

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

8E, Intermediate Care Facilities for Individuals with Intellectual Disabilities

8F, Research-Based Behavioral Health Treatment (RB-BHT) For Autism Spectrum Disorder (ASD)

1-H, Telehealth, Virtual Patient Communications, and Remote Patient Monitoring

1.0 Description of the Procedure, Product, or Service

The North Carolina Innovations Waiver Services (NC Innovations) is a resource for funding services and supports for a Medicaid beneficiary with intellectual and other related developmental disabilities who are at risk for institutional care in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) (Please **refer** to Clinical Coverage Policy 8E for requirements for ICF-IID level of care.).

NC Innovations is authorized by a Medicaid Home and Community-Based Services (HCBS) Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act.

It operates concurrently with a 1915 (b) Waiver, the North Carolina Mental Health/Developmental Disabilities/Substance Abuse Services Health Plan (NC MH/DD/SAS Health Plan). The NC MH/DD/SAS Health Plan functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, substance abuse and intellectual/developmental disabilities services are authorized for Medicaid enrollees. Local Management Entities-Managed Care Organizations (LME/MCOs) are area authorities in the State of NC which are responsible for certain management and oversight activities with respect to publicly funded Division of Mental Health/Developmental Disabilities /Substance Abuse Services (DMH/DD/SAS) and are PIHPs for the waiver.

****Note: PIHP and LME-MCO are used interchangeably throughout this document. This current waiver was renewed and approved to be effective, July 1, 2019, for five calendar years**

CMS approves the services provided under NC Innovations, the number of beneficiaries that may participate each year, and other aspects of the program. The waiver can be amended with the approval of CMS. CMS may exercise its authority to terminate the waiver whenever it believes the waiver is not operated properly.

NC Medicaid, operates the NC Innovations Waiver and contracts with the PIHP to arrange for, manage the delivery of services, and perform other waiver operational functions under the concurrent 1915 (b)(c) waivers. NC Medicaid directly oversees the NC Innovations Waiver, approves all policies and procedures governing waiver operations and ensures that the NC Innovations Waiver assurances are met.

The requirements for administration of NC Innovations include lists of:

- a. target populations;
- b. waived Medicaid requirements;
- c. services;
- d. beneficiaries; and
- e. they also specify the duration of the waiver.

The following regulations give the North Carolina Department of Health and Human Services (DHHS) the authority to set the requirements contained in this policy:

- a. Federal Regulations for HCBS waivers are found in 42 CFR 441 Subpart G.
- b. Section 1915(c) of the Social Security Act authorizes the U.S Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may offer HCBS to state-specified target groups of Medicaid beneficiaries who need a level of institutional care that is provided under the NC Medicaid State Plan (State Plan).
- c. Section 1902(a)(10)(B) of the Social Security Act provides that Medicaid services must be made available to all categorically eligible individuals on a comparable basis. This HCBS waiver targets services only to the specified group of beneficiaries that meet the level of care established for an ICF-IID; allows services that are not otherwise available under the State Plan; and offers services that are not available to beneficiaries who do not participate in the waiver. Thus, the waiver of 1902(a)(10)(B) is an integral feature of the program.

Refer to **Attachment C** for Service Definitions and **Attachment A**, HCPCS Codes, for services which are allowed under the waiver.

1.1 Definitions

a. Agency With Choice

Agency with Choice is an Individual or Family Directed Service Model that is made available to a waiver beneficiary who chooses to direct some or all of his or her services. Also known as the “co-employment option,” an arrangement wherein an organization (a co-employment agency) assumes responsibility for:

1. employing and paying a worker who have been selected by the waiver beneficiary to provide services to the waiver beneficiary;
2. reimbursing allowable services;
3. withholding, filing and paying Federal, state and local income and employment taxes; and
4. providing other supports to the beneficiary. Under this model, the beneficiary acts as the “Managing Employer” and is responsible for hiring, managing, and possibly dismissing the worker.

Under this model, the co-employment agency is considered the common law employer of the worker who the waiver beneficiary recommends for hire.

b. Annual Plan

Annual plan is defined as a 12-month period for the Annual Plan/Individual Support Plan year that runs from the first day of the month following the birth month to the last day of the month of the birth month.

- c. CAP/C**
CAP/C is the acronym for the Community Alternatives Program for Children, which is a program that offers home care for medically fragile children 0-20 years old who otherwise would require hospital or nursing facility care.
- d. CAP/Choice**
CAP/Choice is the acronym for the Community Alternatives Program for Disabled Adults who choose Participant Direction.
- e. CAP/DA**
CAP/DA is the acronym for the Community Alternatives Program for Disabled Adults – a program that provides home care for adults who otherwise would require nursing facility care.
- f. Care Coordination**
Care Coordination is part of the PIHP department that employees or contracts Care Coordinators who deliver Treatment Planning Case Management services.
- g. Care Coordinator**
The role of care coordinator is an individual who provides Treatment Planning Case Management services in the NC Innovations Waiver.
- h. Centers for Medicare and Medicaid Services (CMS)**
The Centers for Medicare and Medicaid Services (CMS) is a federal agency that administers Medicare and Medicaid for the Federal government.
- i. Common Law Employer**
A common law employer-employee relationship generally exists when the person for whom services are performed has the authority to control and direct the individual who performs the services, not only as to the result to be accomplished but also as to the detail and means by which that result is accomplished.
- j. Criminal Background Check**
A criminal background check is a process that is undertaken to determine whether a person who would provide services has been convicted of a crime. Requirements for conducting criminal history and background investigations are typically established under state law and regulations. Under such requirements, a human services agency or health care provider must conduct an investigation prior to hiring a person or permitting an employee to furnish services directly to a beneficiary and, in some cases, may prohibit the employment of an applicant beneficiary who has been convicted of specified crimes.
- k. Deinstitutionalization**
Deinstitutionalization is the reduction in the number of beneficiaries residing in state or community institutions. For Innovations purposes, it also includes movement from a community ICF-IID group home.

l. Division of Health Care Regulation (DHSR)

The Division of Health Care Regulation (DHSR) is located in the Department of Health and Human Services. This is the agency that licenses home care agencies, certifies home health agencies, and performs a variety of licensure, service monitoring, and health planning activities.

m. DMH/DD/SAS

DMH/DD/SAS is the acronym for the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the Department of Health and Human Services. DMH/DD/SAS works with DHB in the administration of the NC Innovations Waiver and NC MH/DD/SA Services Health Plan.

n. Early and Periodic Screening Diagnosis and Treatment (EPSDT)

Early and Periodic Screening Diagnosis and Treatment is Medicaid's comprehensive child health program for individuals under the age of 21. EPSDT is authorized under §1905(r) of the Act and includes the performance of periodic screening of children, including vision, dental, and hearing services. §1905(r)(5) of the Act required that any medically necessary health care service that is listed in §1905(a) of the Act be provided to an EPSDT beneficiary even if the service has not been specifically included in the State plan. Federal EPSDT regulations are located in 42 CFR §441.50 *et seq.* *No NC Innovations services are eligible to be provided through EPSDT.*

o. Employer Authority

Employer authority is defined as the beneficiary direction opportunity by which the beneficiary exercises choice and control over individuals who furnish waiver services authorized in the service plan. Under the employer authority, the beneficiary may function as the co- employer (managing employer) or the common law employer of workers who furnish direct services and support to the beneficiary.

p. Employer or Record

In the Individual and Family Directed Model, the Employer of Record is the adult beneficiary; the parent of the minor beneficiary or the guardian of the beneficiary. The Employer of Record may not be an LLC. The Employer of Record may not provide paid supports to the beneficiary.

q. Federal Financial Participation (FFP)

Is the portion paid by the federal government to states for their share of expenditures for providing Medicaid services and for administering the Medicaid program and certain other human service programs.

r. Freedom of Choice

Freedom of Choice is the right afforded an beneficiary who is determined to be likely to require a level of care specified in a waiver to choose either institutional or home and community-based services, as provided in §1915(c)(2)(C) of the Act and in 42 CFR §441.302(d).

s. Free Choice of Providers

Free Choice of Providers is defined as specified in §1902(a)(23) of the Act and 42 CFR§431.51, the right of a Medicaid beneficiary to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is (a) qualified to furnish the services; and (b) willing to furnish them to the beneficiary. Free choice of provider may be limited under a waiver granted under §1915(b) of the Act. §1915(c) of the Act (the statute authorizing the HCBS waiver program) does not grant the Secretary the authority to waive §1902(a)(23) of the Act.

t. Grievance

A Grievance is an expression of dissatisfaction by or on behalf of a beneficiary about any matter other than an action, as “action” is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the beneficiary’s rights).

u. Grievance Procedure

Grievance procedure is the written procedures pursuant to which a beneficiary may express dissatisfaction with the provision of services by the PIHP and the methods for resolution of Enrollee complaints by the PIHP.

v. HCBS

HCBS is the acronym for home and community-based services. HCBS means services not otherwise furnished under the State's Medicaid Plan that are furnished under a waiver granted by CMS under Section 1915(c) of the Social Security Act and provide opportunities for Medicaid beneficiaries to live, work and play in their own home or community in the same fashion as those without services.

w. Home

Home is also defined as a primary private residence.

x. Individual and Family Direction

Individual and Family Direction, also referred to as Participant Direction or Individual and Family Directed Services (IFDS) is the name for Participant Directed Services in the NC Innovations Waiver Provision of the opportunity is an option under the NC Innovations Waiver for a waiver beneficiary to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

y. Institution

Institution is the context of the waiver application, a hospital, nursing facility or ICF-IID for which the state makes Medicaid payment under the State plan.

z. Intermediate Care Facility for Individual with Intellectual and Developmental Disabilities (ICF-IID)

Is a public or private facility that provides health and habilitation services to individuals with Intellectual and Developmental Disabilities or related conditions (e.g., cerebral palsy).

aa. Level of Care

Level of Care is the specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State plan.

bb. LME/Local Management Entity

Local management entity is a local political subdivision of the state of North Carolina as established under General Statute 122C.

cc. Medically Necessary

Are services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

dd. Participant Direction

Participation direction is defined as a provision of the opportunity for a waiver beneficiary to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.

ee. Person-Centered Planning

Person-centered-planning is the process for planning and supporting the beneficiary receiving services that builds upon the beneficiary's capacity to engage in activities that promote community life and that honor the beneficiary's preferences, choices and abilities. The person-centered planning process involves the family, friends and professionals as the beneficiary desires or requires. The resulting treatment document is the Person-Centered Plan.

ff. PIHP

PIHP is an acronym for prepaid inpatient health plan. An entity that provides medical services to beneficiaries under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries; and does not have a comprehensive risk contract.

gg. Qualified Professional (QP)

Qualified Professional is any individual with appropriate training or experience as specified by the North Carolina General Statutes or by rule of the North Carolina Commission on Mental Health, Developmental Disabilities and Substance Use Services in the fields of mental health or developmental disabilities or substance

abuse treatment or habilitation, including physicians, psychologists, psychological associates, educators, social workers, registered nurses, certified fee-based practicing pastoral counselors, and certified counselors. (NC General Statute 122C-3)

hh. Waiver Year

A waiver year is defined as the 12-month period that CMS uses to authorize, monitor, and control waiver programs and expenditures. The waiver year begins on the effective date of the waiver approval and includes the 12 months following that date. If a subsequent waiver renewal is approved with a different effective date, the waiver year changes to coincide with the renewal effective date.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

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

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise)*;
- b. Provider(s) shall verify each Medicaid beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

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

- a. **Medicaid**
None Apply.

2.2 Special Provisions

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

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

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

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

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

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

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

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NC Tracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NC Tracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

2.3 Eligible Coverage Groups

Upon approval of ICF-IID level of care (LOC), Medicaid beneficiaries in the following coverage groups may receive NC Innovations:

- a. Medicaid to the Aged (M-AA)
- b. Medicaid to the Blind (M-AB)
- c. Medicaid to the Disabled (M-AD)
- d. Health Coverage for Workers with Disabilities (HCWD) Basic Group
- e. IV-E Adoption Assistance and Foster Care (I-AS) 42. CFR 435.115(e)(2)
- f. State Foster Care (H-SF)
- g. State/County Special Assistance to the Aged (S-AA)
- h. State/County Special Assistance to the Disabled (S-AD)

Note: As not all Medicaid beneficiaries are eligible for NC Innovations (refer to **Subsection 3.2**, Medicaid Additional Criteria Covered, below), Care Coordinators shall contact the department of social services (DSS) in the county in which the beneficiary lives to confirm Medicaid eligibility when considering a new applicant for NC Innovations.

2.4 Coordination of the Waiver and Regular Medicaid Services

NC Innovations operates concurrently with the NC MH/DD/SAS Health Plan. The NC MH/DD/SAS Health Plan provides Medicaid State Plan services for behavioral health services as well as inpatient psychiatric and ICF-IID. Approval of the NC Innovations Individual Support Plan does NOT replace the prior approval requirements or other eligibility requirements for services in the Medicaid State Plan, which are outside of the NC MH/DD/SAS Health Plan, such as private duty nursing (PDN), physical therapy (PT), occupational therapy (OT), and speech therapy (ST). These services are not part of the NC Innovations Waiver or NC MH/DD/SAS Health Plan and are accessed through the regular State Medicaid Program according to Medicaid policies and procedures.

3.0 When the Procedure, Product, or Service Is Covered

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

3.1 General Criteria Covered

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

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.1.1 Telehealth Services

As outlined in Attachment A, select services within this clinical coverage policy may be provided via telehealth. Services delivered via telehealth must follow the requirements and guidance in clinical coverage Policy 1-H, Telehealth, *Virtual Patient Communications*, and *Remote Patient Monitoring*, at <https://medicaid.ncdhhs.gov/>.

3.1.2 Telehealth Specific Criteria

In addition to telehealth criteria specified in clinical coverage Policy 1-H, Telehealth, *Virtual Patient Communications*, and *Remote Patient Monitoring*, at <https://medicaid.ncdhhs.gov/>. The provision of NC Innovations waiver services

using telehealth may only occur when it is clinically indicated for the beneficiary and the beneficiary needs only verbal cueing or prompting to complete tasks.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by Medicaid

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover NC Innovations services for a Medicaid beneficiary with intellectual or developmental disabilities, or both, who meets **all** of the following criteria:

- a. Requirements for ICF-IID level of care;
- b. Resides in an ICF-IID facility or is at high risk of being placed in an ICF-IID facility;
- c. Able to maintain his or her health, safety, and well-being in the community with NC Innovations services;
- d. Requires NC Innovations services as identified through a person-centered planning process. The beneficiary shall require at least one waiver service provided monthly as identified in the person-centered planning process and indicated in the Individualized Support Plan (ISP) and Individualized Budget; and
- e. Lives alone or with his or her family or legal guardian, the beneficiary desires NC Innovations participation rather than institutional services.

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

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

4.1 General Criteria Not Covered

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

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by Medicaid

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall require prior approval for NC Innovations services. Provider(s) shall obtain prior approval before rendering NC Innovations services for a Medicaid beneficiary.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request;
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

NC Innovations services require Prior Approval by the PIHP. The PIHP approves the ISP and may approve or reduce or deny individual services. All NC Innovations service beneficiaries shall have an approved plan at least annually to continue participation in the waiver.

5.3 Plan of Care (Individual Support Plan)

5.3.1 Plan of Care Development

Each NC Innovations beneficiary is assigned a Care Coordinator at the PIHP (LME/MCO). The Care Coordinator is employed by the PIHP in a separate unit from the individuals authorizing the plan. Care Coordinators are Qualified Professionals (QP) in the area of Intellectual and Developmental Disabilities (IDD) under the North Carolina credentialing system and are competent in the person-centered planning process.

A Qualified Professional is defined in the North Carolina Administrative Code at 10A NCAC 27G .0104. The ISP is developed through a person-centered planning process led by the Care Coordinator with participation from beneficiary and legally responsible person for the beneficiary to the extent they desire.

a. Prior to the Person-Centered Planning Meeting:

The Care Coordinator offers the beneficiary and legally responsible person, if applicable, information about Individual Family Supports, a model for self-directing services in preparation for the ISP. If the beneficiary and legally responsible person is interested in learning more about Individual Family support, the Care Coordinator arranges for them to receive additional training and information from a Community Navigator. The Care Coordinator also informs the beneficiary and legally responsible person of the funding amount for the self-directed budget if the beneficiary and legally responsible person desires to self-direct one or more services. The Care Coordinator informs the beneficiary and legally responsible person of the beneficiary's individual budget amount and answers any questions regarding the budget.

The Care Coordinator supports the beneficiary to schedule the Person-Centered Planning meeting and invite team members to the meeting at a time and location that is desirable for the beneficiary. When applicable, the Care Coordinator shall invite and coordinate with the Cherokee Indian Hospital Authority (CIHA) Case Manager or Care Coordinator, Tribal Providers and other Tribal Members who are meaningful to the beneficiary.

The Care Coordinator works with the beneficiary and family to develop the Individual Support Plan (ISP). The Care Coordinator helps the beneficiary and legally responsible person determine to what degree they desire to lead the planning team and to identify the membership of the team. In addition to the beneficiary, parents, legal guardians, and Care Coordinator, planning team members may be support providers, family friends, acquaintances and other community members. The beneficiary and Care Coordinator review the team composition to ensure that the people the beneficiary would like to have at the meeting are invited.

The ISP is developed face-to-face with the beneficiary and legally responsible person as clinically indicated. Face-to-face meetings are clinically indicated when the beneficiary cannot participate fully in a planning meeting via teleconference, due to hearing impairment or other communication challenges. The beneficiary continues to have the option for a face-to-face meeting versus a teleconference. The Care Coordinator assists the beneficiary in scheduling the meeting and inviting team members to the meeting at a time and location that is desired by the beneficiary. Each team member receives a written invitation to the meeting.

b. The Individual Support Planning Meeting:

The beneficiary and Care Coordinator shall review with the team all issues that were identified during the assessment processes. Information is organized in a way that allows the beneficiary to work with the team and have open discussion regarding issues to begin action planning. When applicable, this review includes input from the Cherokee Indian Hospital Authority (CIHA) Case Manager or Care Coordinator, Tribal Providers related to the strengths and support needs identified by the Cherokee Indian Hospital Authority (CIHA) Case Manager or Care Coordinator.

The planning meeting also consists of a discussion about monitoring the beneficiary's services, supports and health and safety issues. During the planning meeting decisions are made regarding team members' responsibilities for service implementation and monitoring. While the Care Coordinator is responsible for overall monitoring of the ISP and the beneficiary's situation, other team members, the beneficiary and community support, may be assigned monitoring responsibilities.

