated Participants:	**13363**
Factor D (Divide total by number of participants):	**20248.43**
Average Length of Stay on the Waiver:	297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Medication Dispensing Boxes						
Training/Education and Consultative Services Total:						**182500.00**
Training/Education and Consultative Services	Instance	365	1.00	500.00	**182500.00**	
				GRAND TOTAL:		**270579776.85**
				Total Estimated Unduplicated Participants:		**13363**
				Factor D (Divide total by number of participants):		**20248.43**
				Average Length of Stay on the Waiver:		297

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 2

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**2115921.57**
Adult Day Health	per diem	331	165.91	38.53	**2115921.57**	
Case Management Total:						**18892301.57**
Case Management	15 minutes	10993	121.54	14.14	**18892301.57**	
Institutional Respite Services Total:						**25036.30**
Institutional Respite Services	per diem	18	6.72	206.98	**25036.30**	
Personal Care Aide Total:						**187535697.79**
Personal Care Aide	15 minutes	10638	5080.36	3.47	**187535697.79**	
Care Advisor Total:						**2242064.42**
Care Advisor	15 minutes	1429	110.96	14.14	**2242064.42**	
Financial Management Services Total:						**1362194.25**
Financial Management Services	15 minutes	1429	41.00	23.25	**1362194.25**	
				GRAND TOTAL:		**272319127.35**
				Total Estimated Unduplicated Participants:		**13647**
				Factor D (Divide total by number of participants):		**19954.50**
				Average Length of Stay on the Waiver:		297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Assistance Services Total:						**47386712.11**
Personal Assistance Services	15 iminutes	1297	10529.00	3.47	**47386712.11**	
Assistive Technology Total:						**531801.90**
Assistive Technology	Instance	315	1.00	1688.26	**531801.90**	
Community Transition Services Total:						**49000.00**
Community Transition Services	Instance	98	1.00	500.00	**49000.00**	
Home Accessibility and Adaptation Total:						**3246000.00**
Home Accessibility and Adaptation	Event	1623	1.00	2000.00	**3246000.00**	
Meal Preparation and Delivery Total:						**310783.77**
Meal Preparation and Delivery	Instance	563	184.62	2.99	**310783.77**	
Non-Institutional Respite Services Total:						**919342.49**
Non-Institutional Respite Services	15 minutes	756	350.45	3.47	**919342.49**	
Participant Goods and Services Total:						**29600.00**
Participant Goods and Services	Event	37	1.00	800.00	**29600.00**	
Personal Emergency Response Services Total:						**1944327.13**
Personal Emergency Response Services	per month	6124	10.69	29.70	**1944327.13**	
Specialized Medical Equipment and Supplies - Nutritional Supplements Total:						**861328.00**
Specialized Medical Equipment and Supplies-Nutritional Supplements	Instance	101	410.00	20.80	**861328.00**	
Specialized Medical Equipment and Supplies - Reusable Incontinence supplies Total:						**4012117.34**
Specialized Medical Equipment and Supplies-Reusable Incontinence supplies	Instance	5422	1.00	739.97	**4012117.34**	
Specialized Medical Equipment and Supplies -Disposable liners Total:						**666175.87**
Specialized Medical Equipment and Supplies-Disposable liners	Instance	2337	838.40	0.34	**666175.87**	
			GRAND TOTAL:			**272319127.35**
			Total Estimated Unduplicated Participants:			**13647**
			Factor D (Divide total by number of participants):			**19954.50**
			Average Length of Stay on the Waiver:			297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies -Medication Dispensing Boxes Total:						**2222.83**
Specialized Medical Equipment and Supplies-Medication Dispensing Boxes	Instance	199	1.00	11.17	**2222.83**	
Training/Education and Consultative Services Total:						**186500.00**
Training/Education and Consultative Services	Instance	373	1.00	500.00	**186500.00**	
				GRAND TOTAL:		**272319127.35**
				Total Estimated Unduplicated Participants:		**13647**
				Factor D (Divide total by number of participants):		**19954.50**
				Average Length of Stay on the Waiver:		297

