

**MA-2280-COMMUNITY ALTERNATIVES PROGRAM (CAP) MEDICAID
ELIGIBILITY**

I. INTRODUCTION

A. General

1. Community Alternatives Programs (CAP)

The CAP programs are Medicaid home and community based services waivers granted by the Centers for Medicare and Medicaid Services (CMS).

2. At Risk of Institutionalization

a. The CAP programs allow North Carolina to use Medicaid funds to provide home and community based services to Medicaid recipients who require institutional care (placement in a nursing facility), but for whom care can be provided cost-effectively and safely in the community with CAP services. CAP participants must meet all Medicaid eligibility requirements.

b. Institutional care for CAP is defined as follows:

- (1) CAP for Children (CAP/C): at the ICF and SNF level, and hospital level.
- (2) CAP for Disabled Adults (CAP/DA): at the ICF and SNF level.
- (3) CAP for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD): Intermediate care for the mentally retarded (ICF-MR) level.
- (4) CAP/Choice: at the ICF and SNF level.

3. Services

The CAP programs provide for both medical and non-medical home and community-based services to prevent or delay institutionalization. The programs involve an assessment process, development of a plan of care, and ongoing monitoring of service delivery by a case manager.

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4. Costs

Each CAP program has a cost limit that is related to the cost of comparable institutional care. The total potential Medicaid cost of home and community services for a CAP participant may not exceed the cost limit. These cost limits are sent out as memoranda from the CAP unit to County Directors.

B. Available CAP Programs

North Carolina has 4 CAP waivers to provide services to a limited number of persons in specific groups within the state:

1. CAP for Children (CAP/C)

a. CAP/C is a statewide program which provides an alternative to nursing facility and hospital care for individuals:

- (1) Under age 19,
- (2) Who live in a primary private residence, and whose health, safety and wellbeing can be maintained in their primary residence, (I.B.2.a.)
- (3) Who are medically high risk children and who would be institutionalized in a nursing facility or hospital without the Medicaid payment for the home care available through CAP/C,
- (4) Who can have their needs met through the monthly cost limit,
- (5) Who require Medicaid coverage through CAP/C services in addition to CAP/C case management to remain safely in their primary residence,
- (6) Who have been ruled disabled by Disability Determination Services (DDS.)

NOTE: Children may also be IAS or HSF to qualify for CAP/C.

- b. The CAP Unit of DMA determines whether medical necessity has been established and if an individual may participate.
- c. The Division of Medical Assistance is the state lead agency for CAP/C programs.
- d. The program serves up to 800 individuals statewide during the waiver year.

(I.B.1.d.)

NOTE: The "waiver year" varies, depending upon the start-up date of the waiver.

2. CAP for Disabled Adults (CAP/DA)
 - a. CAP/DA provides an alternative to nursing facility care for persons who are:
 - (1) Age 18 and older, and
 - (2) Live in a private residence.
 - b. Number of Participants
 - (1) CMS determines the number of individuals the state may serve each year.
 - (2) DMA allots a portion of the state's limit to each CAP/DA county.
 - c. County Participation
 - (1) The Board of County Commissioners in each county must decide if the county will participate in the program.
 - (2) An individual must be living in a county that offers the program in order to participate in CAP/DA.
 - d. Lead Agency
 - (1) The lead agency, selected by the Board of County Commissioners, may be either:
 - (a) The county department of social services (dss),
 - (b) The county health department,
 - (c) The county agency for the aged, or
 - (d) A hospital within the county.
 - (2) A list of CAP/DA lead agencies is published annually in the Medicaid Provider Bulletin.

REVISED 08/01/07–CHANGE NO.13-07

(I.B.)

3. CAP for Disabled Adults, Consumer Directed Care (CAP/Choice)
 - a. CAP/Choice is similar to CAP/DA. The eligibility requirements are the same as CAP/DA in I.B.3.a. above.
 - b. The allotments are part of the CAP/DA allotment for each county.
 - c. County participation
 - (1) Requirements for county participation are the same as for CAP/DA in I.B.3.c. above.
 - (2) Cabarrus, Duplin, Forsyth and Surry Counties operate under this pilot.
 - d. Lead agency selection is the same as CAP/DA in I.B.3.d. above.
 - e. CAP/Choice uses a non-traditional case management service. CAP/Choice has four (4) additional services to the usual CAP/DA services.
 - (1) Care Advisor: The care advisor replaces the case manager. This person guides and supports the consumer throughout the planning and delivery process and monitors the provision of care and expenditures.
 - (2) Financial Management Services: A financial manager bills Medicaid for the consumer-directed services available under CAP/Choice, including the personal assistant and also pays the personal assistant for time spent working with the consumer.
 - (3) Personal Assistant Services: The personal assistant provides help with personal and home maintenance tasks. This person is hired by the client and may be a family member.
 - (4) Consumer-Designated Goods & Services: These are services, equipment or supplies not otherwise provided that the client purchases through the Plan of Care to increase independence for daily tasks. For example, the client may purchase a microwave to help the client cook or heat meals, decreasing the time the personal assistant would be needed for such tasks.