The ISP is developed through a person-centered planning process led by the beneficiary and legally responsible person for the beneficiary to the extent they desire. Person-centered planning is about supporting a beneficiary to

realize their own vision for their lives. It is a process of building an effective and collaborative partnership with the beneficiary and working in partnership with him or her to create a road map for reaching the beneficiary's goals. The planning process is directed by the beneficiary and identifies strengths and capabilities, desires and support needs. An ISP that incorporates best practices is a rich, meaningful tool for the beneficiary receiving supports, as well as those who provide the supports. It generates actions, positive steps that the beneficiary can take towards realizing a better, more complete life. Good plans help team members ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to access the quality of services being provided.

A variety of person-centered toolkits (such as Essential Lifestyles Planning (ELP), Making Action Plans (MAPS), Charting the LifeCourse, Supported Decision Making, Personal Futures Planning) are available to gather information and enable the beneficiary to share information with the ISP team. It is also important that Native American influences are made part of the Person-Centered Process for a Native American beneficiary. The beneficiary can complete the toolkit with the assistance of the Care Coordinator or support providers as needed. Based on the unique needs of the beneficiary, a decision can be made to use one toolkit, multiple toolkits or none at all.

c. Individual Support Plan Development:

A written ISP is developed with each beneficiary, utilizing a person-centered planning process that reflects the needs and preferences of the beneficiary. Person-centered planning is a means for people with disabilities to exercise choice and responsibility in the development and implementation of their support plan. A good ISP generates actions, positive steps that the beneficiary can take towards realizing the life that they choose. Good plans also ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to assess the quality of services being provided. Plans draw upon diverse resources, mixing paid, natural (such as family, friends, and neighbors) and other non-paid supports, to best meet the goals set.

Individual support planning is defined as a process, directed by the planning team. The individual support planning process is developed for a beneficiary with long-term services and supports, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the beneficiary. The process allows people, freely chosen by the family of the minor or adult beneficiary, who are able to serve as important contributors. The person-centered planning process enables and assists the beneficiary to identify and access a personalized mix of non-paid and paid services that assist him or her to achieve personally defined outcomes in the most inclusive community setting. The beneficiary identifies planning goals to achieve these personal outcomes in collaboration with those that the beneficiary has identified, including medical and professional staff that may be involved. The identified

outcomes and training, supports, therapies, treatments and other services the beneficiary is to receive to achieve those outcomes become a part of the ISP.

The ISP is updated annually; however, if the beneficiary's provider changes or needs change and requires services to be added, increased, decreased or terminated, a revision to the plan is completed and submitted to the PIHP utilization management for approval. The Care Coordinator reassesses each beneficiary's needs at least annually and develops an updated ISP based on that reassessment. The Care Coordinator follows up and resolves any issues related to the beneficiary's health, safety or service delivery. Unresolved issues are brought to the attention of the PIHP and provider agency by the Care Coordinator to be resolved.

The Care Coordinator provides information to the beneficiary about his or her rights, protections and responsibilities, and the right to change providers. In the event the ISP developed results in denial of services, the Care Coordinator informs the beneficiary of the right to request a fair hearing. The Care Coordinator informs the beneficiary of grievance and complaint resolution processes. This information is provided on an annual basis during the annual ISP process.

Also, as part of the annual review, the Care Coordinator, in consultation with the beneficiary and the team, identifies the most integrated setting appropriate in which to provide supports and services. If the most integrated setting is not available, the Care Coordinator documents in the beneficiary's file the supports and services needed to achieve the most integrated setting, as well as the obstacles and barriers in achieving the most integrated setting.

The ISP describes the services and supports (regardless of funding source) to be furnished, their projected frequency, and type of provider who furnishes each service or support.

A Crisis Prevention Plan is incorporated within the ISP. The Crisis Prevention Plan contains supports and interventions aimed at preventing a crisis (proactive) and supports and interventions to employ if there is a crisis (reactive). A proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to address them. A reactive plan aims to avoid diminished quality of life when crises occur by having a plan in place to respond. The planning team are to consider what the crisis may look like should it occur, to whom it is considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably.

The Crisis Prevention Plan documents:

1. What positive skills the beneficiary has which can be used and increased at times of crisis;
2. How to implement redirection of energies towards exercising these skills that can prevent crisis escalation; and

3. How to implement positive behavioral supports that may be relied upon as a crisis response.
4. Planning for Natural Disasters.
5. Planning for when the primary caregiver is no longer able to support the member in the same capacity.
6. Coping strategies that the beneficiary has practiced while calm and may be helpful during a crisis.
7. Any other relevant Crisis Related information important for the Treatment Team to be aware of.

The Crisis Prevention Plan is an active and living document that is to be used in the event of a crisis. After the crisis, the beneficiary and staff shall meet to discuss how well the plan worked and make changes, as indicated.

The ISP also contains other formal and informal services and supports that the beneficiary wants or needs. The ISP provides for supports and coordination for the beneficiary to access:

1. school-based services;
2. vocational and employment services;
2. generic community resources;
3. resources that impact Social Determinants of Health; and
4. Medicaid State Plan services.

The Care Coordinator ensures that the ISP contains a plan for coordinating services, including the Care Coordinator's responsibility for overall coordination of waiver and other services.

The ISP planning team regularly review the paid service provision of relatives and guardians when they live in the home of the waiver beneficiary to ensure that:

1. the beneficiary has requested this staffing choice,
2. there are no barriers to full community membership and relationship building with non-family members,
3. the staff qualifications needed, and the unique training needs of the beneficiary are met; and
4. the role of relative and legal guardian clearly encourages autonomy and skill building for independence in the community.

Agreement of the beneficiary in this arrangement, if approved by the PIHP, and any identified barriers that need to be addressed are documented in the ISP.

The Individual Support Plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as beneficiary's needs change. Care Coordinators work with the beneficiary to identify potential sources of services and support which includes paid and non-paid natural supports within their community. Also, the PIHP ensures

that a beneficiary eligible for Medicaid has freedom of choice of qualified providers. The process for review and approval of beneficiary ISPs is a primary function of the PIHP. All initial and annual plan updates require an authorized signature(s) and are signed and dated by the providers who are providing services per the ISP.

1. Initial ISP

Initial Plan of Care – Any beneficiary entering the NC Innovations waiver must have an initial level of care determination completed prior to the start of the individual support planning process. Once the level of care determination is complete, the individual support plan must be completed within 60 calendar days. Once the initial Individual Support Plan is complete, the beneficiary’s annual plan due date is identified.

The Care Coordinator shall send the completed ISP and all required documentation so that it is received by the PIHP no later than 60 calendar days after the Level of care approval date (the date that it is approved by the PIHP). If the ISP is not received within the time limit, a new PIHP Level of Care Eligibility Determination Form must be completed and the approval process reinitiated. Individuals are moved onto the waiver and into services as quickly as possible. The dates outlined in the waiver are the maximum allowable. If an interim plan is utilized, the plan must be updated as more information is gathered. This interim plan allows for services to begin immediately, if needed for emergency situations. The interim plan contains all of the mandatory components of an ISP but has less detail than the ISP. For example, if an individual is coming into the waiver through emergency reserve capacity and the immediate need is Residential Supports, the interim plan may reflect this need and note that the plan will be updated to include additional services within 60 calendar days.

2. Annual ISP

Annual updates are due during the birth date month of the beneficiary. For example, the annual update for a beneficiary with a birth date of May 5th is due during the month of May. The effective date of the annual update is always the first of the month following the birth month. In the example illustrated above, the beneficiary’s annual plan would have an effective date of June 1st. Individual Support Plans do not extend beyond 365 calendar days.

3. ISP Revisions

Revisions are made to the Individual Support Plan whenever the beneficiary’s life circumstances change or at the beneficiary’s request. This may occur often or rarely, depending on the individual. This consists of any change in the amount, duration or frequency of a service. A temporary, one-time change in approved service does not require a plan revision. A revision is not needed if the beneficiary goes on vacation and needs to suspend Supported Employment services for two weeks. The beneficiary’s planning team may use common sense and

discretion in applying this exception, and an explanation of the change must be documented in the beneficiary's record. Revisions are also made to the Individual Support Plan (and budget form) when the cost of a service changes. Changes in short-term goals and intervention strategies do not require an ISP update or revision.

The Care Coordinator collaborates with the beneficiary and the team to ensure that the ISP is updated with current and relevant information. Timely updates to the ISP help maintain the integrity of the plan by ensuring those changes are communicated and documented consistently. The ISP is updated or revised by adding a new demographic page and/or using the update to ISP. When the update to the ISP involves a change in the budget, the individual budget page is also updated. Updates or revisions consist of adding an outcome, addressing needs related to the back-up staffing plan and adding new information when the beneficiary's needs change.

5.3.2 Person-Centered Information and Assessments

A variety of information gathering, and assessments must be completed to support the planning process:

a. **Person-Centered Information:**

This involves identifying what is most important to the beneficiary from their perspective and the perspective of others that care about the beneficiary. It involves identifying the beneficiary's strengths, preferences and needs through both informal and formal assessment processes. A variety of person-centered tool kits are available to assist in getting to know the beneficiary. These toolkits contain worksheets, workbooks and exercises that can be completed by the beneficiary, with the assistance of the Care Coordinator or other support person as needed.

b. **NC Innovations Risk/Support Needs Assessment or other DHHS approved Assessments that are being utilized by the LME/MCO:**

This assessment assists the beneficiary and the ISP team in identifying significant risks to the beneficiary's health, safety, financial security and the safety of others around them. In addition, this assessment identifies needed professional and material supports to ensure the beneficiary's health and safety. Risks identified in this assessment could bring great harm, result in hospitalization or result in incarceration if needed supports are not in place.

c. **Information about Support Needs:**

This information assists in assuring that the beneficiary receives needed services, and at the same time, that the beneficiary does not receive services that are unnecessary, ineffective and do not effectively address the beneficiary's identified needs. This can contain information from the Supports Intensity Scale (SIS), health/support assessment and other formal assessment of the beneficiary's support needs.

d. Additional Formal Evaluations:

These are evaluations by professionals, such as physical therapy (PT), occupational therapy (OT), speech therapy (ST), vocational, behavioral, developmental testing, physician recommendations, psychological testing, Nursing, adaptive behavior scales or other evaluations as needed.

e. Self-Direction Assessment:

This is an assessment to determine what types of support the beneficiary and/or legally responsible person needs to self-direct waiver services if self-directed services are requested.

5.3.3 ISP Implementation

The responsibility for implementing the Individual Support Plan (ISP) is shared among all members of the person-centered planning team. The beneficiary directs the planning process to the extent he/she desires and strives to reach the goals identified in the ISP. Other team members are responsible to the extent identified in the ISP.

Service providers are responsible for:

- a. developing intervention strategies and monitoring progress at the service delivery level;
- b. ensuring that staff are appropriately qualified and trained to deliver the interventions necessary to support the accomplishment of goals; and
- c. for clinical supervision of staff.

The Care Coordinator is ultimately responsible for monitoring and overseeing the implementation of the ISP.

The Care Coordinator:

- a. monitors the provision of services through observation of service provision, review of documentation and verbal reports; and
- b. maintains close contact with members of the person-centered planning team to ensure that the ISP is implemented as intended; and
- c. following the PIHP policy, assists the beneficiary and legally responsible person in choosing a qualified provider to implement each service in the ISP.
- d. meets with the beneficiary and legally responsible person;
 - a. provides them with a provider listing of each qualified provider within the PIHP provider network;
 - b. encourages the individual/legally responsible person to select providers that they would like to meet to obtain further information;
 - c. provides any additional information that may be helpful in assisting them to choose a provider;
 - d. facilitates arranging provider interviews on behalf of the beneficiary, and
 - e. documents the beneficiary's choice of provider in the service record, once selected.

5.3.4 ISP Implementation and Monitoring

The Care Coordinator is responsible for monitoring the implementation of the ISP. Services shall be implemented within 45 calendar days of initial ISP approval. The Care Coordinator is responsible for the monitoring of activities.

Monitoring takes place in all service settings and on a schedule outlined in the ISP.

The Care Coordinator is responsible for monitoring the ISP, and reviews goals at a minimum frequency based on the target date assigned to each goal. Goals may be, and often are, reviewed more frequently, based on the needs of the beneficiary. The Care Coordinator also maintains close contact with the beneficiary, the legally responsible person or parent or guardian (if applicable), providers, and other members of the person-centered planning team, noting any recommended revisions needed. This ensures that changes are noted, and updates are effectuated in a timely manner.

Monitoring methods also consist of contacts (face-to-face and telephone calls) with other members of the ISP team and review of service documentation. A standard monitoring checklist is used to ensure that the following issues are monitored:

- a. Verification that services are provided as outlined in the ISP;
- b. The beneficiary has access to services;
- c. Identification of any problems that may arise;
- d. The services meet the needs of the beneficiary;
- e. The back-up staffing plans are documented;
- f. Issues of health and welfare (rights restrictions, medical care, abuse, neglect or exploitation, behavior support plan) are addressed;
- g. That the beneficiary has been offered a free choice of providers; and
- h. That non-waiver services needs have been addressed.

Care Coordinator monitoring occurs monthly and consists of the following:

- a. A beneficiary that is new to the waiver receives face-to-face visits for the first six months and then on a schedule agreed to by the ISP team thereafter, no less than quarterly, to meet their health and safety needs;
- b. A beneficiary whose services are provided by guardians and relatives living in the home of the beneficiary receives monthly face-to-face monitoring visits;
- c. A beneficiary who lives in residential programs receives face-to-face monitoring visits monthly;
- d. A beneficiary who chooses the individual family-directed service option receives face-to-face monitoring visits monthly;
- e. For the months that the beneficiary does not receive face-to-face monitoring, the Care Coordinator has telephone contact with the beneficiary to ensure that there are no issues that need to be addressed;
- f. At least one service is utilized monthly, per waiver eligibility requirements;
- g. NC Innovations services utilized do not exceed authorization. If there is an emergency, the Care Coordinator shall ensure that beneficiary's needs are met and ensure that any updates to the LOC and ISP, based upon the changes in needs of the beneficiary, are processed in a timely manner; and
- h. Home and Community Based Services (HCBS) rules are met. Any concerns noted by the Care Coordinator regarding HCBS (such as privacy, restriction

of rights, access to food) must be reported to the PIHP. Any restrictions to HCBS must be addressed in the ISP.

5.4 Plan of Care Approval Process

5.4.1 Oversight of the Plan of Care Approval Process

Oversight of the process is provided by NC Medicaid. NC Medicaid authorizes the PIHP to approve Individual Support Plans (ISPs) and routinely monitors the ISP Approval Process. NC Medicaid may revoke approval authority if it determines that the PIHP is not in compliance with the waiver requirements. In the case of a revocation, the ISP approval would be carried out by NC Medicaid or a NC Medicaid designee. The ISP approval authorization process verifies that there is a proper match between the beneficiary need and the service provided. This involves identification of over-utilized and under-utilized services through careful analysis of the beneficiary's needs, problems, skills, resources and progress toward the beneficiary's life plan.

5.4.2 ISP Approval and Service Authorization Process

If the beneficiary or legal guardian accepts the plan and the plan appears to meet NC Innovations criteria, the ISP or revision to the ISP and other required information are submitted to the PIHP. Approval of the ISP or revisions to the ISP occurs locally at the PIHP following a process approved by NC Medicaid.

PIHP Individual Support Plan approval staff have extensive expertise in practices and interventions in the field of developmental disabilities. They are trained in the use of clinical practice guidelines developed by the PIHP, person-centered planning, risk planning, level of care determination, assessment, best practice in developmental disabilities, and the requirements of the waiver. Their primary function is to make plan of care approval and authorization decisions by conducting initial, continuing, discharge and retrospective authorizations of services. The work is accomplished through the consistent and uniform application of the PIHP's clinical criteria to each beneficiary's needs to determine the appropriate type of care, in the appropriate clinical setting. Not all amounts or duration requested of a service may be authorized.

5.4.2 ISP Approval Requirements

The ISP approval process by the PIHP verifies that there is a proper match between the beneficiary's needs and the service provided. Once the ISP is approved and services are authorized, the Care Coordinator notifies the beneficiary and legally responsible person of the approval, the services that are to be provided and the start date of services. The beneficiary and legally responsible person is given a copy of the approved ISP and individual budget, and crisis plan, as applicable.

The Care Coordinators developing the plan are employees of the PIHP in a separate unit from the individuals authorizing the plan. The Care Coordinator shall not authorize services in the Individual Support Plan.

The PIHP cannot approve services in excess of limitations outlined in any service definition or in the limits on sets of services.

The minimum information required for Individual Support Plan approval is:

a. Initial ISP Review:

Contact information for the Care Coordinator; Individual Support Plan submitted with an authorized signature (beneficiary or other legally responsible person); the Freedom of Choice Statement; Individual Budget; Initial Level of Care assessment and the supporting evaluations, as applicable; the Risk/Support Needs Assessment; the Supports Intensity Scale ® (SIS); additional assessments; Behavior Support Plan, if available and needed physician orders.

b. Annual ISP Review:

Contact information for the Individual Support Plan, including Freedom of Choice Statement and the annual reassessment of the Level of Care; Individual Budget; the Risk/Support Needs Assessment; the Supports Intensity Scale ®(SIS); additional assessments, as applicable; Behavior Support Plan, if available and needed physician orders. For Annual ISPs, the PIHP completes the final determination for the continued authorization of Level of Care. If the PIHP questions the need for continued ICF-IID level of care, the process for completing an initial Level of Care is followed and needs to be initiated.

c. Revisions:

- a. Contact information for the Care Coordinator includes:
- b. the completed update page of the Individual Support Plan; and the revised Individual Budget; and
- c. if needed, evaluations to support requested services, inclusive of physician orders.