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 3

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**2160669.16**
Adult Day Health	per diem	338	165.91	38.53	**2160669.16**	
Case Management Total:						**19292729.69**
Case Management	15 minutes	11226	121.54	14.14	**19292729.69**	
Institutional Respite Services Total:						**26427.21**
Institutional Respite Services	per diem	19	6.72	206.98	**26427.21**	
Personal Care Aide Total:						**195609710.72**
Personal Care Aide	15 minutes	11096	5080.36	3.47	**195609710.72**	
Care Advisor Total:						**2289133.65**
Care Advisor	15 minutes	1459	110.96	14.14	**2289133.65**	
				GRAND TOTAL:		**282229167.05**
				Total Estimated Unduplicated Participants:		**13936**
				Factor D (Divide total by number of participants):		**20251.81**
				Average Length of Stay on the Waiver:		297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Financial Management Services Total:						**1390791.75**
Financial Management Services	units	1459	41.00	23.25	**1390791.75**	
Personal Assistance Services Total:						**48409709.75**
Personal Assistance Services	15 iminutes	1325	10529.00	3.47	**48409709.75**	
Assistive Technology Total:						**558814.06**
Assistive Technology	Instance	331	1.00	1688.26	**558814.06**	
Community Transition Services Total:						**50000.00**
Community Transition Services	Instance	100	1.00	500.00	**50000.00**	
Home Accessibility and Adaptation Total:						**3314000.00**
Home Accessibility and Adaptation	Event	1657	1.00	2000.00	**3314000.00**	
Meal Preparation and Delivery Total:						**324032.10**
Meal Preparation and Delivery	Instance	587	184.62	2.99	**324032.10**	
Non-Institutional Respite Services Total:						**938799.48**
Non-Institutional Respite Services	15 minutes	772	350.45	3.47	**938799.48**	
Participant Goods and Services Total:						**30400.00**
Participant Goods and Services	Event	38	1.00	800.00	**30400.00**	
Personal Emergency Response Services Total:						**1985601.22**
Personal Emergency Response Services	per month	6254	10.69	29.70	**1985601.22**	
Specialized Medical Equipment and Supplies - Nutritional Supplements Total:						**878384.00**
Specialized Medical Equipment and Supplies-Nutritional Supplements	Instance	103	410.00	20.80	**878384.00**	
Specialized Medical Equipment and Supplies - Reusable Incontinence supplies Total:						**4096473.92**
Specialized Medical Equipment and Supplies-Reusable Incontinence supplies	Instance	5536	1.00	739.97	**4096473.92**	
				GRAND TOTAL:		**282229167.05**
				Total Estimated Unduplicated Participants:		**13936**
				Factor D (Divide total by number of participants):		**20251.81**
				Average Length of Stay on the Waiver:		297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies -Disposable liners Total:						**680785.77**
Specialized Medical Equipment and Supplies-Disposable liners	Instance	2387	838.84	0.34	**680785.77**	
Specialized Medical Equipment and Supplies -Medication Dispensing Boxes Total:						**2204.58**
Specialized Medical Equipment and Supplies-Medication Dispensing Boxes	Instance	203	1.00	10.86	**2204.58**	
Training/Education and Consultative Services Total:						**190500.00**
Training/Education and Consultative Services	Instance	381	1.00	500.00	**190500.00**	
				GRAND TOTAL:		**282229167.05**
				Total Estimated Unduplicated Participants:		**13936**
				Factor D (Divide total by number of participants):		**20251.81**
				Average Length of Stay on the Waiver:		297

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 4

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						**2211809.26**
Adult Day Health	per diem	346	165.91	38.53	**2211809.26**	
Case Management Total:						**19701750.68**
Case Management	15 minutes	11464	121.54	14.14	**19701750.68**	
Institutional Respite Services Total:						**26424.65**
Institutional Respite Services	per diem	19	6.72	206.96	**26424.65**	
Personal Care Aide Total:						**199752490.29**
Personal Care Aide	15 minutes	11331	5080.36	3.47	**199752490.29**	
				GRAND TOTAL:		**288216810.96**
				Total Estimated Unduplicated Participants:		**14231**
				Factor D (Divide total by number of participants):		**20252.74**
				Average Length of Stay on the Waiver:		297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Care Advisor Total:						**2337771.86**
Care Advisor	15 minutes	1490	110.96	14.14	**2337771.86**	
Financial Management Services Total:						**1420342.50**
Financial Management Services	15 minutes	1490	41.00	23.25	**1420342.50**	
Personal Assistance Services Total:						**49432707.39**
Personal Assistance Services	15 iminutes	1353	10529.00	3.47	**49432707.39**	
Assistive Technology Total:						**585826.22**
Assistive Technology	Instance	347	1.00	1688.26	**585826.22**	
Community Transition Services Total:						**51000.00**
Community Transition Services	Instance	102	1.00	500.00	**51000.00**	
Home Accessibility and Adaptation Total:						**3386000.00**
Home Accessibility and Adaptation	event	1693	1.00	2000.00	**3386000.00**	
Meal Preparation and Delivery Total:						**322943.92**
Meal Preparation and Delivery	Instance	587	184.00	2.99	**322943.92**	
Non-Institutional Respite Services Total:						**958256.46**
Non-Institutional Respite Services	15 minutes	788	350.45	3.47	**958256.46**	
Participant Goods and Services Total:						**30400.00**
Participant Goods and Services	event	38	1.00	800.00	**30400.00**	
Personal Emergency Response Services Total:						**2027827.79**
Personal Emergency Response Services	per month	6387	10.69	29.70	**2027827.79**	
Specialized Medical Equipment and Supplies - Nutritional Supplements Total:						**895658.40**
Specialized Medical Equipment and Supplies-Nutritional Supplements	Instance	105	410.10	20.80	**895658.40**	
Specialized Medical Equipment and Supplies - Reusable Incontinence supplies Total:						**4183790.38**