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4. CAP for the Mentally Retarded/Developmentally Disabled (CAP/MR-DD)
 - a. CAP-MR/DD provides an alternative to care in an ICF-MR facility for individuals of all ages who require ICF-MR care and who reside:
 - (1) In a private residence, or
 - (2) In a domiciliary care facility.
 - b. CAP-MR/DD:
 - (1) Is tiered waivers utilized statewide with the exception of counties participating in the Piedmont Innovations Waiver. The counties are Cabarrus, Davidson, Rowan, Stanley and Union.
 - (a) The two waivers are the Supports Waiver (C2) and the Comprehensive Waiver (CM).
 - (b) The assigned waiver is based on the cost of care for an individual per year. Services are limited, to a set maximum dollar amount.
 - (c) The approved waiver, C2 or CM, will be indicated on line 11, Recipient Level of Care, of the MR-2.,(See figure 4.b.)
 - (2) Is administered at the local level by area mental health programs.
 - c. CMS determines the specific number of individuals the state may serve each year.
 - d. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) is the state lead agency for CAP-MR/DD. The Division of Mental Health (DMH):
 - (1) Allots a portion of the state's limit to each area program,
 - (2) Determines which individuals may participate in the program, and
 - (3) Is responsible for the program's operation, with oversight provided by DMA.

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C. Where To Get Assistance With CAP Programs

1. Refer to the CAP program manuals for detailed information and instructions about the various services and requirements of the CAP waiver programs.
2. Use this section of the M-AABD Medicaid Eligibility Manual for information regarding eligibility requirements for the various CAP programs.
3. For assistance in other than eligibility matters with the CAP for Children (CAP/C) program, contact the DMA CAP Unit at 919/855-4380.
4. For assistance in other than eligibility matters with the CAP for Disabled Adults (CAP/DA) program, or the CAP/Choice Program contact the local CAP/DA lead agency.
5. For assistance in other than eligibility matters with the CAP for the Mentally Retarded and Developmentally Disabled (CAP-MR/DD) program, contact the area mental health, developmental disabilities, and substance abuse program.

II. POLICY PRINCIPLES - APPLICABLE TO ALL PROGRAMS

A. General Policy Rules

1. To receive CAP, the a/r must request CAP and be eligible in the Aged, Blind, and Disabled (MAABD) aid program/categories, EXCEPT:
 - a. Children in CAP/C may also be in I-AS or H-SF,
 - b. Children in CAP-MR/DD may also be in I-AS or H-SF, and
 - c. Adults in CAP-MR/DD may also be in S-AAD.
2. Individuals in Family and Children's (FC) Medicaid aid program/categories must be deleted from that coverage and be determined eligible under M-AABD in order to be eligible for CAP services, except as noted in II.A.1.a.,b., and c., above.
3. Recipients with living arrangement codes of 16 (incarcerated) or 17 (Institution for Mental Disease) who are in suspension status for Medicaid are not eligible for CAP.
4. All application processing requirements and time frames for the appropriate aid program/category apply.

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5. The CAP effective date for all CAP programs is the latest of the following:
 - a. The date of the Medicaid application,
 - b. The date of FL-2/MR-2 approval, or
 - c. The date of deinstitutionalization for an institutionalized a/r.
6. All CAP recipients are exempt from Medicaid co payments, and the 24 physician visits per year limit. Refer to MA-2905 and MA-3540, Medicaid Covered Services.
7. The agency designated the responsibility for approving specific CAP programs will consider the following in determining CAP participation (the approving authority differs for each CAP program):
 - a. Medicaid eligibility,
 - b. The risk of institutionalization,
 - c. The type of institutional care appropriate for the CAP Program.
 - d. The need for CAP services,
 - e. The resources available to meet the a/r's home care needs, and
 - f. Whether the needed community care can be provided and the a/r can be maintained safely in the home and within the monthly CAP cost limit.
8. The CAP a/r must have an assessment to determine the need for services appropriate to the particular CAP program. The CAP Assessment is used to start this process.
9. Certification Periods
 - a. CAP a/r's have 6 or 12 months certification periods (c.p.'s). Refer to MA-2350, Certification and Authorization, for instructions on establishing the c.p.
 - b. SSI CAP certification periods are controlled by the SSA. Refer to MA-2350, Certification and Authorization.

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10. Budgeting

a. Financial Responsibility

- (1) There is no spouse-for-spouse or parent-for-child financial responsibility in the CAP programs.
- (2) Only the a/r's income is used to determine financial eligibility and spousal income protection does not usually apply in CAP cases. However, if one spouse is in a nursing facility or other medical institution, the at home CAP spouse is entitled to spousal income protection.
- (3) The income of the CAP a/r is not considered available to a spouse/dependent who is also a Medicaid recipient.
- (4) All assets of a couple owned jointly or individually must be considered when one spouse is in CAP or long-term care (ltc). However, an amount can be protected for the other spouse under the spousal protection reserve regulations. Refer to MA-2231, Community Spouse Resource Protection.
- (5) If both spouses are CAP, each is in a separate budget unit (b.u.) of one.