5.4.3 Additional Service Specific Requirements:

5.4.3.1 Assistive Technology, Equipment, Supplies, Home Modifications and Vehicle Adaptations

- a. For requests for assistive technology equipment and supplies home modifications, and vehicle adaptations, the following additional information is required:
 1. a plan for how the beneficiary and family are to be trained on the use of the equipment;
 2. a request with itemized shipping costs;
 3. other information as required for the specific equipment or supply request;
 4. medical necessity must be documented by the physician, physician assistant, or nurse practitioner for every item provided/billed regardless of any requirements for approval;
 5. A letter of medical necessity written and signed by the physician (including a Doctor of Osteopathic Medicine), physician assistant, or nurse practitioner, or other licensed professional permitted to perform those tasks and responsibilities by their NC State Licensing Board is required;

6. when the physician (including a Doctor of Osteopathic Medicine), physician assistant, or nurse practitioner write the letter of Medical Necessity, a separate prescription is not needed;
 7. when an assessment is completed by another professional (PhD, OT, PT, ST) recommending the medical necessity of specific equipment or supplies, then a physician (including a Doctor of Osteopathic Medicine), physician assistant or nurse practitioner must write a letter of medical necessity OR sign off on the letter of medical necessity prepared by professional AND write prescription; and
 8. when quotes are required for purchases, the PIHP determines how many are required.
- b. For requests for assistive technology equipment and supplies, the following additional information is required in addition to Section 5.4.3.1 above:
1. An assessment or recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the equipment and supplies being requested. The assessment or recommendation must state the amount of an item that a beneficiary shall need.
 2. Supplies that continue to be needed at the time of the beneficiary's Annual Plan must be recommended by an annual re-assessment by an appropriate professional. The assessment or recommendation must be updated if the amount of the item the beneficiary needs changes.
- c. For requests for adaptive car seats, the following additional information is required in addition to Section 5.4.3.1 above:
1. A beneficiary shall have a documented chronic health condition or developmental disability which requires the use of an adaptive car seat for positioning. Car seats are not approved for behavioral restraint.
 2. Providers shall request prior approval with the following information in the assessment:
 - A. Beneficiary's weight;
 - B. Weight limits of the car seat currently used to transport;
 - C. Measurements documented that the beneficiary has a seat to crown height that is longer than the back height of the largest child car safety seat if the beneficiary weighs less than the upper weight limit of the current car seat;
 - D. Reasons why the beneficiary cannot be safely transported in a car seat belt or convertible or booster seat for individual weighing 30 pounds and up; and
 - E. Certification of medical necessity, assessment requirements and price quotes as required by PIHP policy.
- d. For Community Transition, the following additional information is required:
1. A Community Transition Checklist.

- e. For Home Modifications, the following additional information is required:
 - 1. Assessment/recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to home modifications requested.
- f. For Vehicle Adaptations, the following additional information is required:
 - 1. A recommendation by a physical therapist/occupational therapist specializing in vehicle modification or a rehabilitation engineer or vehicle adaptation.
 - 2. The recommendation must contain information regarding the rationale for the selected modification, beneficiary, and pre-driving assessment of the beneficiary driving the vehicle, condition of the vehicle to be modified, and the insurance on the vehicle to be modified. The responsibility of the family keeping their insurance current is between the Department of Motor Vehicles (DMV) and the family.
 - 3. If purchasing a vehicle with a lift on it, the price of the new lift may be covered. The cost of a used lift on vehicle must be assessed and the current value (not the replacement value) may be approved under this service definition to cover this part of the purchase price. In such instances, the beneficiary or family may not take possession of the lift prior to approval by the PIHP Utilization Management Department.
 - 4. Evaluation by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications.
 - 5. The modification must meet applicable standards and safety codes. The Care Coordinator verifies that the modification has been completed and received by the beneficiary, and note any health or safety concerns.
 - 6. If paying for labor and costs of moving devices or equipment from one vehicle to another vehicle, then training on the use of the device is not required.
- g. For Natural Supports Education, the following additional information is required:
 - 1. Long range outcomes directly related to the needs of the beneficiary or natural support's ability to provide care and support to the beneficiary.
- h. For Individual or Family-Directed Supports, the following additional information is required:
 - 1. An Individual or Family Directed Supports Assessment;
 - 2. Representative Needs Assessment and Representative Designation or Agreement, as applicable;
 - 3. Verification of Training for Managing Employer and Representative, if applicable; and
 - 4. Individual and Family Directed Supports Agreement.

5.4.4 Timelines for ISP approval

An approval or an adverse decision of an of Individual Support Plans must be completed in a timely manner. Reviews are completed in 14 calendar days and result in **one** of the following actions:

- a. Plan approval and service authorization;
- b. Plan pended for up to 14 calendar days; or
- c. Denial of request.

5.4.5 Individual Support Plan Approval Notifications

If the PIHP approves the ISP, the PIHP issues service authorizations to the providers indicated in the ISP and gives written notification to the DSS Medicaid Staff of the Initial ISP approval including a copy of the Individual Budget if the beneficiary had a deductible. Services, supplies and equipment must be prior authorized for payment. Following approval of the ISP, the PIHP:

- a. Gives the beneficiary or legal guardian written notification of the ISP approval, and a copy of the approved ISP, including the Individual Budget;
- b. Gives written notification to the DSS Medicaid staff of Annual ISP approval, including a copy of the Individual Budget, if the beneficiary has a deductible; and
- c. Ensures that the ISP is initiated and continues to monitor services.

Note: Services are expected to begin within 45 calendar days following approval of the Initial ISP.

5.4.6 ISP Disapproval Notifications

If the PIHP does not approve the ISP, the PIHP notifies the beneficiary or legal guardian in writing of the denial and the beneficiary's appeal rights. The PIHP notifies the DSS staff of the denial once all appeals processes have been exhausted.

If an ISP is not submitted with an authorized signature (beneficiary or legal guardian) by the expiration of the beneficiary's current ISP, the beneficiary becomes ineligible for continued NC Innovations services. The PIHP terminates the beneficiary from NC Innovations and issues appeal rights to the beneficiary or legal guardian. DSS is notified and may terminate the beneficiary from Medicaid if the individual's Medicaid eligibility is contingent upon NC Innovations waiver participation. If the beneficiary wishes to re-enter the waiver in the same waiver year, the procedures for a new waiver beneficiary's entry into NC Innovations are followed, including obtaining a new level of care. The waiver year begins July 1 and runs to June 30 of the following year.

5.4.7 Additional Limitations or Requirements

A beneficiary may receive funding from only one HCBS Waiver at a time. If the beneficiary is transitioning from another waiver program to NC Innovations, it is critical that the PIHP works with the other waiver program to ensure that the transition to NC Innovations Waiver is coordinated. Currently, the other HCBS Waivers in North Carolina are CAP-C, CAP-DA, and the TBI Waiver.

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

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

Some services distinguish between the professionals and paraprofessionals that may provide them. (Refer to **Attachment C, Service Definitions**, for service-specific requirements.)

Staff shall obtain licensure or certification according to N.C. General Statutes* and practice within the scope of practice as defined by their individual practice board. The following types of staff are recognized:

- a. licensed professional counselor (LPC) or Licensed Clinical Mental Health Counselor (LCMHC)
- b. licensed clinical supervisor (LCS);
- c. licensed clinical social worker;
- d. licensed psychologist;
- e. licensed psychological associate;
- f. certified clinical supervisor;
- g. registered nurse;
- h. licensed practical nurse;
- i. certified nursing assistant I;
- j. certified nursing assistant II;
- k. clinical nurse specialist;
- l. nurse practitioner;
- m. physician assistant;
- n. psychiatrist;
- o. qualified professional;
- p. paraprofessional;
- q. associate professional;
- r. board certified behavioral analyst;
- s. physical therapist;
- t. occupational therapist;
- u. recreation therapist;
- v. Speech Therapist; and
- w. Speech Language Pathologist.

*Therapists employed by Tribal Providers can be licensed in any U.S. State.

Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed

Clinical Mental Health Counselor (LCMHC) and Licensed Professional Counselor Associate (LPCA) is amended to Licensed Clinical Mental Health Counselor Associate (LCMHCA). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.

6.2 Provider Certifications

Competencies of qualified professionals and associate professionals are documented along with supervision requirements to maintain that competency (10A NCAC 27G.0203). Competencies and supervision of paraprofessionals are documented along with supervision requirements to maintain that competency (10A NCAC 27G .0204).

7.0 Additional Requirements

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

7.1 Compliance

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

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All of NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS and its divisions or its fiscal agent.

7.2 General Documentation Requirements

The minimum service documentation requirements for services provided through the NC Innovations Waiver are contained in this section and the *DMH/DD/SAS Records Management and Documentation Manual 45-2*. Information concerning documentation of all Medicaid or State funded services not contained in the NC Innovations Waiver can also be found in the *Records Management and Documentation Manual* <https://medicaid.ncdhhs.gov/>

All Medicaid providers shall document services prior to seeking Medicaid payment. Providers shall document to reflect attempts to ascertain why a beneficiary is not participating in a service or support according to the established schedule or plan.

7.2.1 Service Note

For Service Note requirements, refer to the *Records Management and Documentation Manual* (chapter 5). The following NC Innovation services require a full-service note, which includes Items 1 through 13, under Contents of a Service Note, Chapter 5 of the *Records Management and Documentation Manual*;

- a. Crisis Services (including information as indicated in the beneficiary's intervention plan);
- b. Community Navigator;
- c. Individual Directed Goods and Services (required for service component);
- d. Natural Supports Education; and

e. Specialized Consultative Services.

Services eligible to be provided via telehealth must be provided in accordance with 1-H, *Telehealth, Virtual Patient Communications, and Remote Patient Monitoring* refer to <https://medicaid.ncdhhs.gov/>.

7.2.2 Service Grid

For service grid requirements, refer to the *Records Management and Documentation Manual* (chapter 5). A service grid must have all elements 1 through 10, under Required Elements of a Service Grid, Chapter 5 of the Record Management and Documentation Manual. A service grid must be completed daily or per activity to reflect the service provided and may only be used for the following services:

- a. Community Networking;
- b. Day Supports (Services provided to children through Developmental Day Services- Typically Developing children, must meet the requirements through the NC Division of Child Development’s Child Care requirements, Subchapter 3U- Child Day Care Rules);
- c. Community Living and Support;
- d. Supported Living; Supported Living Periodic; Supported Living Transition;
- e. Residential Supports;
- f. Respite Care; and
- g. Supported Employment.

Residential Supports and Supported Living (per diem service) are billed as one unit. The total amount of time is not required to be document when performing Residential Supports or Supported Living (per diem service).

7.2.3 Signatures

All entries in the service record must be signed with a full signature. A full signature must document the credentials, degree or licensure for professional staff or the position of the individual who provided the service for paraprofessional staff. Refer to the *Records Management and Documentation Manual 45-2 Chapter 5* for electronic signature requirements.

7.2.4 Frequency of Service Documentation

All NC Innovations services require a daily or per activity service note or grid. The person who provided the service shall write and sign the service note or grid. The service note or grid to reflect services provided must be documented on the day that the service was provided. If a service note or grid is not documented on the day the service was provided, it is considered a “late entry.” Late entries are defined as those which are entered after the required time for documentation has expired. The entry must be noted as a “late entry” and at a minimum the date the documentation was made and the date for which the documentation should have been documented. Service documentation must be completed within seven calendar days of the date of service to be billable.

For example, “Late Entry made on 2/15/20 for 2/14/20.” The late entry must include a dated signature.

Service notes must be made at the frequency necessary to indicate significant changes in the beneficiary's status, needs or changes in the ISP.

Services that were denied but are being provided during the appeal of the denial, may continue to be documented by the caregiver and recorded by the provider even though the provider is not being reimbursed during the appeal.

7.2.5 Corrections in the Service Record

Changes or modifications in the original documentation for the purpose of making a correction may be made at any time, when appropriate. Whenever corrections are necessary in the beneficiary's record, service providers shall refer to the procedures as noted in the *Records Management and Documentation Manual 45-2* (Chapter 9).

For quality assurance and reimbursement purposes, all necessary documentation or corrections to support billing must be properly completed within seven business days.

7.2.6 Short-Range Goals, Task Analysis and Strategies

Service providers, Agencies with Choice, and Employers of Record are required to:

- a. develop and implement short-range goals;
- b. develop and implement task analysis and strategies;
- c. ensure short-range goals and task analysis or strategies are in place prior to plan implementation; and
- d. ensure short-range goals and task analysis or strategies are signed by the beneficiary or legal guardian.

7.3 Service Specific Documentation

7.3.1 Assistive Technology Equipment and Supplies

The PIHP shall maintain the following:

- a. Assessment or recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the equipment or supply being requested;
- b. Copy of the physician's signature certifying medical necessity is received along with the request for equipment or supply. The recommendation must be less than one-calendar-year-old from the date the request is received by the PIHP. The assessment confirms medical need for the equipment and identifies the beneficiary's need(s) with regard to specific equipment being requested;
- c. The estimated life of the equipment as well as the length of time the beneficiary is expected to benefit from the equipment, must be indicated in the request;
- d. An invoice from the supplier that shows the date the assistive technology equipment and supplies were provided to the beneficiary and the cost including related charges (such as applicable delivery charges) must be maintained by the PIHP;
- e. Long-range outcomes related to training needs associated with the beneficiary's or family's utilization and procurement of the requested

equipment or adaptations are documented in the Individual Support Plan as appropriate; and

- f. Documentation for specific equipment and supplies as outlined in the definition. See **Appendix C** for these requirements.

7.3.2 Community Navigator

The provider agency shall maintain service notes signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals. The community navigator shall complete a daily per event service note.

7.3.3 Community Networking

- a. The provider agency shall maintain a service note or grid signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goals.
- b. For conferences and classes, purchased in conjunction with these, an invoice is required.
- c. For Community Networking Transportation that is not part of the provision of a staffed service with a per mile charge, a record is maintained that documents the date service was provided, the specific activity that the beneficiary is being transported to or from, and the mileage related to the transportation of the beneficiary. The representative providing transportation shall sign the record.

7.3.4 Community Transition Services

The provider agency shall maintain the approved Community Transition Checklist and a copy of invoices from the suppliers that shows the date the community transition services were provided to the beneficiary and the cost of the services.

7.3.5 Crisis Services

The provider agency shall maintain a service note signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goal regarding intervention plans.

7.3.6 Home Modifications

The PHIP shall maintain the following:

- a. Assessment or recommendation by an appropriate professional that identifies the beneficiary's need(s) with regard to the home modification being requested;
- b. Copy of the physician's signature certifying medical necessity is included with the request for home modifications;
- c. Long-range outcomes related to training needs associated with the beneficiary's or family's utilization and procurement of the requested adaptations are included in the Individual Support Plan as appropriate; and

- d. An invoice from the supplier that shows the date the materials or equipment was provided to the beneficiary, and cost including the related charges such as applicable delivery charges must be maintained by the PIHP.

7.3.7 Individual Directed Goods and Services

An invoice or receipt from the supplier that shows the date the good was provided to the beneficiary and the cost related charges (such as applicable delivery charges) must be maintained by the Financial Support Agency or Agency With Choice.

7.3.8 Natural Supports Education

- a. The provider agency shall maintain a service note signed by the individual providing the service that documents the date of the service, the amount of time involved in the service and a description of the activities related to the long-range outcomes and the short-range goal; or
- b. For conferences, classes, and related materials purchased in conjunction with these, an invoice or receipt is required.

7.3.9 Respite Service

The provider agency shall document respite services once in a calendar day, and the documentation must contain the following components:

- a. name of the beneficiary;
- b. record number;
- c. service provided;
- d. date of service;
- e. duration of service;
- f. task performed, including comments on any behaviors which are considered relevant to the beneficiary's continuity of care;
- g. that special instructions were followed; and
- h. signature (initials, if the full signature is included on the page when the use of a grid is used for documenting).

7.3.10 Specialized Consultation Services

The provider agency shall maintain the Intervention Plan (as applicable) and service note signed by the individual providing the service that documents:

- a. the date of the service;
- b. the amount of time involved in the service; and
- c. a description of the activities related to the long-range outcomes and the short-range goals.

7.3.11 Supported Employment Services

The provider shall document Supported Employment services in a full service noted for each contact or intervention for each date of service, written and signed by the person who provided the service is required. More than one intervention, activity, or goal may be reported in one service note, if applicable. A service note must document ALL following elements:

- a. Individual's name;
- b. Service record identification number;
- c. Date of the service provision;

- d. Name of service provided;
- e. Type of contact (face-to-face, phone);
- f. Place of service;
- g. Purpose of contact as it relates to the PCP goals;
- h. Description of the intervention/prompting provided. Documentation of the intervention must accurately reflect services for the duration of time indicated;
- i. Duration of service, start and end time of intervention; total amount of time spent performing the intervention;
- j. Assessment of the effectiveness of the intervention and the individual's progress towards the individual's goals; and
- k. Date and signature and credentials or job title of the staff member who provided the service.

7.3.12 Vehicle Adaptation

The PIHP shall maintain the following:

- a. Recommended equipment or modification must be justified by an assessment from one or more of the following:
 - 1. physical therapist;
 - 2. occupational therapist specializing in vehicle modifications;
 - 3. a rehabilitation engineer; or
 - 4. vehicle adaptation specialist.
- b. Recommendation of a physician and a certified driving evaluator for people with disabilities when training on the installed device is provided by certified personnel. This applies to adapted steering, acceleration, signaling, and breaking devices.
- c. A physician's signature certifying medical necessity for the equipment or modification for the beneficiary;
- d. The recommendation must be less than one-calendar-year-old from the date the PIHP receives the request;
- e. The estimated life of the equipment as well as the length of time the beneficiary is expected to benefit from the equipment, must be indicated in the request;
- f. An invoice from the supplier that shows the date the vehicle adaptation was provided for the beneficiary and the cost including related charges (such as applicable delivery charges); and
- g. Long-range outcomes related to training needs associated with the beneficiary's or family's utilization and procurement of the requested adaptations documented in the Individual Support Plan as appropriate.

7.4 General Records Administration and Availability of Records

NC Innovations service providers shall make service documentation available to the PIHP, DMH/DD/SAS, NC Medicaid, and CMS to review the documentation to support a claim for NC Innovations services rendered, when requested.

- a. Authorization letters for NC Innovations services;
- b. A copy of the Individual Support Plan, including current long-range outcomes;
- c. Service documentation required in **Subsection 7.2** for service billed;

- d. Copies of any claims submitted to the PIHP for Medicaid billable services as well as related correspondence;
- e. Service providers who provide Before and After school services shall maintain a copy of the IEP (Individualized Educational Plan) and IFSP (Individual Family Support Plan) from the regular day program; and
- f. A signed copy of short-range goals and strategies to meet long-range outcomes in the Individual Support Plan.

7.5 How Long Records Must Be Kept

NC Innovations service providers have a responsibility for fulfilling the record retention and disposition requirements for all the beneficiary related records generated within their agency. Record retention is addressed in the provider contract with the PIHP. The records pertaining to a beneficiary receiving NC Innovations services currently must be maintained by the NC Innovations Provider Agency for 11 years after the date of the last encounter for adults or for minors, 12 years from the 18th birthday. For more information regarding records retention, refer to the *Records Management and Documentation Manual* (Chapter 1).

