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**COMMUNITY ALTERNATIVES PROGRAM (CAP)**

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**REVISED 12/1/2019 – CHANGE NO. 15-19**

**I. INTRODUCTION TO CAP**

Community Alternatives Program (CAP) is a 1915(c) **home and community- based Services Waiver under the Social Security Act**. The Waiver allows **North Carolina Medicaid** funds to be used to provide home and community-based services to Medicaid beneficiaries. These services provide both medical and non-medical home and community-based services to prevent or delay institutionalization.

**II. CAP SERVICES ARE OFFERED IN THE FOLLOWING CATEGORIES:**

**A. CAP for Disabled Adults (CAP/DA)**

**A North Carolina home and community-based services waiver program providing services and supports in the home and community to disabled, blind and aged adults as an alternative to nursing home placement.**

CAP/DA provides community-based services to individuals who:

1. Are age 18 **years** and over;
2. Are aged, (65 years and over);
3. Are determined to require an ICF (Intermediate Care Facility) or SNF (Skilled Nursing Care) level of care under the North Carolina State Medicaid Plan;
4. Are determined to need CAP services based on a reasonable indication of need and assessment as determined by the CAP case management entity;
5. Live in a private residence; **and**
6. Have been determined to be disabled by **Disability Determination Services (DDS)** or the Social Security Administration (**SSA**);

**B. CAP Consumer Direction (CAP/CD)**

**A service delivery option of the Community Alternatives Program that allows a beneficiary to have choice and control over the services and supports received, by allowing the beneficiary the option to direct care.**

CAP/CD provides community-based services to individuals who:

1. Are age 18 years and over;
2. Are aged (65 years and over);
3. Are determined to require a specific level of care under the North Carolina State Medicaid Plan;
4. Are determined to need CAP services based on a reasonable indication of need and assessment as determined by the CAP case management entity;
5. Live in a private residence;
6. Have been determined to be disabled by the Disability Determination Services (DDS) or the Social Security Administration (SSA) and
7. Are able and willing to accept the role and responsibilities to hire individuals and to direct the employee to provide the personal care services to the CAP beneficiary.

CAP/CD beneficiaries may hire Personal Care Assistants (PCA) to provide personal care services. These Personal Care Assistants do not require a licensure or certification and are included in the Service Plan/Plan of Care (POC).

### **C. CAP for Children (CAP/C)**

A North Carolina home and community-based services waiver program. This waiver provides services and supports in the home and community to medically fragile children as an alternative to an institutional placement.

CAP/C provides community-based services to individuals who:

1. Are under the age 21;
2. Are determined to require a specific level of care under the North Carolina State Medicaid Plan;
3. Are determined to need CAP services based on a reasonable indication of need and assessment as determined by the CAP case management entity;

4. Live in a private residence **and**
5. Have been determined to be disabled by **Disability Determination Services (DDS)** **or** the Social Security Administration (**SSA**).

**Exception: MAF, (IV-E) Foster Care and Adoption and State Foster Care beneficiaries do not require a disability determination.**

### **III. REQUESTING CAP SERVICES**

To receive CAP services an applicant/beneficiary (a/b) must meet the Medicaid eligibility requirements in one of the following programs:

- **MAABD (Medicaid for the Aged, Blind and Disabled)**
- **MAF (IV-E Foster Care and Adoption and State Foster Care)**
- **HCWD (Health Coverage for Workers with Disabilities)**

#### **A. The a/b requests CAP services.**

1. Individual is currently not a Medicaid beneficiary
  - a. A Medicaid application must be submitted.
  - b. Evaluate for Medicaid eligibility in appropriate Medicaid programs.
2. Individual is currently a Medicaid beneficiary
  - a. Process as a change in **situation**.
  - b. Evaluate for Medicaid eligibility in appropriate Medicaid programs.
  - c. If the a/b had a deductible, recalculate the deductible for months in the certification period prior to **the** CAP authorization.
  - d. Multiply the monthly **private living arrangement (PLA)** deductible by the number of months in the certification period prior to CAP eligibility to calculate the new deductible amount.
  - e. The new deductible amount may change the authorization date of Medicaid eligibility.
  - f. Any excess expenses previously submitted may be used towards the CAP monthly deductible.