b. One-Third Reduction

Do not apply one-third reduction in CAP, even if applied by SSI.

c. Budget Unit

Always use one for CAP b.u., beginning with the month of approval for CAP.

d. Deductible Cases

- (1) All CAP deductibles are calculated monthly. The 6 month deductible calculations are waived for all CAP cases.
- (2) Never apply a deductible to an SSI individual or an SSI individual in Special Assistance for the Aged or Disabled (S-AAD) who is eligible for CAP, even if there is other countable income. Refer to MA-1100, SSI Medicaid-County DSS Responsibility.
- (3) Use MA-2360, Medicaid Deductible, for deductible requirements, procedures, and regular allowable expenses

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(4) If an individual has a deductible, a copy of the current CAP Plan of Care (POC) must be maintained in the eligibility record. Some expenses which would not be allowed toward a regular Medicaid deductible may be allowed for a CAP deductible only if they are included in the Medicaid column on the CAP Plan of Care (POC) Cost Summary. See [figure 3, Plan of Care](#). If the a/r is responsible for payment of the charge, apply the expense to the CAP deductible.

(a) To be listed in the Medicaid column, the medical service or costs are expected to be paid by Medicaid, except for when the CAP recipient is in deductible status. Since Medicaid requires the provider to be licensed, only licensed provider services can be placed in the Medicaid column. This includes private sitters.

(b) The CAP recipient must be responsible for payment of the charge, in order to apply the charge toward the deductible. This charge must be included in the Medicaid column on the cost summary in the POC.

For example: Adult Day Health services can be applied to the deductible as long as the a/r is responsible for the charge and Adult Day Health services are included in the **Medicaid column** of the Plan of Care.

(c) Items listed in the "Other" column on the cost summary are expected to be paid for by a third party or provided at no charge, and cannot be used toward meeting a deductible. This includes services provided by a non-licensed person.

(5) There are some services (e.g., DME's, home modifications and etc.) that can be used toward a deductible for other Medicaid recipients, but must be included in the Medicaid column on the cost summary in the POC for CAP.

(6) A provider may not inflate charges to the a/r to assist the a/r in meeting a deductible, i.e., charge the a/r more than the provider's usual and customary charge.

(7) Expenses in Excess of the Deductible Amount:

(a) Current c.p.

1) Non-covered expenses applicable to the deductible that meet the requirements in a current c.p. (paid or unpaid) and are in excess of the amount of the monthly deductible may be "rolled over" to a subsequent month in the same c.p.

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(II.A.5. (a))

- 2) Non-covered expenses must be applied to the deductible before applying expenses that may be covered.
- 3) Expenses in a current c.p. that may be covered by Medicaid must be applied only after applying all non-covered expenses.

(b) Prior c.p.

The unpaid portion of medical bills from a prior c.p. in excess of the amount of the deductible may be "rolled over" to a subsequent c.p. if the bills:

- 1) Remain unpaid,
- 2) Have not been applied to a deductible that was met, and
- 3) Meet the other requirements of MA-2360, Medicaid Deductible.

(c) Refer to MA-2360, Medicaid Deductible, for deductible policy.

11. Retroactive Eligibility

There is no retroactive coverage for CAP services; however there is retroactive coverage for regular Medicaid services, if eligibility requirements are met in the retroactive period,

12. Reserve

- a. The reserve limit is for a b.u. of one in all CAP cases. Refer to MA-2230 Financial Resources, for instructions regarding reserve requirements and procedures.
- b. Spousal resource protection applies in CAP. The at home CAP spouse is entitled to resource protection. Refer to MA-2231, Community Spouse Resource Protection.

13. Transfer of Assets

Transfer of assets sanctions apply to all CAP programs, including CAP-MR/DD. Refer to MA-2240, Transfer of Resources.

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14. Eligibility Information System (EIS) Entries

- a. A CAP indicator code in EIS controls the payment for CAP services and the various exemptions for the CAP a/r, such as the exemption from prescription limits and co payments.
- b. Failure to enter the CAP "indicator code" will result in denied claims.
- c. Failure to enter the CAP "end date" when CAP services are terminated may result in payment errors, which will be the financial responsibility of the county department of social services (dss).
 - (1) If the a/r moves out of the county or becomes institutionalized (placement in a nursing facility), keying the county transfer, a ltc living arrangement code, or a patient monthly liability (pml) amount automatically closes CAP without the CAP termination information having to be entered by the county dss.
 - (2) When the entire case is closed, entering the termination code automatically closes CAP without the CAP termination information having to be entered by the county dss.
- d. EIS instructions are found in EIS-3101.

15. Notices

- a. Automated and manual notices are used for CAP cases. When using an "other code" you must key the notice text on page two of the DSS-8125.
- b. Send the CAP Case Manager a copy of the notices sent to the a/r.

Examples: DSS-8108, Notice of Benefits, DSS-8109, Your Application for Benefits Is Being Denied Or Withdrawn, DSS-8110, Your Benefits Are Changing.

- c. Refer to MA-2420, Notice and Hearings Process.