7.6 Individual and Family Directed Services Documentation

A beneficiary or their legal guardian who elects to direct their own services are required to have the individual workers document services following the above referenced criteria.

For a beneficiary who elects the Employer of Record Model, the documentation is stored in the beneficiary's or family's home. If the beneficiary or their family decide to stop self-directing services under the Employer of Record Model, all documentation is returned to the PIHP. For a beneficiary electing the Agency With Choice Model, the documentation is stored as directed by the Agency With Choice.

The Quality Management Department at the PIHP conducts annual reviews of service documentation. For additional information regarding documentation for beneficiary or family directed services, refer to the PIHP Employer Handbook.

8.0 Policy Implementation/Revision Information

Original Effective Date: April 1, 2005

Revision Information:

Date	Section Revised	Change
08/01/2013	All sections and attachment(s)	New policy documenting current coverage, effective August 1, 2013, for Medicaid beneficiaries of NC Innovations Waiver Services. This policy is documenting the 1915 (c) waiver that began April 1, 2005. NC Innovations is authorized by a Medicaid Home and Community-Based Services (HCBS) Waiver granted by the Centers for Medicare and Medicaid Services (CMS) under Section 1915 (c) of the Social Security Act. The most current waiver renewal was approved to be effective, August 1, 2013 for five years. This policy will not apply to NCHC beneficiaries as it is a waiver, not a State Plan service.
08/28/2013	All sections and attachment(s)	Minor revisions to correct grammar and clarify coverage
03/01/2014	Section 2.3: Eligible Coverage Groups	Added the Health Coverage for Workers with Disabilities Basic Group as an eligible covered group
03/01/2014	Section 2.3: Eligible Coverage Groups	Removed typo from #11 under Aids for Daily Living
03/01/2014	Attachment C: Service Definitions	Added Food Thickeners for adults under the section Aids for Daily Living of the Assistive Technology Equipment and Supplies definition
03/01/2014	All sections and attachment(s)	Minor revisions to grammar, numbering, format, and template language
08/01/2014	All Sections and Attachments	Reviewed policy grammar, readability, typographical accuracy, and format. Policy amended as needed to correct, without affecting coverage.
08/01/2014	All Sections and Attachments	Updated policy template language.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.
11/01/2016	All Sections and Attachments	Updated policy in accordance with Technical Amendment to Innovations Waiver effective 11/1/16. New service definitions: Community Living and Supports as a replacement of the former Personal Care, In Home Skill Building, and In-Home Intensive Supports; Supported Living; and Community Navigator as a replacement of the former Community Guide. The Waiver amendment will also provide increased

Date	Section Revised	Change
		flexibility of existing services. The Respite definition has been altered to allow for Respite activities in an AFL setting. The residential unit costs were reevaluated based on updated direct care hour assumptions; the State also refined this assumption to include a mix of individual and group care hours. Day Habilitation changed from a 15-minute unit to an hourly unit; note that this does not have an overall financial impact on the waiver. In addition, House Bill 916 requires the expansion of resource allocation to all MCOs. Currently, Cardinal Innovations is the only MCO using the resource allocation model. The model is a mechanism for determining individual budgets for beneficiaries on the Innovations Waiver. It is based on age, residential status, and SIS (Support Intensity Scale) assessment index score.
12/15/2016	Attachment B	Inadvertently listed 4 minors or 4 adults with a developmental disability may live in 5600 F type facilities. Licensure rules under DHSR does not allow this. Changed to 3 minors or 3 adults. These corrections had no change on the Amendment Date.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
12/15/2019	Attachment A	Added: Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.
12/15/2019	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
12/15/2019	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
05/01/2022	All Sections and Attachments	Updated policy according to Innovations Waiver Renewal effective 07/1/19. Removed Personal Care and In Home Skill Building Added clarifying information related to Supported Living (including adding Supported Living Periodic and

Date	Section Revised	Change
		Supported Living Transition Services) Added information about Employment Education to Day Supports and Community Networking Updated Individual and Family Directed Section Added Slot Allocation Process Section
05/01/2022	Related Clinical Coverage Policies	1-H, Telehealth, Virtual Patient Communications, and Remote Patient Monitoring
05/01/2022	Subsection 3.1.1	Added new subsection 3.1.1 Telehealth Services.
05/01/2022	Subsection 3.1.2	Added new subsection 3.1.2 Telehealth Specific Criteria
05/01/2022	Subsection 6.1	Added: “Licensed Clinical Mental Health Counselor (LCMH)” and “Licensed Clinical Mental Health Counselor Associate (LCMHA)” to comply with NC General Assembly Session Law 2019-240 Senate Bill 537. Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.
05/01/2022	Subsection 6.1	Added: “Note: To comply with the NC General Assembly Session Law 2019-240 Senate Bill 537, licensure name for Licensed Professional Counselor (LPC) is amended to Licensed Clinical Mental Health Counselor (LCMHC) and Licensed Professional Counselor Associate (LPCA) is amended to Licensed Clinical Mental Health Counselor Associate (LCMHCA). Policy amendment(s) will be effective the date the related rule change for 10A NCAC 27G is finalized.”
05/01/2022	7.2.1 Service Note	Services eligible to be provided via telehealth must be provided in accordance with <i>1-H, Telehealth, Virtual Patient Communications, and Remote Patient Monitoring</i> Refer to https://medicaid.ncdhhs.gov/ .
05/01/2022	Attachment A, Letter C	Added columns to service codes indicating if the services were eligible for telehealth. Added: “Note: Please refer to Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring for virtual patient communications and remote patient monitoring utilization and billing guidance.”
05/01/2022	Attachment A, Letter D	Added the following language for telehealth services: Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for services provided via telephonic, audio-only communication.

Date	Section Revised	Change
05/01/2022	Attachment A, Letter F	Added the following language: Telehealth claims should be filed with the provider's usual place of service code(s) Added the following language: Services may be provided in a hotel, shelter, church or other setting based on the beneficiary's needs.
05/01/2022	Attachment C	Added the following language: Individuals who receive Day Supports do not have to attend the Day Supports facility and therefore are often in the community with individuals without intellectual and developmental disabilities.
05/01/2022	Attachment F	Added language regarding criteria for beneficiaries to exceed the \$135,000 waiver limit.
05/01/2022	Attachment C	Included Updated Supported Employment Definition
4/15/2023	All Sections and Attachment(s)	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 4/15/2023 with an effective date of 4/1/2023.

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NC Tracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid.

A. Claim Type

Professional (CMS-1500/837P transaction) billed through the PIHP.

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

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

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

A diagnosis of an Intellectual Disability or a related condition is must be present to bill for this service (42 CFR 435.1010). A related condition is defined as a severe, chronic disability that meets all of the following conditions:

1. It is attributable to—
 - a. Cerebral palsy or epilepsy; or
 - b. Any other condition, other than mental illness, found to be closely related to an intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of person with intellectual disability, and requires treatment or services similar to those required for these persons.
2. It is manifested before the person reaches age 22.
3. It is likely to continue indefinitely.
4. It results in substantial functional limitations in three or more of the following areas of major life activity:
 - a. Self-care.
 - b. Understanding and use of language.
 - c. Learning.
 - d. Mobility.
 - e. Self-direction.
 - f. Capacity for independent living.

Note: Providers using the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0–5) manual shall submit claims using the ICD-10 diagnosis code that corresponds to the chosen DC:0-5 diagnosis.

C. Code(s)

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

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

	HCPCS Code(s)
HCPCS Codes	Telehealth Billable Services (with GT modifier)
H2011	
H2015	X
H2015 HQ	X
H2015 U1	
H2015 U2	X
H2016	
H2016 HI	
H2025	X
H2025 HQ	X
H2025 TS	X
H2025 TS HQ	X
S5110	X
S5111	
S5150	
S5150 HQ	
S5150 US	
S5165	
T1005 TD	
T1005 TE	
T1015	
T1999	
T2013	
T2013 HQ	X
T2013 TF	X
T2013 TF HQ	
T2014	
T2020	
T2021	X
T2021 HQ	X
T2021 TF HQ	X
T2025	X
T2025 HO	
T2025 U1	
T2025 U2	
T2025 U3	X
T2025 U3	
T2027	
T2029	
T2033	X

T2033 HI	X
T2033 TF	X
T2033 U1	X
T2033 U2	X
T2034	
T2038	
T2039	
T2041	X
T2041 U1	X

Unlisted Procedure or Service

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

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

Note: Please refer to Clinical Coverage Policy 1-H: Telehealth, Virtual Patient Communications, and Remote Patient Monitoring for utilization and billing guidance on virtual patient communication codes (e.g., online digital E&M, telephonic E&M, and interprofessional consultation) and remote patient monitoring codes (e.g., self-measured blood pressure and remote physiologic monitoring) billable by eligible psychiatric prescribers but which are not contained in clinical coverage Policy 8C, *Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers*, <https://medicaid.ncdhhs.gov/>.

D. Modifiers

Non-Telehealth Claims: Provider(s) shall follow applicable modifier guidelines.

Telehealth Claims: Modifier GT must be appended to the CPT or HCPCS code to indicate that a service has been provided via interactive audio-visual communication. This modifier is not appropriate for services provided via telephonic, audio-only communication.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Billing units vary by service. Refer to **Attachment C, Service Definitions**, to determine the billing units for each service.

F. Place of Service

Services generally can be provided at a location that best meets the beneficiary’s needs. Services may be provided in a hotel, shelter, church or other setting based on the beneficiary’s needs. However, some services must be provided at a specific location. Refer to the **Attachment C**,

Service Definitions, for specific information about any limitations on where a service can be provided.

Telehealth claims should be filed with the provider's usual place of service code(s).

Home and Community Characteristics:

HCB Settings requirements apply to Residential Supports, Day Supports and Supported Employment.

- a. The following HCBS Characteristics must be met in all settings:
 1. The setting is integrated in and supports full access of a beneficiary receiving Medicaid HCBS to the greater community;
 2. Individuals are provided opportunities to seek employment and work in competitive integrated settings, engage in community life and control personal resources;
 3. Individuals receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS;
 4. Individuals select the setting from among available options, including non-disability specific settings and an option for a private unit in a residential setting (with consideration being given to financial resources);
 5. Each individual's rights of privacy, dignity, respect and freedom from coercion and restraint are protected;
 6. Settings optimize, but do not regiment, individual initiative, autonomy and independence in making life choices;
 7. Settings also facilitate individual choice regarding services and supports, and who provides these.
- b. The following additional HCBS Characteristics must be met in Provider Owned or Controlled Residential Settings:
 1. Provide, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law for the state, county, city or other designated entity;
 2. Provide privacy in sleeping or living unit;
 3. Provide freedom and support to control individual schedules and activities, and to have access to food at any time;
 4. Allow visitors of the beneficiary's choosing at any time;
 5. Are physically accessible.

Any modification of these conditions under 42 CFR 441.301(c)(4)(VI)(A) through (D) must be supported by a specific assessed need and justified in the person-centered service plan.

Refer to North Carolina DHHS's HCBS Transition Plan for additional information, <https://www.ncdhhs.gov/about/department-initiatives/home-and-community-based-services-final-rule/hcbs-resources>

Monitoring for Home and Community Characteristics:

Residential Supports, Day Supports, and Supported Employment must follow the Home and Community Based Services Final Rule as outlined in North Carolina' DHHS State Transition Plan.

Services in the Home of a Direct Service Employee:

If the team is in agreement that a beneficiary needs to receive, Community Living and Support or Respite services in the home of a direct service employee, the Provider Agency, Employer of Record or Agency With Choice is required to complete the Health and Safety Checklist and Justification for Services form prior to the delivery of service in that home and every six months afterwards, as long as the service continues to be provided in that location. The beneficiary or legally responsible person shall sign this checklist. A beneficiary should consider the provision of services in the direct service employee's home very carefully. While the checklist covers basic health and safety concerns, it does not provide for an independent review or cover the same areas that formal licensure of service locations covers.

Services Provided Outside North Carolina

According to 42 CFR 431.62, waiver services to be delivered out-of-state are subject to the same requirements as services delivered out-of-state under the Medicaid State Plan. For a beneficiary living in a county bordering another state, the beneficiary may receive services from an enrolled NC Innovations Provider Agency located within 40 miles of the border of the county.

The following guidelines are to be used when a beneficiary travels out-of-state:

1. Services are for a beneficiary who has been receiving services from direct-care staff while in-state and who are unable travel without their assistance.
2. A beneficiary who lives in alternative family living home or foster home may receive services when traveling with their alternative family living or foster family out-of-state under these guidelines.
3. A beneficiary who resides in a residential setting is allowed to go out-of-state on vacation with their residential provider, and continue to receive services, if the beneficiary's cost of care does not increase.
4. Written prior approval of the request for their staff to accompany a beneficiary out-of-state must be received from the supervisor of the staff person and the PIHP.
5. Waiver services may not be provided outside of the United States of America.
6. Provider agencies shall ensure that the staffing needs of all their beneficiaries can be met.
7. Supervision of the direct-service employee and monitoring of care must continue.
8. The ISP must not be changed to increase services while out-of-state. Services can only be reimbursed to the extent they would be had they been provided in-state, and only for the benefit of the beneficiary.
9. Respite services are not provided during out-of-state travel since the caregiver is present during the trip.
10. If licensed professionals are involved, Medicaid cannot waive any other state's licensure laws. A NC licensed professional may or may not be licensed to practice in another state. A licensed professional employed by Tribal Providers can be licensed in any U.S. State.
11. Medicaid funds cannot be used to pay for room, board, or transportation costs of the beneficiary, family, or staff.

12. Provider agencies, Employers of Record and Agencies With Choice assume all liability for their staff when out-of-state.

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices>

H. Reimbursement

Providers are reimbursed by the PIHP.

Attachment B: Terms of Service

A. Absences, Movement from the PIHP Area and Terminations

If the beneficiary is hospitalized, placed in an ICF-IID facility, admitted to a state psychiatric facility, becomes an inmate in a public correctional institution or will be absent for 30 calendar days or more, the Care Coordinator should notify DSS as soon as they are aware of an absence of 30 days or more. DSS will direct the Care Coordinator about continuing Medicaid eligibility.

B. Hospitalizations

When a beneficiary is admitted to a hospital, the PIHP suspends the delivery of NC Innovations funding. Care Coordination may be provided for the purposes of discharge planning as long as activities do not occur that duplicate the services provided by hospital staff. No NC Innovations Services may be billed to Medicaid for a beneficiary who is hospitalized. The Care Coordinator notifies the service providers of the suspension and the projected resumption date. The length of time the beneficiary is hospitalized determines what else must be done as detailed below.

1. **30 calendar days or less:** normal tasks of coordinating the temporary changes in services with providers, monitoring the beneficiary's situation, and working with hospital discharge planners and others to assure services and supports upon discharge. The Care Coordinator notifies the DSS staff of the admission. NC Innovations services, supplies, and equipment cannot be provided or billed to Medicaid during hospitalizations.
2. **Over 30 calendar days:** DSS staff is notified. Medicaid staff determines when the NC Innovations indicator on the Eligibility Information System (EIS) is to be removed. This removes the beneficiary from NC Innovations funding. Once the DSS staff determines the effective date of the termination, the Care Coordinator follows the termination procedures. If the person later wishes to be re-enrolled to NC Innovations, the PIHP and Care Coordinator considers the person a new beneficiary. A beneficiary re-enrolled to NC Innovations within the same Waiver year re-enters the slot that he or she left.

C. Admission to ICF-IID or Other Institution

When a NC Innovations funded beneficiary is admitted to an ICF-IID facility, nursing facility, or psychiatric institutional setting other than a hospital, the beneficiary shall be terminated from NC Innovations on the date of institutionalization. If the beneficiary wishes to resume NC Innovations participation upon discharge, the PIHP considers the person a new beneficiary. The provision of Institutional Respite (at a private or State facility) does not constitute admission to an ICF-IID facility.

D. Temporary Absence from Area

When a beneficiary temporarily leaves the area, the PIHP suspends the delivery of NC Innovations services. The Care Coordinator tracks the length of the absence as extended absences can affect Medicaid eligibility. If the absence is 30 calendar days or more, the Care Coordinator notifies the DSS staff. The DSS staff determines when the NC Innovations indicator on the Eligibility Information System (EIS) is to be removed. Once the Medicaid staff determines the effective date of the termination, the Care Coordinator follows the termination procedures.

E. Service Breaks

The beneficiary may miss a service for a variety of reasons. Holidays, family vacations, weather conditions, illnesses, and scheduling conflicts can cause brief interruptions in services. Breaks in service are to be documented by the provider and monitored by the Care Coordinator. When such an interruption occurs, the service may be rescheduled, depending on the nature of the service missed. Providers should keep in mind the limits on sets of services when determining if services may be rescheduled, especially if multiple providers serve the beneficiary. The provider contacts the Care Coordinator if there are questions regarding the rescheduling of the service. This exception to providing services as approved on the plan may not be used if the beneficiary missed services while he or she was ineligible for Medicaid or NC Innovations. Services missed during periods of ineligibility may not be rescheduled. Service breaks do not require Back-Up Staffing Reporting to the PIHP.

F. Terminations

Termination may be due to a variety of reasons, including ineligibility for Medicaid, moving outside the catchment area, institutionalization, or failure to qualify for program participation. Depending on the reason for termination, it may be initiated by the county DSS, the PIHP, or the beneficiary or legal guardian.

Terminations must be completed with full regard for the beneficiary's rights, including those related to a fair hearing. All terminations **must** be coordinated with DSS. Written notifications of terminations must be sent trackable to the beneficiary or legal guardian, the PIHP and DSS.

G. DSS Terminates Medicaid Eligibility

If DSS proposes to terminate the beneficiary's Medicaid eligibility, DSS sends a notice to the beneficiary or legal guardian. Medicaid rules determine the timing of the notice. In many instances, it is sent at least 10 days prior to the proposed date of action. The notice states the proposed termination date, the reason for termination, and appeal rights. Medicaid terminations usually are effective the last day of the month. In some instances, the beneficiary's eligibility for Medicaid continues through the appeal process. The beneficiary may continue NC Innovations services as long as the beneficiary remains eligible for Medicaid and NC Innovations.