GRAND TOTAL:	**288216810.96**
Total Estimated Unduplicated Participants:	**14231**
Factor D (Divide total by number of participants):	**20252.74**
Average Length of Stay on the Waiver:	297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies-Reusable Incontinence supplies	Instance	5654	1.00	739.97	4183790.38	
Specialized Medical Equipment and Supplies -Disposable liners Total:						695046.05
Specialized Medical Equipment and Supplies-Disposable liners	Instance	2437	838.84	0.34	695046.05	
Specialized Medical Equipment and Supplies -Medication Dispensing Boxes Total:						2265.12
Specialized Medical Equipment and Supplies-Medication Dispensing Boxes	Instance	208	1.00	10.89	2265.12	
Training/Education and Consultative Services Total:						194500.00
Training/Education and Consultative Services	Instance	389	1.00	500.00	194500.00	
				GRAND TOTAL:		288216810.96
				Total Estimated Unduplicated Participants:		14231
				Factor D (Divide total by number of participants):		20252.74
				Average Length of Stay on the Waiver:		297

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

i. Non-Concurrent Waiver. Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.

Waiver Year: Year 5

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Adult Day Health Total:						2250164.33
Adult Day Health	per diem	352	165.91	38.53	2250164.33	
Case Management Total:						20119364.55
Case Management	15 minutes	11707	121.54	14.14	20119364.55	
Institutional Respite Services Total:						28977.20
Institutional Respite Services	per diem	20	7.00	206.98	28977.20	
				GRAND TOTAL:		294356268.49
				Total Estimated Unduplicated Participants:		14533
				Factor D (Divide total by number of participants):		20254.34
				Average Length of Stay on the Waiver:		297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Aide Total:						**203983414.09**
Personal Care Aide	15 minutes	11571	5080.36	3.47	**203983414.09**	
Care Advisor Total:						**2387979.04**
Care Advisor	15 minutes	1522	110.96	14.14	**2387979.04**	
Financial Management Services Total:						**1450846.50**
Financial Management Services	15 minutes	1522	41.00	23.25	**1450846.50**	
Personal Assistance Services Total:						**50565311.92**
Personal Assistance Services	15 iminutes	1384	10529.00	3.47	**50565311.92**	
Assistive Technology Total:						**616214.90**
Assistive Technology	Instance	365	1.00	1688.26	**616214.90**	
Community Transition Services Total:						**52000.00**
Community Transition Services	Instance	104	1.00	500.00	**52000.00**	
Home Accessibility and Adaptation Total:						**3386000.00**
Home Accessibility and Adaptation	event	1693	1.00	2000.00	**3386000.00**	
Meal Preparation and Delivery Total:						**330656.27**
Meal Preparation and Delivery	Instance	599	184.62	2.99	**330656.27**	
Non-Institutional Respite Services Total:						**978929.51**
Non-Institutional Respite Services	15 minutes	805	350.45	3.47	**978929.51**	
Participant Goods and Services Total:						**31200.00**
Participant Goods and Services	event	39	1.00	800.00	**31200.00**	
Personal Emergency Response Services Total:						**2070689.35**
Personal Emergency Response Services	per month	6522	10.69	29.70	**2070689.35**	
Specialized Medical Equipment and Supplies - Nutritional Supplements Total:						**921248.64**
Specialized Medical Equipment and Supplies-Nutritional Supplements	Instance	108	410.10	20.80	**921248.64**	
				GRAND TOTAL:		**294356268.49**
				Total Estimated Unduplicated Participants:		**14533**
				Factor D (Divide total by number of participants):		**20254.34**
				Average Length of Stay on the Waiver:		297

Waiver Service/ Component	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Specialized Medical Equipment and Supplies - Reusable Incontinence supplies Total:						**4272586.78**
Specialized Medical Equipment and Supplies-Reusable Incontinence supplies	Instance	5774	1.00	739.97	**4272586.78**	
Specialized Medical Equipment and Supplies -Disposable liners Total:						**709876.74**
Specialized Medical Equipment and Supplies-Disposable liners	Instance	2489	838.84	0.34	**709876.74**	
Specialized Medical Equipment and Supplies -Medication Dispensing Boxes Total:						**2308.68**
Specialized Medical Equipment and Supplies-Medication Dispensing Boxes	Instance	212	1.00	10.89	**2308.68**	
Training/Education and Consultative Services Total:						**198500.00**
Training/Education and Consultative Services	Instance	397	1.00	500.00	**198500.00**	
				GRAND TOTAL:		**294356268.49**
				Total Estimated Unduplicated Participants:		**14533**
				Factor D (Divide total by number of participants):		**20254.34**
				Average Length of Stay on the Waiver:		297