16. Appeals

Appeal requirements apply to CAP cases just as with any other Medicaid case.

- a. For appeals (FL-2/MR-2 issues) on level of care, the client first appeals to the DMA Hearing Office at 2501 Mail Service Center (MSC), Raleigh, North Carolina 27699-2501. Further appeal will go to the Office of Administrative Hearings (OAH).

(II.A.16.)

- b. For appeals regarding denial of CAP services, termination of CAP services, or reduction in CAP services, hold a local hearing at the county dss. If further appeal is required, hold a state appeal through the Division of Social Services Hearing and Appeals. See MA-2420, Notice and Hearings Process.

17. Estate recovery applies to CAP cases. (See DMA Admin. Letters, 9-05, 12-03 and 23-96.)

B. Policy Principles and Services for Specific CAP Programs

1. CAP/C - See IV.
2. CAP/DA - See V.
3. CAP/Choice – See VI.
4. CAP-MR/DD - See VII.

III. PROCEDURES - APPLICABLE TO ALL PROGRAMS

A. Processing CAP Referrals

1. When an individual requests CAP services for or on behalf of the a/r (the a/r must be aware of the referral) or is referred to the county agency to be evaluated for CAP:
 - a. Determine whether the individual is currently approved in deductible status/authorized for Medicaid.
 - (1) If he is not currently an active Medicaid recipient, take an application and other appropriate action to determine eligibility.
 - (2) If he is currently an active Medicaid recipient, determine eligibility in the proper aid program/category for a CAP program.
 - b. Explain the various options for Medicaid coverage to the a/r or responsible party, noting which options relate to CAP participation.
2. Medicaid Eligibility and CAP Eligibility

Determine eligibility according to requirements for the appropriate aid program/category.

- a. All application processing time frames apply unless the individual referred for CAP is already a Medicaid recipient.

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(III.A.2.)

- b. Approve for CAP services only after receipt of an official letter of approval from the appropriate CAP lead agency.
- c. When Medicaid eligibility can be established regardless of eligibility for CAP:
 - (1) Do not wait for CAP approval.
 - (2) Authorize, if appropriate, as for any other applicant.
 - (3) For applications, send a DMA-5099, Notice of Pending for Deductible, if the applicant has a deductible. Refer to MA-2304, Processing the Application.
 - (4) When the Plan of Care is approved:
 - (a) Apply CAP budgeting the first month that CAP is effective, (Refer to II.A.5. and II.A.10.), and
 - (b) If there was a private living arrangement (pla) deductible for the c.p., recalculate the deductible for months prior to CAP approval, and
 - (c) Enter CAP indicator code.
- d. When Medicaid eligibility cannot be established without eligibility for CAP:
 - (1) Verify the status of the Plan of Care with the CAP case manager,

AND
 - (2) Deny the application if the CAP decision is not received by the 45/90th day. Refer to MA-2304, Processing the Application.
- e. Do the following if the a/r was previously in regular Medicaid in deductible status with spousal/parental financial responsibility applied, and CAP participation is approved.
 - (1) Six months deductible has been met.
 - (a) Begin CAP budgeting with monthly deductibles the month following the month CAP eligibility is approved.

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- (b) Recompute the pla budget for the months in the c.p. in which spousal/parental financial responsibility applied prior to CAP approval.
 - (c) Compute the monthly budget for the month of CAP approval using only the a/r's income and an income limit of one.
 - (d) Add the monthly excesses for steps (b) and (c), above, to determine the recomputed deductible for the months prior to CAP budgeting.
 - (e) Send an adequate DSS-8110, Notice of Change in Benefits, to inform the a/r of the earlier date the deductible was met:
- (2) Six months deductible not met at time CAP participation approved:
- (a) Recompute the deductible for the number of months in regular Medicaid and authorize if eligible,
 - (b) Send the DMA-5099, Your Application for Medicaid is Pending for a Deductible, for an applicant, or
 - (c) Send a DSS-8110 (Adequate) for a recipient.
3. If there is excess reserve for regular Medicaid on the 45/90th day, deny the application if CAP has not been approved.

Apply spousal resource protection in CAP, but not in regular pla Medicaid.

B. Procedures for Specific CAP Programs:

1. CAP/C - See IV.
2. CAP/DA - See V.
3. CAP/Choice – See VI.
4. CAP-MR/DD - See VII.

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(III.)

C. Health Insurance

1. Determine whether there is any third party liability, including dollar amounts and type of coverage.
2. Document the coverage on DMA-5008, Verification/Eligibility Determination
3. Enter health insurance information into EIS according to EIS-3350.

D. Eligibility Documentation for CAP

1. File in the case record a copy of the CAP approval letter, the DSS-8108, Notice of Benefits (unless automated notice was used), and the current FL-2/MR-2(s) to document eligibility for CAP participation.
2. For deductible cases, also file in the case record a copy of the Plan of Care Cost Summary in order to indicate the CAP services that may be applied to a deductible.