H. ISP is Disapproved

If the PIHP does not approve a beneficiary's Individual Support Plan, due process is followed per the Medicaid Billing Guide, <https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

I. Beneficiary Institutionalized or Beneficiary's Level of Care Changes

If the beneficiary is admitted to an ICF-IID or nursing facility or if the beneficiary's level of care is changed to Intermediate, Skilled, or Hospital Level of Care on a Level of Care Form (or on an FL-2), the Care Coordinator terminates the beneficiary on the date of admission or date of change of Level of Care. Also, if the beneficiary is admitted to a hospital for a stay longer than 30 calendar days, the Care Coordinator consults with DSS about possible termination.

The PIHP sends written notification of the termination to DSS, informs the beneficiary or legal guardian in writing of the termination, and sends written notification to Provider Agencies, Employers of Record, Financial Support Agencies or Agencies With Choice to stop services.

J. Beneficiary Moves Out of State

If the termination of NC Innovations is due to the beneficiary moving out of the state, the termination is usually the last day of the month. The PIHP notifies DSS of the termination. Notification of termination must be written.

K. Beneficiary Dies

If the beneficiary dies, the Care Coordinator notifies the PIHP, and the PIHP notifies DSS and Provider Agencies of the death. Medicaid shall not pay for any services after the date of the beneficiary's death. Notification of termination must be written. DMH/DD/SAS Rules regarding death reporting are followed.

L. Failure to Use Services

The Innovations waiver requires that a service be used at least monthly. The following services are excluded from being considered a service to be used monthly: Assistive Technology, Vehicle Modification, Home Modifications, Community Transition, and Respite. If a beneficiary does not use an Innovations waiver service for a period of 30 calendar days, the PIHP shall send a written notice to the beneficiary that failure to use services for a period of 30 calendar days may result in a termination from the waiver. The PIHP shall attempt to engage the beneficiary in services. After a second 30-day period, the PIHP shall contact NC Medicaid to discuss termination of the beneficiary from the waiver. The beneficiary shall be notified of termination in writing and due process is followed.

The exception to monthly service use requirements is if the beneficiary is under the age of 21 with a diagnosis of Autism Spectrum Disorder (ASD) and is actively engaged in a research-based intervention for the treatment of ASD. If the beneficiary is not actively engaged in a research-based intervention for the treatment of ASD (that is refusing services or service no longer found to be medically necessary), they shall receive an Innovations waiver service within 30 days to avoid termination from the waiver.

M. Other North Carolina Innovations Terminations

If the termination of NC Innovations is for reasons other than those covered above (such as refusal of monitoring, refusal of SIS assessment), the Care Coordinator coordinates the proposed termination date with DSS. The PIHP shall give the waiver beneficiary at least 10 days written advance notice of the proposed termination. The reason for termination and the beneficiary's appeal rights must be provided. The date of termination is the last day of the month of NC Innovations eligibility. When the termination is final, the Care Coordinator notifies DSS of the termination in writing. The PIHP notifies provider agencies of the termination.

Attachment C: Service Definitions

NC Innovations service definitions and the specific provider requirements for each definition are included in the following pages:

Assistive Technology Equipment and Supplies: T2029

Assistive Technology, Equipment and Supplies (ATES) are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain, or improve functional capabilities of individuals. Assistive Technology and Supplies can be accessed when the item requested will belong to the individual. This service covers purchases, leasing, trial periods and shipping costs, and as necessary, repair/modification of equipment required to enable individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. Cost of Monthly monitoring, connectivity, and internet charges may be covered when it is required for the functioning of the item and system. Service contracts and extended warranties may be covered for a one-year time frame. All items must meet applicable standards of manufacture, design, and installation. The Individual Support Plan clearly indicates a plan for training the individual, the natural support system and paid caregivers on the use of the requested equipment and supplies.

A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the person. This service may cover an evaluation, when the Medicaid State Plan option has been exhausted.

Monitoring systems using video, web-cameras, or other technology are available on an individual basis, when the individual and the support team agrees it is appropriate and meets the health and safety needs of the individual. Remote support technology may only be used with full consent of the individual and his or her guardian and that consent is indicated in the individual's plan of care (including if the individual has a reference for the location of any monitoring equipment; such as where they are comfortable with a camera being located in their primary residence). The individual and guardian can revoke consent if they are no longer interested in monitoring systems.

Medical necessity must be documented by the physician, physician assistant, or nurse practitioner, for every item provided/billed regardless of any requirements for approval. A letter of medical necessity written and signed by the physician, physician assistant, or nurse practitioner, or other licensed professional permitted to perform those tasks and responsibilities by their NC state licensing board, may be submitted along with the Certificate of Medical Necessity/Prescription.

Note: The Certificate of Medical Necessity/Prescription still must be completed and signed by the physician (including doctor of osteopathic medicine), physician assistant, or nurse practitioner. When the physician, physician assistant, or nurse practitioner write the letter of Medical Necessity, a separate prescription is not needed.

When an assessment is completed by another professional (PhD, OT, PT, ST) recommending the medical necessity of specific equipment or supplies, the physician (including doctor of osteopathic medicine), physician assistant, or practitioner shall write a letter of medical necessity OR sign off on the letter of medical necessity prepared by a professional AND write the prescription.

Assistive Technology: Equipment and Supplies covers the following list of categories:

- a. Aids For Daily Living or Aids to increase Independent Living
- b. Aids For Gross Motor Development or Fine Motor Skill Development
- c. Environmental Controls and Modifications
- d. Positioning Systems or Devices to aid with Positioning
- e. Alert and Monitoring Systems
- f. Sensory Aids
- g. Communication Aids not covered by regular Medicaid State Plan
- h. Mobility Aids not covered by DME
- i. Nutritional supplements covered under the NC DME fee schedule for adults
- j. Medical Supplies not covered by regular state plan formulary.

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

- a. a plan for how the person and family will be trained when needed on the use of the equipment;
- b. a written recommendation that includes a physician signature certifying medical necessity (not required for repair); or signature of other appropriate licensed professionals as determined by the PHIP policies
- c. shipping costs must be itemized in the request to be included; taxes are not coverable;
- d. other information as required for the specific equipment or supply request;
- e. quote(s) (PIHP determines how many quotes are required.)

For requests for supplies covered under this definition, the following additional information is required:

- a. A Statement of Medical Necessity completed by an appropriate professional that identifies the person's need(s) with regard to the equipment and supplies being requested. The Statement of Medical Necessity must state the amount and type of the item that a person needs.
- b. Supplies that continue to be needed at the time of the person's Annual Plan must be recommended by an annual Statement of Medical Necessity by an appropriate professional. The Statement of Medical Necessity must be updated if the amount of the item the person needs changes.

Exclusions

- a. Items that are not of direct or remedial benefit to the person are excluded from this service
- b. Recreational items that would normally be purchased by a family
- c. Non-Adaptive Computer desks and other furniture items are not covered.
- d. Service and maintenance contracts and extended warranties; and equipment or supplies purchased for exclusive use at the school/home school.
- e. Computer hardware solely to improve socialization or educational skills, to provide recreation or diversion activities, or to be used by any person other than the beneficiary.
- f. Hot tubs, Jacuzzis, and pools.
- g. Items utilized as restraints.
- h. Items that are coverable under the Medicaid Durable Medical Equipment benefit should not be covered by NC Innovations ATES.

Limits on amount, frequency, or duration

The service is limited to expenditures of \$50,000 (ATES and Home Modifications) over the life of the waiver period. This limit does not include nutritional supplements and monthly alert monitoring / connectivity system charges.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
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Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Type	
Specialized Vendors	
License	
Applicable state/local business license	
Certification	
Other Standard	
Meets applicable state and local requirements and regulations for type of device that the business is providing.	
Provider Type	
Alert Response Centers	
License	
Applicable state/local business license	
Certification	
Other Standard	
Response Centers must be staffed by appropriately trained individuals, 24 hours/day, 365 days/year Meets applicable state and local requirements and regulations for type of device that the vendor is providing.	
Provider Type	
Durable Medical Equipment Providers	
License	
Applicable state/local business license	
Certification	
enrolled vendor	
Other Standard	
Meets applicable state and local requirements and regulations for type of device that the business is providing.	
Provider Type	
Home Care Agencies	
License	
Licensed by the NC DHHS, Division of Health Services Regulation, in accordance with NCGS 131E, Article 6, Part C	
Certification	
NC Medicaid enrolled vendor	

Other Standard

Meets applicable state and local requirements and regulations for type of device that the business is providing.

Provider Type

Commercial/Retail Businesses

License

Applicable state/local business license

Certification

Other Standard

Meets applicable state and local requirements and regulations for type of device that the business is providing.

Community Living and Support-T2013TF; Group-T2021TF HQ

Community Living and Support is an individualized or group service that enables the waiver beneficiary to live successfully in their own home, the home of their family or natural supports and be an active member of their community. A paraprofessional assists the beneficiary to learn new skills and/or supports the beneficiary in activities that are individualized and aligned with the beneficiary's preferences. The intended outcome of the service is to increase or maintain the beneficiary's life skills or provide the supervision needed to empower the beneficiary to live in the home of their family or natural supports or in their private primary residency, maximize his or her self-sufficiency, increase self-determination and enhance the beneficiary's opportunity to have full membership in his/her community. Community Living and Support enables the beneficiary to learn new skills, practice and/or improve existing skills.

Areas of skill acquisition are:

- a. interpersonal, independent living,
- b. community living,
- c. self-care,
- d. and self-determination.

Community Living and Support provides supervision and assistance for the person to complete an activity to his/her level of independence. Areas of support consist of assistance in monitoring a health condition, nutrition or physical condition, incidental supervision, daily living skills, community participation, and interpersonal skills.

Community Living and Support provides technical assistance to unpaid supports who live in the home of the beneficiary to assist the beneficiary to with maintaining skills learned. This assistance can be requested by the unpaid support or suggested by the Individual Support Planning team and must be a collaborative decision. The technical assistance is incidental to the provision of Community Living and Supports.

Exceptional Needs:

Community Living and Supports Exceptional Needs are used to meet exceptional, short term situations that require services beyond 12 hours per day. The Individual Support Plan documents the exceptional supports needed based on the SIS® or other assessments that explain the nature of the issue and the expected intervention. A plan to transition the individual to sustainable supports is required. The plan may document the use of assistive technology or home modifications to reduce the amount of the support for behavioral and/or safety issues. Medical, behavioral, and support issues require documentation of when the situation is expected to resolve, evaluations/assessments needed to assist in resolving issues, and other service options explored. EPSDT and other appropriate State Plan services must always be utilized before waiver services are provided.

All Requests for Community Living and Supports require prior approval by the PIHP:

- a. Requests for up to 12 hours daily may be authorized for the entire plan year.
- b. Requests for up to 16 hours daily may be authorized for a six-month timeframe, within the plan year.
- c. Requests for more than 16 hours daily are authorized for up to a 90-day period within the plan year. In situations requiring an authorization beyond the initial 90-day period, the PIHP shall approve such authorization based on review of Medical Necessity. The treatment team should meet to review individuals' status and identify sustainable supports, if available and information from the meeting should be included in the individual's ISP. Review of other options should include options within the Innovations Waiver, as well as options outside of the Innovations waiver such as Medicaid State Plan Services.

The service may be provided in the home or community. The involvement of unpaid supports in the generalization of the service is an important aspect to ensure that achieved goals are practiced and maintained. Services may be allowed in the private home of the provider or staff of an Employer of Record at the discretion and agreement of the support team and when consistent with the ISP goals. If services are provided in the primary residence of the provider or staff of the employer of record, the Health and Safety Checklist must be completed before service begins and every six months thereafter.

Exclusions

- a. Transportation to and from the school setting is not covered under the waiver and is the responsibility of the school system.
- b. (This service includes only transportation to/from the person's home or any community location where the person is receiving services.) Incidental housekeeping and meal preparation for other household members is not covered under the waiver.
- c. The paraprofessional is responsible for incidental housekeeping and meal preparation only for the beneficiary.
- d. A beneficiary who receives Community Living and Supports may not receive Residential Supports or Supported Living at the same time.
- e. This service is not available at the same time of day as Community Networking, Day Supports, Supported Living, Supported Employment, Respite or one of the State Plan Medicaid Services that works directly with the person, such as Private Duty Nursing.

Limits on amount, frequency, or duration

The amount of Community Living and Supports is subject to the limitations on the sets of services.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input checked="" type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input checked="" type="checkbox"/> Relative <input checked="" type="checkbox"/> Legal Guardian

Provider Type

Provider Agencies

License

NC G.S. 122 C

Tribal Providers are not subject to licensure.

Certification

NC G.S. 122

Other Standard

Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- a. Are at least 18 years old
- b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in Cardiopulmonary Resuscitation (CPR) and First Aid
- f. Qualified in alternatives to restrictive interventions
- g. Qualified in the customized needs of the beneficiary as described in the ISP.
- h. High school diploma or high school equivalency (GED)
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- j. Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies.
- k. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of PIHP.

Professional Competency

Support Professionals shall have competency in the following areas:

- a. Communication-The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility_-The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through

further education and training.

Provider Type

Employee in a self-directed arrangement

Staff that work with an NC Innovations beneficiary are approved by Employer of Record OR recommended by Managing Employer and approved by Agency with Choice and meet the following criteria:

Agency staff that work with beneficiaries:

- a. At least 18 years old
- b. If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance
- c. Criminal background checks present no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Qualified in alternatives to restrictive interventions
- g. Qualified in the customized needs of the beneficiary as described in the ISP
- h. High school diploma or high school equivalency (GED)
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- j. State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director
- k. Agencies with Choice follow the NC State Nursing Board regulations
- l. Has an arrangement with an enrolled crisis services provider to respond to beneficiary crisis situations
- m. Upon enrollment with the PIHP, the Agency with Choice shall have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice shall be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication- The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis, and crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.

- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility - The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Community Navigator: Periodic-T2041 U1; Monthly-T2041

The purpose of Community Navigator Services is to promote self-determination, support the beneficiary in making life choices, provide advocacy and identify opportunities to become a part of their community. Community Navigator provides support to the beneficiary and planning teams in developing social networks and connections within local communities. Community Navigator Services also emphasizes, promotes and coordinates the use of generic resources to address the beneficiary needs in addition to paid services. Community Navigator provides an annual informational session on Self-Determination and Self Direction. The beneficiary and legally responsible person may choose to opt out of this annual informational session.

These services also support the beneficiary, representatives, and Managing Employers by providing assistance to those that direct their own waiver services.

Community Navigator is mandatory for all Employers of Record until competence in directing service is demonstrated. Community Navigator Services may be intermittent and fade as community connections develop and skills increase in individual direction. Community Navigators assist and support (rather than direct and manage) the beneficiary throughout the service delivery process. Community Navigator Services are intended to enhance, not replace, existing natural and community resources.

If the beneficiary requires paid supports to participate or engage once connected with the activity, Community Networking is the appropriate service to utilize to refer and link the beneficiary.

Specific functions are:

Informational Session

- a. Annual Informational Session on Self Direction
- b. Annual Informational Session on rights and self-determination

Self-Determination

- a. Encourage exploration of possibilities related to life goals, defining what those are and the steps that they need to take in order to have those met.
- b. Support an individual to make decisions that are important to them.
- c. Promote choice making to support the individual's strengths and interests.
- d. Provide education on decision making, risk taking, and natural consequences.
- e. Provide education which guides the individual in problem solving, decision making and navigating multiple state systems.
- f. Promote advocacy and collaborating with other individuals and organizations on behalf of the individual
- g. Guidance with managing their individual budget.
- h. Supporting the person in preparing, participating in and implementing plans of any type (IEP, ISP, or service plans outside of NC Innovations)
- i. Supports the person in the person-centered planning process (such as development of ELP, MAPs, Circle)
- j. Assistance with guardianship or establishing alternatives to guardianship, restoration of rights, Supplemental Security Income issues, disability determination issues, Division of Social Services issues, and financial / legal planning.
- k. Provide education about appropriate accommodation needs.
- l. Supports the individual in devising / negotiating roommate agreements.
- m. Supports and educates the individual in preparing and participating in staff interviews.

- n. Assistance with the development of Life related emergency plans.

Community Connections

- a. Support the beneficiary in identifying the resources in his/her community and determine steps to increase the individual's opportunity to expand valued social relationships and build connections within the beneficiary's local community through unpaid supports.
- b. Assist with locating and accessing non-Medicaid community supports and resources that are related to achieving the beneficiary's life goals.
- c. Assist with locating options for renting or purchasing a personal residence, assisting with purchasing furnishings for the personal residence

Self-Direction

- a. Provide training on the Individual and Family Directed Supports Options, if the beneficiary is considering directing services and supports (Agency With Choice and Employer of Record Models)
- b. Coordinate services with the Financial Support Services provider such as guidance on use of the Individual and Family Directed Budget (Employer of Record Model)
- c. Provide information/coaching/technical assistance on recruiting, hiring, managing, training, evaluating, and changing support staff (Agency With Choice and Employer of Record Models)
- d. Provide information/coaching/technical assistance with the development of schedules and outlining staff duties (Agency With Choice and Employer of Record Models)
- e. Provide information/coaching/technical assistance to understand staff financial forms, staff qualifications and employee record keeping requirements (Agency With Choice and Employer of Record Models)
- f. Provide information/coaching/technical assistance on maintenance of records in accordance with the Employer of Record Model (Employer of Record Models)
- g. Coordinate services with the Agency with Choice if the individual is directing services under the Agency with Choice Model
- h. Provide information/technical assistance to the individual on setting staff pay rates (Employer of Record).

Tenancy Support

- a. Develop an independent housing plan based on the beneficiary's preferences and possible barriers
- b. Assist with housing search process
- c. Assist with housing application process, including assistance with applying for housing Vouchers and applications
- d. Identifying resources to cover expenses.
- e. Assisting the individual to create a budget to cover expenses
- f. Ensure that the living environment is safe and move-in ready
- g. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized
- h. Assistance with finding and establishing a relationship with a housemate
- i. Assistance with obtaining and identifying resources to assist the beneficiary with financial education and planning for housing.
- j. Assistance with budgeting for housing and living expenses
- k. Assistance with coordinating resources to complete the move
- l. Training on how to be a good tenant.