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

**B. Individuals requesting CAP services must have a CAP assessment to determine the need for services relevant to the appropriate CAP program.**

**C. Upon completion of the CAP assessment the local agency will receive **the following:****

**For Approvals:**

1. The DHB-2193, Memorandum of CAP Waiver Enrollment Status and
2. The Service Plan, which includes The Plan of Care Summary (POC)

**For Denials:**

1. The DHB-2193, Memorandum of CAP Waiver Enrollment Status and
2. The Notice of Denial of CAP participation.

**D. When Medicaid eligibility can be established regardless of CAP eligibility:**

1. Do not wait for CAP approval; **and**
2. Authorize, if appropriate, as for any other application/change in situation. Follow the basic income rules section, [MA-2260, Financial Eligibility Requirements-PLA](#).

**E. When Medicaid eligibility cannot be established without CAP eligibility:**

1. Verify the status of the **Service Plan/Plan of Care** with the CAP case manager, and
2. Deny the application if the **decision for CAP participation DHB-2193, Memorandum of CAP Waiver Enrollment Status**, is not received by the 45/90th calendar day.

#### **IV. BUDGETING**

Upon receipt of the DHB-2193, Memorandum of CAP Waiver Enrollment Status, CAP budgeting applies the month of the CAP Effective Date.

**A. Follow the basic income rules section, [MA-2260, Financial Eligibility Requirements-PLA](#).**

For keying instructions refer to NC FAST Job Aid: [Community Alternatives Program \(CAP\), Traumatic Brain Injury \(TBI\) & Innovations](#)

In addition to the basic income rules the following apply to CAP.

1. There is no spouse-for-spouse or parent-for-child financial responsibility (income limit of one).
2. Only the income of the a/b is used in determining financial eligibility, beginning the month of CAP approval.
3. The one-third reduction budgeting does not apply to a **Supplemental Security Income (SSI)** beneficiary.

**B. Follow the basic resource rules section, [MA-2260, Financial Eligibility Requirements-PLA](#).**

In addition to the basic resource rules, the following apply to CAP:

1. Evaluate all assets of a married a/b living with their spouse (jointly or individually owned) when one spouse is a CAP **beneficiary**;
2. Compare available resource amount to the resource limit of one; **and**
3. Evaluate spousal resource protection (if applicable).

**C. Transfer of Assets**

To determine if any transfers have occurred the local agency must explore all assets on all applications, redeterminations, and change in situations for applicants/beneficiaries requesting or receiving institutional services or in-home health services. Evaluate the evidence presented by the applicant(s), spouse or the applicant's representative concerning any asset transferred. The evidence may establish the transfer occurred for a reason other than to establish or retain Medicaid eligibility. Follow the rules in section, [MA-2240, Transfer of Assets](#).

**V. DEDUCTIBLE**

**A. Follow procedures in [MA-2360, Medicaid Deductible](#).**

**B. In addition to the basic deductible rules the following apply to CAP.**

1. All CAP deductibles are calculated monthly.
2. **CAP (Medically Needy) certification periods are 6 months.**
3. Expenses listed on the **Service Plan/Plan of Care** are allowed in addition to other allowable Medicaid expenses. **Items that are listed directly on the Service Plan/Plan of Care may be waiver and non-waiver services and/or**

supplies. The CAP case manager may need to verify if these services or supplies are “medically necessary” and prescribed by a physician. Other items may be listed in the service plan that specifically describe how that item will be used to maintain the community placement due to the disability. Follow rules in section, [MA-2360, Medicaid Deductible](#) for Allowable Expenses.

For CAP deductible beneficiaries, apply allowable medical expenses toward the monthly deductible. Cost of Care cannot be applied prior to the effective date of the Service Plan/Plan of Care date.

For keying instructions refer to NC FAST Job Aid: [Managing Spend Down Evidence](#).

## **VI. CAP PARTICIPATION**

The CAP effective date is the latest of the following:

- A. The date of the Medicaid application;
- B. The CAP Effective Date on the [DHB-2193, Memorandum of CAP Waiver Enrollment Status](#);
- C. The date of de-institutionalization; or
- D. The effective date stated in a state court resolution or a court order.

## **VII. RECERTIFICATION**

All recertifications must be completed as ex-parte by first using electronic data sources and available agency records to determine continued eligibility. The local agency will receive the [DHB-2193, Memorandum of CAP Waiver Enrollment Status and Service Plan/POC Summary](#) from the CAP case management entity.