E. Notices

1. Follow all notice requirements in MA-2420, Notice and Hearings Process.
2. CAP Approved
 - a. Send the DSS-8108, Notice of Benefits:
 - (1) If the CAP Plan of Care and participation is approved, and
 - (2) All other factors of eligibility are met.
 - b. If there is a deductible, explain on the DSS-8108 that authorization for additional months will be granted only after the monthly deductible has been met.
 - c. Send an adequate DSS-8110, Your Benefits are Changing, each time the deductible is met, stating that eligibility is through the last day of that month.
3. CAP Denied – A/R Eligible for Regular Medicaid

If the CAP Plan of Care and participation is denied and the a/r is eligible for regular Medicaid:

- a. Send the DSS-8108, Notice of Benefits, notifying of eligibility for Medicaid, and

(III.E.3.)

b. Send a DSS-8109, Your Application is Being Denied or Withdrawn, notifying of denial for CAP services and file in the case record.

4. CAP Denied – A/R Not Eligible for Regular Medicaid

If the a/r is found to be ineligible for both CAP and regular Medicaid, send one DSS-8109, Your Application is Being Denied or Withdrawn, to deny for both.

F. Deductible Cases

1. Calculate deductibles for CAP a/r's on a monthly basis.
2. Do not compute a deductible for an SSI individual eligible for CAP, even if there is other countable income.
3. Since there is no financial responsibility of spouse/parent(s), do not apply medical expenses of the spouse/parent(s) to the CAP deductible.
4. Applying Medical Expenses to a CAP Deductible:
 - a. Follow procedures in MA-2360, Medicaid Deductible, to determine when bills incurred prior to a current c.p. or during a current c.p. can be applied to the deductible.
 - b. Since CAP deductibles are monthly:

Apply the case management fee to the deductible on the day of the month that services are first provided to the a/r.

The entire monthly case management fee cannot be applied as a single charge unless the specific CAP program bills case management as a monthly amount. If the CAP program bills case management in 15 minute increments, case management cannot be billed prior to the date of service. Refer to CAP program manuals for detailed instructions regarding billing.

Example: Case management fee is \$509.00. The A/R receives first service on May 10th. Do not apply the charges on May 1st because the client had not received the services on that date. Apply the charges on May 10th.

5. Non-Covered/Covered Expenses. Apply charges to the deductible following procedures in II.A.10.d., above and MA-2360, Medicaid Deductible.

(III.)

G. Temporary Absence for Hospitalization

1. Hospital Stay Less Than 30 Days:
 - a. Continue CAP budgeting, and
 - b. Follow procedures in MA-2360, Medicaid Deductible, for instructions on applying hospital charges to the deductible.
2. Hospital Stay 30 Days and over:
 - a. Send a timely DSS-8110, Your Benefits are Changing, to terminate CAP services effective the first day of the month following the 31st day.
 - b. Evaluate eligibility for Medicaid in long-term care (ltc) according to MA-2270, Long-Term Care Need and Budgeting.
 - c. Compute a patient monthly liability (pml) no earlier than the first day of the month in which falls the 31st day, subject to timely notice requirements.
 - d. Enter the pml and ltc living arrangement code in EIS which will automatically terminate CAP.

H. Redetermination of Eligibility/Change in Situation

1. SSI recipients on CAP do not require a redetermination of Medicaid eligibility.
2. Categorically needy, no money payment (CNNMP) requires a yearly Medicaid redetermination. Determine all other cases every 6 months.

Determine that the CAP recipient continues to be financially eligible counting only his income and resources.
3. Follow Special Assistance (SA) redetermination policy when SA recipients are receiving CAP services.
4. If the a/r becomes ineligible for CAP services, terminate the CAP coverage by deleting the CAP indicator code, the "begin date," and the "end date" in EIS.

(III.)

I. Termination Of CAP Services

1. Determine continuing eligibility for Medicaid, as appropriate.
2. If CAP terminates and regular Medicaid continues:
 - a. Recompute the budget for the remainder of the c.p.
 - b. Apply parental/spousal financial responsibility if appropriate.
3. If the CAP case manager notifies the IMC that CAP participation is to be terminated, or if it is learned by any means that an a/r may no longer be eligible for CAP, determine the a/r's eligibility for Medicaid without CAP participation:
 - a. If eligible for Medicaid without CAP, delete the CAP code, enter the end date and continue as regular Medicaid.
 - b. If not eligible, propose termination following procedures in MA-2420, Notice and Hearings Process.
4. Termination Notices:
 - a. When the CAP case manager notifies the IMC in writing that participation in CAP is to be terminated:
 - (1) If only CAP services are being terminated and the individual remains eligible for Medicaid, send an adequate DSS-8110.
 - (2) If Medicaid will terminate because eligibility is dependent upon eligibility for CAP services, or if termination of CAP services will result in a Medicaid deductible, send a timely DSS-8110.
 - b. If CAP and Medicaid eligibility will terminate:
 - (1) Send a DSS-8110, Your Benefits Are Changing, stating that both CAP and Medicaid will terminate.
 - (2) Follow all notice requirements in MA-2420, Notices and Hearings Process, including the right to a fair hearing. The a/r has the right to request a hearing if he disagrees with any decision regarding his benefits.