Exclusions	
<p>a. This service does not duplicate Care Coordination. Care coordination under managed care includes the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the beneficiary consistent with 42 CFR 438.208(c).</p> <p>b. The creation and the facilitation of the Individual Support Plan is the responsibility of the Care Coordinator. The Community Navigator can assist the beneficiary with preparing for the Individual Support Plan.</p> <p>c. If a provider does not provide Agency with Choice Services, the only other service that they may provide to the same beneficiary, in addition to Community Navigator Services, is Community Transition.</p> <p>d. An agency may provide both Community Navigator Services and Agency with Choice Services to the same individual, in addition to Community Transition, Financial Support Services, Individual Goods and Services, and Primary Crisis Response Services.</p> <p>e. The Community Navigator Self-Directed activities as listed above, can only to be used to provide support to the individual under Individual and Family Directed Supports: Employer of Record and Agency with Choice Models, as approved in this Waiver.</p>	
Limits on amount, frequency, or duration	
Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Type	
License	
Certification	
Other Standard	
Provider Type	
Provider Agencies approved as a provider in the PIHP provider network.	
License	
Certification	
NC G.S. 122C, as applicable	
Other Standard	
Agency staff that work with beneficiaries:	
<p>a. Are at least 18 years old</p> <p>b. If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>c. Criminal background checks present no health and safety risk to beneficiary</p>	

- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Qualified in alternatives to restrictive interventions
- g. Qualified in the customized needs of the beneficiary as described in the ISP
- h. High school diploma or high school equivalency (GED)
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- j. Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies.
- k. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.
- l. Meets Community Navigator competencies as specified by NC Medicaid.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility -The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Community Networking: Service-Individual H2015; Group H2015 HQ; Class and Conference-H2015U1; Transportation - H2015U2

Community Networking services provide individualized day activities that support the waiver beneficiary's definition of a meaningful day in an integrated community setting, with persons who are not disabled. If the beneficiary requires paid supports to participate / engage once connected with the activity, Community Networking can be used to refer and link the beneficiary. This service is provided separate and apart from the beneficiary's primary private residence, other residential living arrangement, and/or the home of a service provider. These services do not take place in licensed facilities and are intended to offer the beneficiary the opportunity to develop meaningful community relationships with non-disabled individuals. Services are designed to promote maximum participation in community life while developing natural supports within integrated settings. Community Networking services enable the beneficiary to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community. As the beneficiary gains skills and increase community connections, service hours may fade.

Community Networking services consist of:

- a. Participation in adult education (College, Vocational Studies, and other educational opportunities);
- b. Development of community-based time management skills;
- c. Community-based classes for the development of hobbies or leisure/cultural interests;
- d. Volunteer work;
- e. Participation in formal/informal associations and/or community groups;
- f. Training and education in self-determination and self-advocacy;
- g. Using public transportation;
- h. Inclusion in a broad range of community settings that allow the beneficiary to make community connections;
- i. For children, staffing supports are covered to assist children to participate in day care, after school, and summer programs that serve typically developing children and are not funded by Day Supports;
- j. Payment for attendance at classes and conferences is also included.
- k. Payment for memberships can be covered when the beneficiary participates in an integrated class; and
- l. Transportation, when the activity does not include staffing support and the destination of the transportation is an integrated community setting or a self-advocacy activity. Payments for transportation are an established per trip charge or mileage.

Community Networking integrated, community-based employment-focused skill development consists of:

- a. Career Exploration;
- b. Discovery and Career Planning;
- c. Participation in Workshops and Classes on Topics Related to integrated employment;
- d. Skill and Education-Focused Activities;
- e. Volunteering Opportunities (Career Focus); and
- f. Social Networking and Skills for Social Capital to Obtain/Maintain community based integrated employment.

This service includes a combination of training, personal assistance and supports as needed by the beneficiary during activities. Transportation to/from the beneficiary’s residence and the training site(s) is covered.

Payment for attendance at classes and conferences is also covered.

Exclusions

This does not cover the cost of hotels, meals, materials or transportation while attending conferences.

This service does not cover activities that would normally be a component of a beneficiary’s home/residential life or services.

This service does not pay day care fees or fees for other childcare related activities.

The waiver beneficiary may not volunteer for the Community Networking service provider.

Volunteering may not be done at locations that would not typically have volunteers (that is, hair salon or florist) or in positions that would be paid positions if performed by an individual that was not on the waiver.

This service may not duplicate or be furnished/claimed at the same time of day as Day Supports, Community Living and Support, Residential Supports, Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the beneficiary.

For a beneficiary who is eligible for educational services under the Individuals With Disability Educational Act, Community Networking does not cover transportation to/from school settings. (Transportation to/from beneficiary’s home or any community location where the beneficiary may be receiving services before/after school is covered for this service.)

This service does not pay for overnight programs of any kind.

Classes that offer one-to-one instruction are not covered.

Classes that are in a nonintegrated community setting are not covered.

Limits on amount, frequency, or duration

Payment for attendance at classes and conferences cannot exceed \$1,000/ per beneficiary plan year. The amount of community networking services is subject to the “Limits on Sets of Services.”

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed
	<input checked="" type="checkbox"/> Individual/Family Directed

Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person
	<input type="checkbox"/> Relative
	<input type="checkbox"/> Legal Guardian

Provider Type

Employee in a beneficiary-directed arrangement

License

Certification

Other Standard

Agency staff that work with beneficiaries:

- a. Comply with NC G.S.122C as applicable
- b. Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice
- c. Are at least 18 years old
- d. If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance
- e. Criminal background checks present no health and safety risk to beneficiary
- f. Not listed in the North Carolina Health Care Abuse Registry
- g. Qualified in CPR and First Aid
- h. Qualified in alternatives to restrictive interventions
- i. Qualified in the customized needs of the beneficiary as described in the ISP
- j. High school diploma or high school equivalency (GED)
- k. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- l. Supervised by the Employer of Record and the Managing Employer
- m. For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- n. State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director.
- o. Agencies with Choice follow the NC State Nursing Board regulations
- p. Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies.
- q. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication- The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration

- with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
 - f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
 - g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
 - h. Cultural Humility the Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
 - i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Provider Type

Provider Agencies Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- a. Are at least 18 years old
- b. If providing transportation, have a valid North Carolina or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance
- c. Criminal background checks present no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries shall be qualified in the customized needs of the beneficiary as described in the ISP.
- g. High school diploma or high school equivalency (GED)

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.

- h. Cultural Humility - The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development -The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204(b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Community Transition: T2038

The purpose of Community Transition is to provide initial set-up expenses for adults to facilitate their transition from a Developmental Center (institution), community ICF-IID Group Home, nursing facility or another licensed living arrangement (group home, foster home, Psychiatric Residential Treatment Facility, alternative family living arrangement), a family home or one person AFL(Alternative Family Living) to a living arrangement where the individual is directly responsible for his or her own living expenses. This service may be provided only in a private home or apartment with a lease in the beneficiary's, legal guardian's, representative's name or a home owned by the beneficiary. In situations when a beneficiary lives with a roommate, Community Transition cannot duplicate items that are currently available.

Covered transition services are:

- a. Security deposits that are required to obtain a lease on an apartment or home;
- b. Essential furnishings, such as furniture, window coverings, food preparation items, bed and bath linens;
- c. Moving expenses required to occupy and use a community domicile;
- d. Set-up fees or deposits for utility or service access, such as telephone, electricity, heating and water; and/or
- e. Service necessary for the beneficiary's health and safety such as pest eradication and one-time cleaning prior to occupancy and coordination of care pre-transition.

Community Transition expenses are furnished only to the extent that the beneficiary is unable to meet such expense or when the support cannot be obtained from other sources. These services are available only during the three-month period that commences one calendar month in advance of the beneficiary's move to an integrated living arrangement.

The Community Transition Checklist is completed to document the items requested under this definition. The Checklist is submitted to the PIHP by the agency that is providing the services.

Exclusions

Community Transition does not cover monthly rental or mortgage expense; regular utility charges; and/or household appliances or diversional/recreational items such as televisions, streaming devices, VCR players and components and DVD players and components. Service and maintenance contracts and extended warranties are not covered. Community Transition services can **be accessed only one time from either the 1915b or 1915c waiver** over the life of the waiver.

Limits on amount, frequency, or duration

The cost of Community Transition has a life of the waiver limit of \$5,000.00 per beneficiary. Community Transition includes the actual cost of services and does not cover provider overhead charges.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian

Provider Type

Specialized Vendor Suppliers

License
Certification
Other Standard
Meets applicable state and local regulations for type of service that the provider/supplier is providing as approved by PIHP.
Provider Type
Agencies that provide Community Navigator Services
License
Certification
Other Standard
NC G.S. 122C, as applicable Credentialed as a provider in the PIHP provider network Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP.
Provider Type
Commercial/Retail Businesses
License
Applicable state/local/ Tribal business license
Certification
Other Standard
Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP.

**Crisis Services: Crisis Intervention & Stabilization Supports-H2011;
Crisis Consultation-T2025-U3; Out of Home Crisis-T2034**

Crisis Supports provide intervention and stabilization for a beneficiary experiencing a crisis. Crisis Supports are for a beneficiary who experiences acute crises and who presents a threat to the beneficiary's health and safety or the health and safety of others. These behaviors may result in the beneficiary losing his or her home, job, or access to activities and community involvement. Crisis Supports promote prevention of crises as well as assistance in stabilizing the beneficiary when a behavioral crisis occurs. Crisis Supports are an immediate intervention available 24 hours per day, 7 days per week, to support the individual. Service authorization can be granted verbally or planned through the ISP to meet the needs of the individual. Following service authorization, any needed modifications to the ISP and individual budget will occur within five working days of the date of verbal service authorization. The Comprehensive Crisis Plan must be updated as warranted in collaboration with the team within 14 days of a crisis, in an effort to ensure it meets the beneficiary's needs and is reflective of anything learned from the crisis.

Crisis Intervention & Stabilization Supports

Staff trained in Crisis Services Competencies is available to provide "first response" crisis services to individuals they support, in the event of a crisis. These activities are:

- a. Assess the nature of the crisis to determine whether the situation can be stabilized in the current location or if a higher-level intervention is needed
- b. Determine and contact agencies needed to secure higher level intervention or out-of-home services
- c. Provide direction to staff present at the crisis or provide direct intervention to de-escalate behavior or protect others living with the individual during behavioral or medical episodes.
- d. Contact the Care Coordinator within 48 hours following the intervention to arrange for a treatment team meeting for the individual and/or provide direction to service providers who may be supporting the individual in day programming and community settings, such as direct intervention to de-escalate behavior or protect others during behavioral episodes. This may consist of enhanced staffing provided by a QP or AP to provide one additional staff person in settings where the beneficiary may be receiving other services.

Out-of-Home Crisis Supports

- a. Out-of-home crisis is a short-term service for an individual experiencing a crisis and requiring a period of structured support and/or programming. The service takes place in a licensed facility. Out of-home crisis may be used when an individual cannot be safely supported in the home, due to his/her behavior, and implementation of formal behavior interventions have failed to stabilize the behaviors, and all other approaches to ensure health and safety have failed. In addition, the service may be used as a planned respite stay for waiver beneficiary's who have heightened behavioral needs.
- b. Out-of-Home Crisis services are authorized in increments of up to 30 calendar days.
- c. Crisis Consultation
- d. Crisis consultation is for individuals that have significant, intensive, or challenging behaviors or medical conditions that have resulted or have the potential to result in a crisis situation. Consultation is provided by staff that meets the minimum staffing requirements of a Qualified Professional, who have crisis experience. Non-licensed staff must meet the core competency requirements outlined in the Waiver and the activities performed by non-licensed staff must be overseen by licensed staff with experience serving individuals with IDD and behavioral health

needs.

- e. Crisis consultation may be used to:
1. Facilitate up to monthly treatment team meetings with other members of the treatment team to:
 - A. Discuss clinical findings / situations and recent crises regarding the individual;
 - B. Evaluate and refinement of the Comprehensive Crisis Plan after a crisis in collaboration with the beneficiary’s team to include unplanned and preplanned crisis management approaches to address crises before, during and after the crisis;
 - C. Communicate any changes that should occur to the Comprehensive Crisis Plan with the Care Coordinator
 2. Train, educate, and provide ongoing technical assistance to the natural supports and direct support professional on crisis interventions and strategies to mitigate issues that resulted in the crisis, and on implementation of the crisis plan;
 3. Develop and implement strategies to aid the person in returning home after an out of home crisis stay or hospitalization; and
 4. Referral for medication evaluation if appropriate.

Exclusions

This service may not duplicate services provided under Specialized Consultation Services.

Limits on amount, frequency, or duration

Crisis Intervention & Stabilization Supports may be authorized for periods of up to 14 calendar day increments per event.

Out-of-Home Crisis services may be authorized in increments of up to 30 calendar days.

Service Delivery Method

- Provider Directed**
 Individual/Family Directed

Specify whether the service may be provided by (check all that apply):

- Legally Responsible Person**
 Relative
 Legal Guardian

Provider Type

Provider Agencies (Primary Crisis Response Services) approved as a provider in the PIHP provider network.

License

Certification

Other Standard

Agency staff that work with beneficiaries:

- a. Are at least 18 years old
- b. Provided by a qualified professional in the field of developmental disabilities, who meets competencies established by the PIHP
- c. If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance
- d. Criminal background check presents no health or safety risk to beneficiary
- e. Not listed in the North Carolina Health Care Abuse Registry

- f. Must be qualified in CPR, First Aid and NCI
- g. Qualified in alternatives to restrictive interventions
- h. Must be qualified in the customized needs of the beneficiary as described in the ISP.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility_-The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. This includes national accreditation within the prescribed timeframe.

Staff providing Crisis Services, including first response activities, shall demonstrate strong clinical skills, professional qualifications, experience, and competency. Staff shall meet all applicable competency requirements including crisis prevention, intervention and resolution techniques and trauma-informed care.

Crisis Services staff shall have access to a board-eligible or board-certified psychiatrist OR psychiatric nurse practitioner with a minimum of one year of experience serving individuals with IDD and mental health needs OR a physician assistant with a minimum of one year of experience serving individuals with IDD and mental health needs. In addition, all Crisis Services staff must have access to a licensed practicing psychologist with a minimum of one year of experience in working with individuals with IDD.

Provider Type

Independent Practitioners or Provider Agencies (Crisis Behavioral Consultation)

License

Licensure specific to discipline

Certification

Other Standards

Approved by the PIHP as an Independent Practitioner or as a provider in the PIHP provider network

Staff that work with beneficiaries:

- a. Are at least 18 years old
- b. Criminal background check presents no health and safety risk to beneficiary
- c. Not listed in the North Carolina Health Care Abuse Registry
- d. Staff holds NC license for psychologist or psychological associate. A psychologist or psychological associate employed by a Tribal Provider may be licensed in any U.S. State.
- e. Meets Crisis Services Competencies specified by NC Medicaid.
- f. Qualified in customized needs of the beneficiary as described in the ISP

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication- The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility -The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accreditation agencies. If a provider agency the organization shall be established as a legally constituted entity, capable of meeting all the requirements of the PIHP

Staff providing Crisis Services, including first response activities, shall demonstrate strong clinical skills, professional qualifications, experience, and competency. Staff shall meet all applicable competency requirements including crisis prevention, intervention and resolution techniques and trauma-informed care.

Crisis Services staff shall have access to a board-eligible or board-certified psychiatrist OR psychiatric nurse practitioner with a minimum of one year of experience serving individuals with IDD and mental health needs OR a physician assistant with a minimum of one year of experience serving individuals with IDD and mental health needs.

Provider Type

Provider Agencies who operate licensed facilities approved as a provider in the PIHP provider network.

License

NC G.S, 122C
10 NCAC 27G.5100 or waiver licensure granted by licensing agency

Certification

Other Standards

Agency staff that work with beneficiaries:

- a. Are at least 18 years old
- b. If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance
- c. Criminal background checks present no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Qualified in alternatives to restrictive interventions
- g. Qualified in the customized needs of the beneficiary as described in the ISP
- h. High school diploma or high school equivalency (GED)
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication- The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration

with others.

- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility -The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.
- j. Upon enrollment with the PIHP, shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Staff providing Crisis Services, including first response activities, shall demonstrate strong clinical skills, professional qualifications, experience, and competency. Staff shall meet all applicable competency requirements including crisis prevention, intervention and resolution techniques and trauma-informed care.

Crisis Services staff shall have access to a board-eligible or board-certified psychiatrist OR psychiatric nurse practitioner with a minimum of one year of experience serving individuals with IDD and mental health needs OR a physician assistant with a minimum of one year of experience serving individuals with IDD and mental health needs.

In addition, all Crisis Services staff shall have access to a licensed practicing psychologist with a minimum of one year of experience in working with individuals with IDD.

Day Supports Group-T2021HQ; Individual-T2021; Developmental Day-T2027

Day Supports is a group, facility-based service that provides assistance to the beneficiary with acquisition, retention, or improvement in socialization and daily living skills and is one option for a meaningful day.

“Facility-Based” means that individuals who receive this service are often in a licensed Day Supports provider facility that serves individuals with Intellectual and Developmental Disabilities. Individuals who receive Day Supports do not have to attend the Day Supports facility and therefore are often in the community with individuals without intellectual and developmental disabilities. Developmental Day is provided in day care settings with children who do not function with an intellectual or developmental disability.

For individuals who are aging, Day Supports can provide a structured day program with nursing supervision in an Adult Day Health/Adult Day Care Program. Adult Day Care/ Adult Day Health services provide an organized program of services during the day in a community group setting to support the personal independence of older adults and promote their social, physical, and emotional well-being.

Day Supports emphasizes inclusion and independence with a focus on enabling the individual to attain or maintain his/her maximum self-sufficiency, increase self-determination and enhance the person’s opportunity to have a meaningful day. To ensure informed choice among a variety of options for a meaningful day, individuals new to the service and 16 years of age and older, will receive education on available options during the planning meeting. Education must include exposure to the same day activities as others in the community and the structure of Day Supports must provide the opportunity to discover his or her skills, interests, and talents in his or her community. Grouping of individuals must be appropriate to the age and preferences of the person.

For school-aged or younger children, Developmental Day is a service which provides individual habilitative programming in a licensed childcare center. It is designed to meet the developmental needs of the child in an inclusive setting to promote skill acquisition in areas such as self-help, fine and gross motor skills, language and communication, cognitive and social skills in order to facilitate their functioning in a less restrictive environment. For individuals who are eligible for educational services under the Individuals with Disability Educational Act, Day Supports is the payer of last resort for Developmental Day.

For working-age individuals (ages 16 or older) not also working in competitive integrated employment, Day Supports may include career and employment exploration through educational and experiential opportunities designed to identify specific interests and aptitudes for paid work. This includes experience and skills transferable to competitive integrated employment, and also typically include business tours, informational interviews and job shadows, related to identified interests, experiences and skills, in order to explore potential opportunities for competitive integrated employment in the person’s local area. Beneficiaries should have Long and Short-Range Goals related to Employment Exploration included in their ISP.