1. The caseworker is required to:
  - a. Conduct all electronic matches, including Online Verification System (OVS);
  - b. Check other available records; and
  - c. Contact the beneficiary only when continuing eligibility cannot be determined by the available information.
2. Continued Need Review

The CAP case management entity will complete a Continued Need Review (CNR) assessment annually to determine the continued need for CAP services based on medical, functional, and psychosocial care needs of the beneficiary for safe community living.

- a. If continuing need of CAP participation is established, recertify for the appropriate certification period, not to exceed 12 months; 6 months if the beneficiary has a monthly deductible.
- b. If there is no continuing need of CAP participation, evaluate for all other programs/categories.

SSI beneficiaries do not require a recertification of Medicaid eligibility. However, SSI beneficiaries still require a CNR to determine CAP participation.

## VIII. CHANGES IN SITUATION

### A. Hospital/Nursing Facility Stays

The local agency will receive the [DHB-2193, Memorandum of CAP Waiver Enrollment Status for Hospital/Nursing Facility stays](#).

1. Stays 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. **Stays** 30 Days and over
  - a. Send a timely [DSS-8110, Notice of Modification, Termination, or Continuation of Public Assistance](#), to terminate CAP services effective the first day of the month following the 31st day.
  - b. Evaluate eligibility for Medicaid by applying [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 the 31<sup>st</sup> day falls, subject to timely notice requirements.
  - d. If discharge occurs between 30 and 90 days and the beneficiary resumes CAP services, the local agency will receive the [DHB-2193, Memorandum of CAP Waiver Enrollment Status](#), and Plan of Care Summary from the CAP case management entity.
  - e. For stays over 90 days, a new referral must be made to the CAP Lead Agency for redetermination of CAP eligibility before CAP services can resume.

## **B. Termination of CAP Services**

1. The local agency will receive the [DHB-2193, Memorandum of CAP Waiver Enrollment Status](#).
2. Re-compute the budget for the remainder of the 6 or 12-month certification period.
3. Apply spouse-for-spouse or parent-for-child financial responsibility.
4. Caseworkers are required to send appropriate termination notices. Follow rules in section, [MA-2420, Notice and Hearings Process](#).
  - a. When CAP services are terminating; send an adequate notice.
  - b. When Medicaid will terminate; send a timely notice.
  - c. When CAP services and Medicaid are terminating; send a timely notice.

## **C. Change in Level of Care/Acuity Level**

The local agency will receive the [DHB-2193, Memorandum of CAP Waiver Enrollment Status](#) and POC Summary from the CAP case management entity there is a change in the level of care/acuity level.

## **D. Transition from CAP/DA to CAP/CD**

The local agency will receive the [DHB-2193, Memorandum of CAP Waiver Enrollment Status](#), and POC Summary from the CAP case management entity when the category transitions from CAP/DA to CAP/CD.

## **E. Transition from CAP/CD to CAP/DA**

The local agency will receive the [DHB-2193, Memorandum of CAP Waiver Enrollment Status](#) and POC Summary from the CAP case management entity when the category transitions from CAP/CD to CAP/DA.

## **F. Service Plan/POC Revision**

The local agency will receive the [DHB-2193, Memorandum of CAP Waiver Enrollment Status](#) and POC Summary from the CAP case management entity when there is a Service Plan/POC Revision.



For keying instructions refer to NC FAST Job Aid: [Community Alternatives Program \(CAP\), Traumatic Brain Injury \(TBI\) & Innovations.](#)

### **G. County Transfer**

When a CAP beneficiary moves to another county, it does not affect CAP services. CAP coverage continues in the new county. The local agency will **receive the original DHB-2193, Memorandum of CAP Waiver Enrollment Status and the Service Plan/Plan of Care** from the **CAP case management entity**.

For keying instructions refer to NC FAST Job Aid: [Completing a County Case Transfer.](#)

### **IX. NOTICES**

**The caseworker** must send the CAP case manager a copy of all notices **that are** sent to the applicant/beneficiary (a/b). Follow rules in section, [MA-2420, Notice and Hearings Process.](#)

### **X. APPEALS**

CAP Services appeals go directly to the [Office of Administrative Hearings \(OAH\).](#)

Follow [MA-2420, Notice and Hearings Process](#) for Medicaid Eligibility appeals.

For keying instructions refer to NC FAST Job Aid: [Appeals](#)