J. EIS Instructions for Entering CAP Data

Follow EIS instructions in EIS-3101.

IV. CAP/C

A. Policy Rules

1. The policy rules in II. A. above apply to CAP/C.
2. A CAP/C a/r must have prior approval for ICF or SNF level of care as indicated on an approved FL-2. The DMA CAP Unit will determine the need for hospital level of care after prior approval for nursing facility level of care has been obtained.
3. CAP/C cases are approved by the DMA CAP Unit. The CAP Unit will send an approval letter to the CAP/C case manager with a copy to the Medicaid eligibility supervisor in the county dss.
4. Children in CAP/C may be in MAB, MAD, I-AS, or H-SF.
5. The CAP/C a/r must have the required forms completed to determine the need for the following CAP/C services:
 - a. Case Management,
 - b. CAP/C Personal Care Services,
 - c. Waiver supplies: nutritional supplements taken by mouth when ordered by a physician and reusable incontinence undergarments for children and disposable liners for the undergarments.
 - d. Home modifications: wheelchair ramps, widening of doorways for wheelchair access, safety rails, non-skid surfaces, (rough surfaced strips of adhesive made to adhere to non-covered areas such as concrete, wood, tile, linoleum, porcelain or fiber glass), hand held showers, and grab bars,
 - e. Hourly nursing services: RN and LPN,
 - f. Unskilled Respite Care: In-home nurse aide level 1 or 2, and
 - g. Institutional Respite Care.

B. Procedures

1. Follow procedures in III.A. above for CAP/C.
2. When the plan of care is approved, determine financial eligibility for CAP/C.
 - a. Income

(IV.A.B.2.a.)

The child is a Medicaid individual. Complete a budget computation using only the CAP/C a/r's income. Refer to MA-2250, Income and MA-2260, Financial Eligibility Regulations-PLA, and MA-3300, Income (Family and Children's Manual.)

- (1) If income exceeds the income limit for a b.u. of 1, the a/r will have a monthly deductible.
 - (a) The amount of monthly excess income, rounded to the nearest dollar, is the amount of the monthly deductible.
 - (b) Apply charges to the deductible following procedures in II.A.10.d., above and MA-2360, Medicaid Deductible.
- (2) If there is no excess income, the a/r is eligible without a deductible.

b. Reserve

- (1) Determine reserve eligibility using only the a/r's reserve and the resource limit for a budget unit of one. See MA-2230, Financial Resources and MA-2260, Financial Eligibility Regulations - PLA.
- (2) If there is no excess reserve for the a/r, the a/r meets the reserve requirements for CAP/C.
- (3) If the CAP/C a/r's assets exceed the M-AABD reserve limit for a b.u. of one, he is not eligible for Medicaid.

3. CAP Assessment and CAP Plan of Care

The CAP Assessment and the CAP Plan of Care ([See Figure 3.](#)) are necessary for approval of the CAP/C application, but are not the responsibility of the IMC.

- a. A social worker/registered nurse team must complete the CAP Assessment.
- b. The case manager must complete the CAP Plan of Care to show the home and community care the a/r needs.
- c. The case manager must submit the CAP Assessment and the CAP Plan of Care to the DMA CAP Unit within 60 days of the FL-2 approval date.

4. EIS Entries

Refer to EIS-3101 for instructions on entering information into EIS.

V. CAP/DA

A. Policy Rules

1. Policy rules in II. above apply to CAP/DA.
2. Either the DMA CAP Unit or the local CAP/DA lead agency that has been delegated approval authority by DMA will determine whether an a/r may participate in CAP/DA.
3. A CAP/DA a/r must have prior approval for ICF and SNF level of care as indicated on an approved FL-2. [\(See figure 4a.\)](#)
4. The local CAP/DA lead agency will arrange for an assessment to be completed to determine the need for CAP/DA services.
5. The CAP/DA a/r must be in the M-AABD aid program/categories.
6. The Client Information Sheet [\(See figure 1\)](#) is used to provide a current and accurate source of client information. The CAP case manager completes this during the initial assessment for new applicants enrolled in the CAP program and during the CNR for existing recipients.
7. The CAP/DA a/r must have a CAP/DA Data Set [\(See figure 2\)](#) completed for an assessment to determine the need for the following CAP/DA services:

Note: The CAP/DA Data Set and Client Information Sheet are used for the CAP/DA and CAP/Choice programs only. CAP/C and CAP/MR-DD still use the original CAP Assessment form. All programs still use the original Plan of Care.

- a. Case management,
- b. Adult day health care,
- c. Waiver supplies: nutritional supplements taken by mouth when ordered by a physician, medication dispensing boxes, and reusable incontinence undergarments and the disposable liners for the undergarments.
- d. Home mobility aids: wheelchair ramps, widening of doorways for wheelchair access, safety rails, non-skid surfaces, handheld showers, and grab bars,
- e. Respite care: in-home and institutional,
- f. Home delivered meals,

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(V.A.7.)