When Day Supports are provided in facility-based setting, the setting must be compliant with the standards outlined in the Home and Community-Based Settings Rule and must not isolate the beneficiary from community members not receiving HCBS services. Facility-based Day Supports must be provided by a licensed Day Supports provider that serves individuals with Intellectual and Developmental

Disabilities.

The Innovations beneficiary who receives facility-based Day Supports do not have to attend the Day Supports facility and therefore are able to maximize their time in the community with individuals without intellectual and developmental disabilities. Developmental Day is provided in day care settings with children who do not function with an intellectual or developmental disability.

Day Supports provided in a facility-based setting, including licensed community day programs, may include prevocational activities. A beneficiary receiving prevocational services must have employment-related goals in their ISP; competitive integrated employment in the community at or above the minimum wage is considered to be the optimal outcome of prevocational services.

Individual Day Supports are available to meet specific and well documented needs of each beneficiary. These circumstances may include the provision of individual supports due to behavioral or psychiatric destabilization, medical concerns/necessity, or other infrequent and exceptional circumstances. Individual Day Supports related to medical, behavioral, and physical support needs require supporting medical or behavioral records and accompanying documentation in the ISP supporting the need for individual services as the most appropriate option.

Day Supports are furnished in a non-residential setting, separate from the home or residential setting where the beneficiary resides. A beneficiary may receive Day Supports outside the facility as long as the outcomes are consistent with the goals described in the Individual Support Plan.

Transportation to/from the beneficiary's home, the day supports facility and travel within the community is included in the payment rate. Transportation to and from the licensed day program is the responsibility of the Day Supports provider.

Transportation to/from school settings is not included for beneficiary who is eligible for educational services under the Individuals With Disability Educational Act. This includes transportation to/from the beneficiary's home or any community location where the beneficiary may be receiving services before or after school.

NC Innovations Day Supports Group can be provided in a group setting that includes State-funded Day Supports / Activity as long as the NC Innovations definition is met, and the staff meet the qualifications of NC Innovations Day Supports Group.

Day Supports is billed in 1-hour unit increments. An individual must receive Day supports 15 minutes before the 1-hour unit may be billed.

Exclusions

This service may not duplicate services, nor can they be furnished or billed at the same time of day as services, provided under Community Networking, In-Home Intensive Supports, Community Living and Supports, Supported Living, Residential Supports, Supported Employment and/or one of the State Plan Medicaid Services that works directly with the beneficiary.

Waiver funding is not available for vocational services delivered in facility based, sheltered work settings, or Adult Developmental Vocational Program.

The following criteria differentiate between prevocational and vocational services:

- a. Prevocational services are provided to individuals who are not expected to join the general work force within one year of service initiation, except if expected to join the general workforce through the use of Supported Employment services.
- b. Prevocational services include activities that are not directed at teaching job-specific tasks but at underlying skills that may support the individual to increase his/her ability to pursue competitive integrated employment with the assistance of Supported Employment services as needed.

Limits on amount, frequency, or duration

The amount of Day Supports is subject to the Limits on Sets of services.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian

Provider Type

Provider Agencies

License

NC G.S. 122 C,
Tribal Providers are not subject to Licensure or certification.

Certification

NC G.S. 122 C
Tribal Providers are not subject to Licensure or certification.

Other Standard

Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- a. Are at least 18 years old
- b. If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Qualified in alternatives to restrictive interventions
- g. Qualified in the customized needs of the beneficiary as described in the ISP.
- h. High school diploma or high school equivalency (GED)
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility -The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all the requirements of PIHP.

Provider Type

Adult Day Health and Day Care Programs approved as a provider in the PIHP provider network

License

Certification

Certified by NC Division of Aging
Tribal Providers are not subject to certification by the NC Division of Aging.

Other Standard

Agency staff that work with beneficiaries:

- a. Are at least 18 years old
- b. If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary

- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Qualified in alternatives to restrictive interventions
- g. Qualified in the customized needs of the beneficiary as described in the ISP.
- h. High school diploma or high school equivalency (GED)

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility_-The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Provider Type

Licensed Developmental Day Care Programs

License

NC G.S. 122 C

Certification

NC G.S. 122 C

Other Standard

Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- a. Are at least 18 years old
- b. If providing transportation, have a valid North Carolina or other valid driver’s license, a safe driving record and an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as

described in the ISP.

- e. Not listed in the North Carolina Health Care Abuse Registry
- f. Qualified in CPR and First Aid
- g. Qualified in alternatives to restrictive interventions
- h. High school diploma or high school equivalency (GED)
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility -The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of PIHP.

Provider Type

Before and After School Day Care Programs Operated by NC Public School System or Operated by the Cherokee Indian School System approved as a provider in the PIHP provider network.

License

Certification

Other Standard

Agency staff that work with beneficiaries:

- a. Are at least 18 years old
- b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license, a safe driving record and an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Qualified in alternatives to restrictive interventions
- g. Qualified in the customized needs of the beneficiary as described in the ISP.
- h. High school diploma or high school equivalency (GED)

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility -The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall be established as a legally constituted entity capable of meeting all the requirements of the PIHP.

**Financial Support Services-T2025-U1
Employer Supplies T2025-U2**

Financial Support Services (FSS) is the umbrella service for the continuum of supports offered to NC Innovations individuals who elect the Individual and Family Directed Services Option, Employer of Record Model. Financial Support Services are provided to assure that funds for self-directed services are managed and distributed as intended. The service also facilitates employment of support staff by the Employer.

- a. Filing claims for self-directed services and supports;
- b. Payment of payroll to employees hired to provide services and supports;
- c. Deducting all required federal, state, and local taxes, including unemployment fees, prior to issuing paychecks to employees;
- d. Ordering employment related supplies and paying invoices for other expenses such as training of employees;
- e. Administering benefits for employees hired to provide services and supports;
- f. Maintaining ledger accounts for each individual's funds;
- g. Producing expenditure reports that are required, including reports to the individual/ employer/family, concerning expenditures of funds against their budgets;
- h. Requesting and reviewing criminal background checks, driver's license checks, and health care registry checks of providers of self-directed services;
- i. Tracking and monitoring individual budget expenditures;
- j. Facilitating Workers Compensation Application on behalf of the Employer of Record; and/or
- k. Serving as the Internal Revenue approved Fiscal Employer Agent.

A beneficiary who chooses to self-direct via the Employer of Record model may require equipment necessary to carry out duties of Employer of Record and may access this service. Employer Supplies may include the following equipment and typical office supplies needed to perform duties may be purchased (this is not an all-inclusive list):

- a. Laptop, Computer, and Printer used to by the Employer of Record to carry out administrative duties of Employer of Record;
- b. Electronic Health Records (EHR) Software or subscription (annual or monthly) used to perform Employer of Record duties;
- c. Windows or other Operating System;
- d. Monthly connectivity (Internet) charges may be covered when it is required for the Employer of Record to perform Employer of Record duties. (such as processing timesheets, using financial Support Services portal, or utilizing EHR software;
- e. Microsoft Subscription or other Office Comparable Products- annual or monthly fees;
- f. Annual subscription of Virus/Malware Protection;
- g. 1 year computer warranty;
- h. Laptop bag (if computer is a laptop;)
- i. Printer;
- j. Ink or a subscription;
- k. Office supplies (file folders, notebook, binders, pens, pencils, calculator, etc.);
- l. Computer Repair- Repair of equipment is covered for items purchased through the waiver for the Employer of Record (EOR) if the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The EOR must own any equipment that is repaired;
- m. Lock box for the storage of medications;
- n. One laptop computer and one EHR software may be purchased over the life of the waiver;

- o. EHR software may be upgraded more than once over the life of waiver, if necessary, to maintain functionality of software. Documentation to show that if upgrade is not completed, software does not function, is required from vendor to support request.

Employer Supplies may also be utilized to pay for training and other work-related requirements, such as Hepatitis B Vaccines for employees. (this is not an all-inclusive list):

- a. Training for new Employees – CPR, First Aid, Blood borne Pathogens, Medication Administration, other Beneficiary Specific Training;
- b. Hepatitis B Vaccine for Employees per Bloodborne Pathogen Requirements;
- c. Protective Equipment for Employees such as Gloves, CPR mask, and First Aid Kit;
- d. Lock box and file cabinet to secure PHI and Employee Personal Information;

Note- for additional information about Individual and Family Directed Services (IFDS), please see Attachment H

Exclusions

The provider of financial support services may only additionally provide Community Navigator services. The financial support service may bill for the following services: community transition services, and individual goods and services under the NC Innovations waiver.

The financial supports agency may be an Agency with Choice and provide Community Navigator. They may bill for community transition and individual goods and services to the same beneficiary. Community Transition Services and Individual Goods and Services are not directly provided by the FMS. For example, if the individual needs a deposit to turn on their electricity to move into their own home and it is authorized by the PIHP, then the provider of financial support services would issue payment to the utility company on behalf of the beneficiary. Another service provider may not wish to just issue payments without a charge. Regarding Community Navigator, the provider choice is offered by the Care Coordinator.

Items not coverable by Employer Supplies (this is not an all-inclusive list):

- a. Wireless keyboards
- b. Mouse (unless the EOR is purchasing a desktop and the desktop does not include a mouse)
- c. Computer Protective Cases (outside of one laptop bag for EORs who utilize a laptop)
- d. Additional Computer Screens (a desktop computer should include one monitor)
- e. IT help desk service for support to operate the equipment
- f. Office/Desk Chair

Limits on amount, frequency, or duration

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian

Provider Type

Provider Agencies

License

Applicable state/local/Tribal business license

Certification

Other Standard

NC G.S. 122C, as applicable

- a. Approved as a provider in the PIHP provider network
- b. Approved by the Internal Revenue Service to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6,
- c. Bonded
- d. Meets all IRS requirements and be certified by the IRS as an employer agent
- e. Understands the laws and rules that regulate the expenditure of public funds
- f. Able to utilize accounting systems that operate effectively on a large scale as well as track individual budgets
- g. Able to develop, implement, and maintain an effective payroll system that adheres to all related tax obligations, both payment and reporting
- h. Able to conduct criminal and other required background checks
- i. Able to generate service management and statistical information and reports during each payroll cycle
- j. Have at least two years of basic accounting and payroll experience

Home Modifications: S5165

Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the beneficiary or to enhance the individual's level of independence. Home Modifications are intended to increase the beneficiary's capability to access his/her environment and are of direct or remedial benefit to the beneficiary or in some way related to the beneficiary's disability. A private residence is a home owned by the individual or his/her family (natural, adoptive, or foster family). Items that are portable may be purchased for use by a beneficiary who lives in a residence rented by the beneficiary or his/her family. This service covers purchases, installation, maintenance, and as necessary, the repair of home modifications required to enable individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional will drive the request for the modification, outlining medical necessity and is obtained to ensure that the equipment will meet the needs of the beneficiary.

Medical necessity must be documented by the physician, physician assistant, or nurse practitioner, for every item provided/billed regardless of any requirements for approval. A letter of medical necessity written and signed by the physician, physician assistant, or nurse practitioner, or other licensed professional permitted to perform those tasks and responsibilities by their NC state licensing board, may be submitted along with the Certificate of Medical Necessity/Prescription. Note: the Certificate of Medical Necessity/Prescription still must be completed and signed by the physician, physician assistant, or nurse practitioner.

All Home Modifications requiring a building permit must meet county code to pass inspection.

Items that are not of direct or remedial benefit to the beneficiary are excluded from this service. Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The beneficiary or his/her family must own any equipment that is repaired.

Covered Modifications may include, but are not limited to:

- a. Ramps and Portable Ramps
- b. Grab Bars
- c. Handrails
- d. Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside an individual's home
- e. Porch stair lifts
- f. Modifications and/or additions to bathroom facilities
- g. Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, installation of pocket doors, swing-clear (recessed) hinges, modification of door swing direction, excluding locks that restrict a beneficiary's rights
- h. The following specific specialized adaptations:
 1. Shatterproof windows
 2. Floor coverings for ease of ambulation for individuals with mobility limitations
 3. Modifications to meet egress regulations directly related to the modification requested
 4. Automatic door openers
 5. Medically necessary portable heating and/or cooling adaptation to be limited to one unit per

- beneficiary
- 6. Installation of rounded counter tops
- 7. Lowering of shelves, closet dowel rods and cabinets
- 8. Protective covering for ramp
- 9. Wall coverings to prevent damage

If an approved Modification is in the process of being completed, and additional issues are discovered that would prevent the approved Modification from being completed in a safe manner or from passing inspection; a plan revision must be submitted to request the necessary materials and labor to complete the modification in a safe manner.

Exclusions

A beneficiary who receives Residential Supports may not receive this service.

- a. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- b. Central air conditioning; general plumbing; swimming pools; Jacuzzis; fences; service and maintenance contracts and extended warranties are not covered.
- c. Locks that are used to restrict an individual’s rights are not a covered modification.
- d. Equipment or supplies purchased for exclusive use at the school/home school are not covered.
- e. Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.
- f. Home Modifications do not cover new construction, costs associated with building a new home, financing of a new home, and/or down payment of a new home.
- g. Items that would normally be available to any child, and are ordinarily provided by the family, are not covered.
- h. Home Modifications exclude adaptations, improvements or repairs to the residence which are of general utility and are not of direct or remedial benefit to the individual or in some way related to the individual’s disability.

Incidental issues that are discovered during the home modification process, that do not impact safety; and are not necessary for the approved home modification to be able to be completed; and do not impact the modification passing inspection, are the responsibility of the homeowner.

Limits on amount, frequency, or duration

The service is limited to expenditures of \$50,000 of supports (ATES, Home Modifications) over the duration of the waiver.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
Provider Type	
Specialized Vendors	
License	

Applicable state/local business license
Certification
Other Standard
All services are provided according to applicable State or local building codes and other regulations. All items must meet applicable standards of manufacture, design, and installation.
Provider Type
Commercial/Retail Businesses
License
Applicable state/local business license
Certification
Other Standard
All services are provided in accordance with applicable State or local building codes and other regulations. All items must meet applicable standards of manufacture, design, and installation.

Individual Goods and Services: T1999	
<p>Individual Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the Individual Support Plan (including improving and maintaining the beneficiary’s opportunities for full membership in the community) and meet the following requirements:</p> <ol style="list-style-type: none"> the item or service would decrease the need for other Medicaid services; OR promote inclusion in the community; OR increase the beneficiary’s safety in the home environment; AND the beneficiary does not have the funds to purchase the item or service. <p>The ISP must outline how each of the applicable requirements are met, including that the beneficiary does not have the funds to purchase the item or service.</p>	
Exclusions	
<p>Individual Goods and Services do not include experimental goods and services inclusive of items which may be defined as restrictive under NC G.S. 122C-60. This service is available only to beneficiaries who self-direct at least one of their services. The purchase, rental, or leasing of cars/vans/trucks is not permissible under this definition. The purchase of animals, food, nutritional supplements, alcohol, and tobacco are not coverable under this definition.</p>	
Limits on amount, frequency, or duration	
<p>The cost of individual directed goods and services for each beneficiary cannot exceed \$2,000.00 per beneficiary plan year annually.</p>	
Service Delivery Method	<input type="checkbox"/> Provider Directed <input checked="" type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input checked="" type="checkbox"/> Relative <input checked="" type="checkbox"/> Legal Guardian
Provider Type	
Employee in a beneficiary-directed arrangement	
License	
Certification	
Other Standard	
<p>Staff that work with beneficiaries are approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice.</p> <p>Agency staff that work with beneficiaries:</p> <ol style="list-style-type: none"> Are at least 18 years of age If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license and a safe driving record and has an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to beneficiary Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP. 	

g. High school diploma or high school equivalency (GED).

For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by THE PIHP Medical Director or Assistant Medical Director.

Agencies with Choice follow State Nursing Board Regulations. Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Provider Type

Commercial/Retail Businesses

License

Applicable state/local business license

Certification

Other Standard

Meets applicable state and local requirements for type of item that the vendor is providing

Provider Type

Agency With Choice

License

Certification

Other Standard

Agency enrolled with PIHP
NC G.S.122C, as applicable
Meets applicable state and local requirements for type of item that the vendor is providing

Provider Type

Financial Support- Agency

License

Certification

Other Standard

Agency enrolled with PIHP
NC G.S.122C, as applicable
Meets applicable state and local requirements for type of item that the vendor is providing

Natural Supports Education: Individual-S5110; Conference-S5111

Natural Supports Education provides training to families and the beneficiary’s natural support network in order to enhance the decision making capacity of the natural support network, provide orientation regarding the nature and impact of the intellectual and other developmental disabilities upon the beneficiary, provide education and training on intervention and strategies, and provide education and training in the use of specialized equipment and supplies. The requested education and training must have outcomes directly related to the needs of the beneficiary or the natural support network’s ability to provide care and support to the beneficiary. In addition to individualized natural support education, reimbursement will be made for enrollment fees and materials related to attendance at conferences and classes by the primary caregiver. The expected outcome of this training is to develop and support greater access to the community by the beneficiary by strengthening his or her natural support network.

Exclusions

The cost of transportation, lodging, and meals are not included in this service.

Natural Supports Education excludes training furnished to family members through Specialized Consultation Services.

Training and education, including reimbursement for conferences, are excluded for family members and natural support networks when those members are employed to provide supervision and care to the beneficiary.

Limits on amount, frequency, or duration

Reimbursement for conference and class attendance will be limited to \$1,000 per year.

Service Delivery Method

- Provider Directed**
- Individual/Family Directed**

Specify whether the service may be provided by (check all that apply):

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

Provider Type

Employee in a beneficiary-directed arrangement

License

Certification

Other Standard

Staff are approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice and are:

Agency staff that work with beneficiaries:

- a. Are at least 18 years of age
- b. If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license and a safe driving record and has an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as

described in the ISP.

- g. High school diploma or high school equivalency (GED).
- h. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation-The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics-The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility -The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences.
- i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Supervised by the Employer of Record or Managing Employer

Qualified in the customized needs of the beneficiary as described in the Individual Support Plan

Agencies with Choice follow the NC State Nursing Board regulations.

State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by The PIHP Medical Director or Assistant Medical Director. Upon enrollment with the PIHP, the Agency with Choice shall have achieved national accreditation with at least one of the designated accrediting agencies.

The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Has expertise as appropriate in the field in which the training is provided in the ISP.