- g. In-home aide services: levels II and III-personal care, and
 - h. Telephone Alert (Emergency Response Systems).
8. The CAP/DA a/r must have a CAP/DA Data Set, CAP Plan of Care and Client Information Sheet completed, but they are not the responsibility of the IMC.
- a. A social worker/registered nurse team must complete the CAP/DA Data Set.
 - b. The case manager must complete the CAP Plan of Care to show the home and community care the a/r needs.
 - c. The case manager must submit the CAP/DA Data Set and the CAP Plan of Care to the approval authority, and a decision made, within 60 days of the FL-2 approval date.
9. CAP/DA cases are approved:
- a. By the local CAP/DA lead agency if DMA has given that agency approval authority.
 - b. By the DMA CAP Unit if the local lead agency does not have approval authority.

The DMA CAP Unit at 919/855-4360 can verify who has approval authority.

NOTE: The agency having approval authority will send written notification of the approval to the county dss.

B. Procedures

1. Follow procedures in III.A. above for CAP/DA.
2. Budgeting

Compute the budget with a b.u. of one beginning the month that CAP is effective and following budgeting principles in MA-2250, Income, and MA-2260, Financial Eligibility Regulations – PLA.

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(V.B.)

3. Certification and Authorization

a. For an application:

- (1) Certify the case for 6 or 12 months,

AND
- (2) Follow the procedures in MA-2350, Certification and Authorization.
- (3) The approval and CAP information are entered following the instructions in EIS-3101.

b. For an ongoing case, continue in the established c.p.

4. EIS Entries

Refer to EIS-3101 for instructions on entering information into EIS.

5. Send the appropriate notice(s).

6. Inform the CAP/DA case manager of the decision.

7. Annual Re-evaluation

- a. The CAP/DA case manager must complete a Continued Need Review (CNR) annually on each case.
- b. The annual screening/assessment for the CNR must be complete according to instructions in the CAP/DA program manual.

NOTE: The CNR date and the date that Medicaid eligibility must be redetermined are separate distinct actions. For SSI CAP cases there is no Medicaid eligibility redetermination.

8. Transfers

- a. When a CAP/DA a/r moves from one county to another the IMC will transfer the Medicaid to the new county and delete the CAP indicator code from EIS.
- b. The new county of residence determines if the a/r will be placed on a waiting list. It is the responsibility of the CAP/DA case manager to notify the IMC and provide an approval letter for the CAP indicator code to be put back in EIS.
- c. Follow county transfer procedures in MA-2221, County Residence.

VI. CAP/CHOICE

A. Policy Rules

1. Policy rules are the same for those in CAP/DA in V. A. above.
2. The care advisor replaces the case manager in V.A.7. and 8. above. The recipient works with the care advisor to determine needed care.

B. Procedures

1. Procedures are the same as those for CAP/DA in V. B above.
2. The care advisor replaces the case manager in V.B.6.,7., and 8. above.

VII. CAP-MR/DD

A. Policy Rules

1. Policy rules in II. A. above also apply to CAP-MR/DD cases.
2. Children in CAP-MR/DD may be in M-AABD and also be in I-AS or H-SF, or adults may be in S-AAD if living in a domiciliary care facility.
3. A CAP-MR/DD a/r must have prior approval for ICF-MR by means of the MR-2. ([See Figure 4b.](#))
 - a. One MR-2 is required for CAP-MR/DD in a private residence,

AND
 - b. Two MR-2's are required for CAP-MR/DD services to a recipient of S-AAD in a domiciliary care facility.
 - (1) One MR-2 approved for ICF-MR level of care, and
 - (2) The second MR-2 recommends domiciliary care with CAP services.
 - c. ICF-MR Level of Care is assessed and documented on the MR-2, line 11, by a physician or clinical psychologist licensed by the State of North Carolina. Line 11 of the MR-2 will indicate into which CAP-MR/DD waiver, Supports Waiver (C2) or the Comprehensive Waiver (CM) the recipient will be placed.

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(VII.A.)

4. In the Supports Waiver (C2), the CAP-MR/DD a/r, must have a CAP assessment completed to determine the need for the following CAP-MR/DD services;
 - a. Day Supports,
 - b. CAP-MR/DD personal care,
 - c. Respite care: institutional and non-institutional,
 - d. Adult day health,
 - e. Home and Community Supports,
 - f. Behavior Consultant,
 - g. Supported employment services,
 - h. Crisis Respite,
 - i. Crisis Services,
 - j. Specialized Consultative Services,
 - k. Augmentative communication devices,
 - l. Personal Emergency Response System (PERS),
 - m. Home modifications,
 - n. Specialized Equipment and Supplies,
 - o. Individual Caregiver Training and Education,
 - p. Long Term Vocational Supports,
 - q. Vehicle Adaptations and,
 - r. Transportation.
5. In the Comprehensive Waiver (CM), the CAP-MR/DD a/r must have a CAP assessment completed to determine the need for the services listed above in VII. 7. A.4., and the following CAP-MR/DD services;
 - a. Home Supports
 - b. Residential Supports

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6. The CAP-MR/DD Services Branch in DMH/DD/SAS will approve CAP-MR/DD cases.
 - a. CAP-MR/DD Services will send a letter of approval to the CAP-MR/DD case manager and to the Medicaid eligibility supervisor in the county dss.
 - b. The case manager will also notify the county dss.

B. Procedures

1. Follow procedures in III.A. above for CAP-MR/DD.
2. Budgeting

Compute the budget with a b.u. of one beginning the month that CAP is effective and following budgeting principles in MA-2250, Income, and MA-2260 Financial Eligibility Regulations – PLA, and MA-3300, Income (Family and Children’s Manual.)
3. The DMH/DD/SAS-405, CAP-MR/DD Plan of Care or CNR, must be completed by the case manager and submitted to DMH/DD/SAS for a determination of eligibility for the CAP-MR/DD program.
4. All other eligibility factors apply.
5. File in the case record:
 - a. One copy of the MR-2 to document the need for ICF-MR level of care, or
 - b. Two copies of the MR-2, if appropriate, to document the recommendation for domiciliary care with CAP services.
6. EIS Entries

Refer to EIS-3101 for instructions on entering information into EIS.
7. Transfers

If a CAP-MR/DD recipient moves out of the county, the case manager will terminate services and notify the IMC of the move.

VIII. MONEY FOLLOWS THE PERSON

The Division of Medical Assistance received a demonstration grant to institute the Money Follows the Person Program (MFP). MFP is intended to transition individuals from institutions who want to live in the community, and provide quality programs and services that are person-centered, appropriate and needs based in both home and community-based settings.

In order to be eligible, MFP applicants must meet all the eligibility criteria for enrollment in CAP/Choice, CAP/DA, CAP-MR/DD or the Program for All-Inclusive Care for the Elderly (PACE) in addition to criteria unique to the MFP Program. Individuals transition into a CAP waiver program or PACE on their first day in the community. Slots have been reserved in each CAP waiver program for MFP participants.

Potential MFP recipients will be identified by a regional Transition Coordinator, who will work closely with the facilities, the recipient, the families and the county dss. The Transition Coordinator coordinates with the county dss to ensure that the individual will remain Medicaid eligible when transitioned into MFP. MFP includes coverage of all CAP services plus some additional services, MFP is available statewide with the exception that those who reside in the five counties served by the Piedmont Innovations Waiver (Cabarrus, Davidson, Rowan, Stanley and Union) are not eligible.

A. DSS Responsibilities

1. The county dss is responsible for determining eligibility for the appropriate CAP program.
 - a. CAP/Choice
 - b. CAP/DA
 - c. CAP-MR/DD
 - d. Program of All-Inclusive Care for the Elderly (PACE)
2. If an individual or his personal representative expresses interest in applying for MFP and the individual is not currently Medicaid eligible, take and process an application the same way you would a CAP case. If the applicant has not been referred to the local lead agency or Local Management Entity or PACE organization by the MFP Transition Coordinator, contact the MFP Program Coordinator at (919) 855-4270 and inform him that a Medicaid applicant has expressed interest in MFP.
3. Budgeting

Follow current CAP policy for all eligibility requirements and budgeting.

NOTE: A Special Use code of "MF" and begin and end dates will be entered by DMA.

(VIII.)

B. Transition Coordinator Responsibilities

1. Screen MFP applicants for all MFP eligibility criteria. To be eligible to participate in MFP an individual must:
 - a. Receive inpatient services paid for by Medicaid in qualified institutions that serve individuals who are elderly, disabled or developmentally disabled, and
 - b. Have resided in an institution for a minimum of six months, and
 - c. Continue to require the level of care provided by the institution, and
 - d. Meet the criteria for enrollment in CAP/Choice, CAP/DA, CAP-MR/DD or in the Program of All-Inclusive Care for the Elderly (PACE), and
 - e. Be moved into a qualified residence in the community.
2. Coordinate with county dss to ensure that the individual will remain Medicaid eligible when transitioned into MFP.
3. Verify that the individual has been in an appropriate facility for at least a six month period.
4. Inform the individual, his legal guardian, and identified family members that an MFP recipient with a CAP deductible will be responsible for paying for MFP and CAP services until his monthly deductible is met
5. Contact the local lead agency or Local Management Entity or PACE organization to begin the process of assessing, determining eligibility, and development of the plan of care/person centered plan.
6. Develop an MFP Transition Plan.
7. Inform the individual, his legal guardian, and identified family members of policy regarding protection from abuse, neglect, and exploitation.
8. Train the individual, his legal guardian, and identified family members in responding and reporting critical incidents and other processes.

(VIII.)

C. MFP Individual Moves to Another County

1. CAP/MFP recipient moves

An CAP/MFP recipient who moves from one county to another remains MFP or CAP eligible unless they move to one of the five Piedmont Innovations Waiver counties.

2. PACE/MFP recipient moves

An PACE/MFP recipient who moves to another county may no longer be PACE and MFP eligible (see MA-2275, Program of All-Inclusive Care for the Elderly (PACE)). The individual must be evaluated for CAP eligibility in the new county. If found eligible for CAP in the new county, MFP eligibility may resume.