Provider Type
Provider Agencies
License
Certification
Other Standard
<p>Approved as a provider in the PIHP provider network.</p> <p>Agency staff that work with beneficiaries:</p> <ol style="list-style-type: none"> a. Are at least 18 years of age b. If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license and a safe driving record and has an acceptable level of automobile liability insurance c. Criminal background check presents no health and safety risk to beneficiary d. Not listed in the North Carolina Health Care Abuse Registry e. Qualified in CPR and First Aid f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP. g. High school diploma or high school equivalency (GED). h. Has expertise as appropriate in the field in which the training is provided in the ISP. i. Qualified in the customized needs of the beneficiaries as described in the Individual Support Plan <p>Professional Competency</p> <p>Support Professionals have competency in the following areas:</p> <ol style="list-style-type: none"> a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication. b. Person-Centered Practices -The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals. c. Evaluation and Observation -The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services. d. Crisis Prevention and Intervention -The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others. e. Professionalism and Ethics -The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights. f. Health and Wellness -The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being. g. Community Inclusion and Networking -The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life. h. Cultural Humility_-The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences. i. Education, Training and Self-Development -The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies.

The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Residential Supports: Level 1 H2016; Level 2 T2014; Level 3 T2020; Level 4 H2016H1

Residential Supports provides individualized services and supports to enable a beneficiary to live successfully in a Group Home or Alternative Family Living (AFL) setting of their choice and be an active participant in his/her community. The intended outcome of the service is to increase or maintain the beneficiary's life skills, provide the supervision needed, maximize his/her self-sufficiency, increase self-determination and ensure the person's opportunity to have full membership in his/her community.

Residential Supports includes learning new skills, practice and improvement of existing skills, and retaining skills to assist the person to complete an activity to his/her level of independence. Residential Supports includes supervision and assistance in activities of daily living when the beneficiary is dependent on others to ensure health and safety.

Transportation to and from the residence and points of travel in the community is included to the degree that they are not reimbursed by another funding source.

Residential Support is provided to a beneficiary who lives in a community residential setting that meets the home and community-based characteristics as outlined in the Waiver in Appendix C. Residential Supports may additionally be provided in an AFL situation. The site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for the cost of care. These sites are licensed or unlicensed in accordance with state rule. All unlicensed AFL sites will be reviewed using the PIHP AFL checklist for health and safety related issues. NC Innovations respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports. Respite may also be provided for participation in non-integrated camps or for participation in non-integrated Support Groups.

LEVELS

Residential Supports levels are determined by the Individual Budget Tool and other evidence of support need. The SIS Level is only one piece of evidence that may be considered.

Level 1: SIS Level A

Level 2: SIS Level B

Level 3: SIS Level C and D

Level 4: SIS Level E, F, and G

The results of a SIS and the Base Budget are guidelines that do not constitute a binding limit that may not be exceeded on the amount of services that may be requested or authorized in a Plan of Care.

Vehicle Modifications may be accessed when the vehicle belongs to the individual and can transition to other settings with the individual.

Exclusions

A beneficiary who receives Residential Supports may not receive Home Modifications, Community Living and Supports, Respite (unless the individual resides in an AFL), Supported Living, or State Plan Personal Care Services. Assistive Technology Equipment & Supplies may be accessed when the item belongs to the individual and can transition to other settings with the individual.

This service is not available at the same time of day as Community Networking, Day Supports,

Community Living and Supports, Supported Living, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.

Payments for Residential Supports do not include payments for room and board, the cost of facility maintenance and upkeep.

Primary AFL Staff who provide Residential Supports should not provide other waiver services to the beneficiary. In specific situations, to ensure beneficiary health and safety the LME/MCO may approve the AFL to serve as short term back up staff for day services (Day Supports, Community Networking or Supported Employment). This approval must be documented in the Individuals record at both the LME/MCO and the provider agency.

There are four Supervised Living C group homes of over 6 beds that serve Innovations Waiver recipients. These homes were grandfathered in from the CAP MR/DD waiver and are not allowed to have new admissions.

- a. Camden Road Home is licensed for 8 beds and there are two waiver beneficiaries residing there.
- b. Sixth Street Home is licensed for 9 bed and one waiver beneficiary resides there.
- c. Transylvania Association for Disabled Citizens is licensed for 8 beds and four waiver beneficiaries reside there.
- d. Benjamin House is licensed for 12 beds and five waiver beneficiaries reside there.

Limits on amount, frequency, or duration

The amount of Residential Supports is subject to the Limits on Sets of Services.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input checked="" type="checkbox"/> Relative <input checked="" type="checkbox"/> Legal Guardian

Provider Type

5600 Supervised Living facilities Type B for Children:

- 4 beds or less for newly developed facilities; 6 beds or less for existing.
- 3 bed facilities may apply to DHSR to increase their bed size to 4 if they meet DHSR requirements.

5600 Supervised Living facilities Type C for adults:

- 4 beds or less for newly developed facilities; 6 beds or less for the four noted above that are licensed for more than 6 beds. There are no new admits to these facilities.
- 3 bed facilities may apply to DHSR to increase their bed size to 4 if they meet DHSR requirements.

License

10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147
Type: B

10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147
Type: C

Certification

Other Standard

Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- a. Are at least 18 years of age
- b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- g. High school diploma or high school equivalency (GED).
- h. Qualified in alternatives to restrictive interventions
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices -The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation -The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention -The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics -The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness -The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking -The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility -The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development -The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Qualified in the customized needs of the beneficiary as described in the ISP.

Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Enrolled to provide Crisis Services or has an arrangement with an enrolled Crisis Services Provider to respond to beneficiary crisis situations. The Beneficiary may select any enrolled Crisis Services provider in lieu of this provider however.

Provider Type

5600 Supervised living facilities type F (Licensed AFLs):

- serve no more than 3minors or 3adults with a developmental disability

Unlicensed supervised living homes (AFLs) may only serve one adult as criteria not being met for 10A NCAC 27 G.5601 (b) (1) or (2)

License

NC G.S. 122 C10 A NCAC 27G.5600, (c) (6) statutory authority: NC General Statute 143B-147
Type: F

Certification

Other Standard

Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- Are at least 18 years of age
- If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance
- Criminal background check presents no health and safety risk to beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in CPR and First Aid
- Qualified in alternatives to restrictive interventions
- Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- High school diploma or high school equivalency (GED).

Professional Competency

Support Professionals have competency in the following areas:

- Communication- The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- Person-Centered Practices-The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- Evaluation and Observation-The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- Crisis Prevention and Intervention-The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- Professionalism and Ethics-The Support Professional works in a professional and ethical manner,

- maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness-The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
 - g. Community Inclusion and Networking-The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
 - h. Cultural Humility_-The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
 - i. Education, Training and Self-Development-The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Paraprofessionals providing this service must be supervised by a Qualified Professional.

Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Enrolled to provide Crisis Services or has an arrangement with an enrolled Crisis Services Provider to respond to beneficiary crisis situations. The Beneficiary may select any enrolled Crisis Services provider in lieu of this provider. The site must be the primary residence of the AFL provider (includes couples and single_people) who receive reimbursement for cost of care.

Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of THE PIHP.

Back-up staff must be employees of the agency.

Respite: Individual-S5150; Group-S5150HQ; Nursing Respite, RN-T1005TD; Nursing Respite, LPN- T1005TE; Facility-S5150US

Respite services provide periodic or scheduled support and relief to the primary caregiver(s) from the responsibility and stress of caring for the beneficiary. NC Innovations respite may also be used to provide temporary relief to a beneficiary who resides in Licensed or Unlicensed AFL, but it may not be billed on the same day as Residential Supports unless it is for a beneficiary to access a summer camp or support group. This service enables the primary caregiver to meet or participate in planned or emergency events, and to have planned time for him/her and/or family members. This service also enables the individual to receive periodic support and relief from the primary caregiver(s) at his/her choice. Respite may be utilized during school hours for sickness, injury, or when a student is suspended or expelled. Respite may include in and out-of-home services, inclusive of overnight, weekend care, or emergency care (family emergency based, not to include out of home crisis). The primary caregiver(s) is the person principally responsible for the care and supervision of the beneficiary and must maintain his/her primary residence at the same address as the beneficiary.

Exclusions

- a. The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID Facility.
- b. This service may not be used as a regularly scheduled daily service in individual support.
- c. This service is not available to beneficiaries who reside in licensed facilities that are licensed as 5600B or 5600C. Staff sleep time is not reimbursable.
- d. Respite services are only provided for the beneficiary; other family members, such as siblings of the beneficiary, may not receive care from the provider while Respite Care is being provided/billed for the beneficiary.
- e. Respite Care is not provided by any person who resides in the beneficiary's primary place of residence.
- f. Respite may be allowed in the private home of the provider or staff of an Employer of Record at the discretion and agreement of the support team and when consistent with the ISP goals.
- g. Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved by the State that is not a private residence.
- h. For a beneficiary who is eligible for educational services under Individual's With Disability Educational Act, Respite does not include transportation to and from school settings. This includes transportation to and from beneficiary's home, provider home where the beneficiary is receiving services before/after school or any community location where the beneficiary may be receiving services before or after school.
- i. Respite may not be used a beneficiary who is living alone or with a roommate; staff sleep time is not reimbursable.
- j. This service is not available at the same time of day as Community Networking, Day Supports, Community Living and Supports, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.
- k. Residential Support AFL cannot be billed on the same day as Per Diem Respite for the same beneficiary.

Limits on amount, frequency, or duration

The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID

Facility.	
Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input checked="" type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input checked="" type="checkbox"/> Relative <input checked="" type="checkbox"/> Legal Guardian

Provider Type
Employee in a beneficiary-directed arrangement
License
Certification
NC G.S. 122 C, as applicable
Other Standard
<p>Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice</p> <p>Agency staff that work with beneficiaries:</p> <ol style="list-style-type: none"> Are at least 18 years of age If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to beneficiary Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid Qualified in alternatives to restrictive interventions Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP. High school diploma or high school equivalency (GED). <p>Professional Competency</p> <p>Support Professionals have competency in the following areas:</p> <ol style="list-style-type: none"> Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication. Person-Centered Practices -The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals. Evaluation and Observation -The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services. Crisis Prevention and Intervention -The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others. Professionalism and Ethics -The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights. Health and Wellness -The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being. Community Inclusion and Networking -The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major

- transitions that occur in community life.
- h. Cultural Humility_-The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences.
- i. Education, Training and Self-Development -The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director. If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina Agencies with Choice follow State Nursing Board Regulations Upon enrollment with the PIHP, the Agency With Choice shall-have achieved national accreditation with at least one of the designated accrediting agencies.

The Agency With Choice shall be established as a legally constituted entity capable of meeting all the requirements of the PIHP. Services provided in the home of the direct service employees are subject to the checklist and monthly monitoring by the Agency With Choice qualified professional or the Employer of Record

Provider Type
Provider Agencies, facility based and in-home services
License
NC G.S. 122 C
Certification
NC G.S. 122 C
Other Standard

Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- a. Are at least 18 years of age
- b. If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license and a safe driving record and has an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- g. Qualified in alternatives to restrictive interventions
- h. High school diploma or high school equivalency (GED).
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices -The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation -The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention -The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics -The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness - The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking - The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility - The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences.
- i. Education, Training and Self-Development - The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina.

Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall-be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Provider Type

Provider Agencies who operate private respite homes

License

Private home respite services serving individuals outside their private homes are subject to licensure under NC G.S. 122C Article 2 when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.

Certification

NC G.S. 122 C

Other Standard

Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- a. Are at least 18 years of age
- b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- g. Qualified in alternatives to restrictive interventions
- h. High school diploma or high school equivalency (GED).
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices -The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation -The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention - The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics - The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness - The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking - The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility - The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development - The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the PIHP

Services provided in the private home of the direct service employee are subject to the checklist and

monthly monitoring by the qualified professional

Provider Type

Nursing Respite, Provider Agencies

License

Certification

NC G.S. 122 C

Other Standard

Approved as a provider in the PIHP provider network

Agency staff that work with beneficiaries:

- a. Are at least 18 years of age
- b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- g. High school diploma or high school equivalency (GED).
- h. Qualified in alternatives to restrictive interventions
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- j. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices - The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation - The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention - The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics - The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness - The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking - The Support Professional helps individuals to be a part

of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.

- h. Cultural Humility - The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development - The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional

Provider Type

Nursing Respite Home Care Agencies Approved as a provider in the PIHP provider network

License

Licensed by the NC DHHS, Division of Health Services Regulation in accordance with NCGS 131E, Article 6, Part C

Certification

Other Standard

NC G.S. 122C, as applicable

Agency staff that work with beneficiaries:

- a. Are at least 18 years of age
- b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- g. Qualified in alternatives to restrictive interventions
- h. High school diploma or high school equivalency (GED).
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices - The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.

- c. Evaluation and Observation - The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention - The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics - The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness - The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking - The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility - The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development - The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies. The organization shall be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the qualified professional

Specialized Consultation Services: T2025; BCBA T2025 HO

Specialized Consultation Services provide expertise, training and technical assistance in a specialty area (psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy, physical therapy, nutrition, nursing, and other licensed professionals who possess experience with individuals with Intellectual / Developmental Disabilities) to assist family members, support staff and other natural supports in assisting the beneficiary with developmental disabilities. Under this model, family members and other paid/unpaid caregivers are trained by a certified, licensed, and/or registered professional, or qualified assistive technology professional to carry out therapeutic interventions, consistent with the Individual Support Plan.

Activities covered are:

- a. Observing the individual to determine needs;
- b. Assessing any current interventions for effectiveness;
- c. Developing a written intervention plan, which may include recommendations for assistive technology/equipment, home modifications, and vehicle adaptations or therapeutic exercises / interventions / strategies. Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, direct support professionals and natural supports;
- d. Developing a written intervention plan, which may include preventative strategies, behavioral interventions and strategies. Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, direct support professionals and natural supports;
- e. Training and technical assistance of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan;
- f. Observe, record data and monitor implementation of therapeutic interventions/support strategies;
- g. Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan;
- h. Revision of the intervention plan as needed to assure progress toward achievement of outcomes
- i. Participating in team meetings; and/or
- j. Tele-consultation through use of two-way, real time-interactive audio and video to provide behavioral and psychological care when distance separates the care from the individual.

This service may be used for evaluations for adults when the State Plan limits have been exceeded.

Exclusions

Specialized Consultative Services excludes services provided through Natural Supports Education and Crisis Services. This service may not duplicate services provided to family members through natural supports education.

Limits on amount, frequency, or duration

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian

Provider Type
Independent Practitioners
License
Licensure specific to discipline, if applicable
Certification
Certification or registration specific to discipline, if applicable
Other Standard
<p>NC G.S.122C, as appropriate</p> <ul style="list-style-type: none"> a. Approved by the PIHP b. At least 18 years old c. Criminal background check presents no health and safety risk to beneficiary d. Not listed in the North Carolina Health Care Abuse Registry e. Qualified in the customized need of the beneficiaries as described in the Individual Support Plan <p>Staff shall hold an appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology, nursing and nutrition; board certified behavior analyst, MA; master’s degree and expertise in augmentative communication; state certification in assistive technology and state certification in recreation therapy.</p>
Provider Type
Provider Agencies
License
Certification
Other Standard
<p>NC G.S.122C, as appropriate</p> <ul style="list-style-type: none"> a. Approved as a provider in the PIHP provider network b. Agency staff that work with beneficiaries: c. At least 18 years old d. Criminal background check presents no health and safety risk to beneficiary e. Not listed in the North Carolina Health Care Abuse Registry f. Qualified in the customized needs of the beneficiary as described in the Individual Support Plan <p>Staff shall hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology and nutrition; state certification for recreational therapy; board certified behavior analyst-MA; master’s degree and expertise in augmentative communication; state certification in assistive technology.</p>

Supported Employment Services: Individual-H2025; Group-H2025HQ

Supported Employment-Individual services provide assistance, based on individual circumstances and need, to explore, seek, choose, acquire, maintain, increase and/or advance in competitive integrated employment.

Competitive integrated employment is an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage.

This service is available to any beneficiary ages 16 and older for whom individualized, competitive integrated employment has not been achieved, and/or has been interrupted or intermittent. Assistance with increasing or advancing in competitive integrated employment is available to beneficiaries, ages 16 and older, for whom their current competitive integrated employment is insufficient in terms of meeting the beneficiary's goals for hours worked and income earned, or is considered underemployment in that the beneficiary desires, and could reasonably be expected to achieve, a promotion to a position with increased responsibilities and pay.

Documentation is maintained in the file of each provider agency specifying that the particular service(s) being provided under this Supported Employment-Individual service category is not otherwise available, without undue delay, to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973, or under the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Initial Supported Employment-Individual services may include any of the following, based on individual beneficiary circumstances and needs:

- a. Services that support a beneficiary to explore, and make an informed choice about pursuing, competitive integrated employment. When this service is used to assist a beneficiary to explore, and make an informed choice about pursuing, competitive integrated employment, this service includes, at minimum:
 1. Sufficient but time-limited job and career exploration activities to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to competitive integrated employment;
 2. Uniquely arranged business tours, informational interviews and/or job shadows, that are specifically related to the person's identified interests, experiences and/or skills, to explore potential opportunities for competitive integrated employment in the person's local area;
 3. Introductory, basic education on the numerous work incentives for individuals receiving publicly funded benefits (e.g. SSI, SSDI, Medicaid, etc.)
 4. Introductory education on how Supported Employment-Individual services work (including Vocational Rehabilitation services). Educational information is provided to the person and the legal guardian and/or most involved family member(s), if applicable, to ensure legal guardian and/or family support for the person's choice to pursue competitive integrated employment. The educational aspects of this service shall include addressing any concerns, hesitations or objections of the person and the legal guardian and/or most involved family member(s), if applicable.
- b. Targeted and time-limited employment navigation assistance that is designed to assist a beneficiary who wants to pursue and obtain competitive integrated employment to access needed employment services and supports from non-Medicaid sources [Vocational Rehabilitation; NC Works programs and services; Special Education; Ticket to Work; Work Incentives Planning and Assistance (WIPA) program].
- c. Services to support an individual to successfully seek, choose, acquire, increase and/or advance in competitive integrated employment which may include career/educational counseling,

discovery, job shadowing, job development/placement, customized job development, training or assistance in resume preparation, job interview skills and/or learning other skills necessary for success, and assistance in the use of educational resources and development of study skills. When this service is used to assist a beneficiary to seek, choose, acquire or advance in competitive integrated employment, the employment or self-employment outcome must be consistent with the individual's interests, preferences, strengths, skills and conditions identified as necessary for success, in order to maximize the likelihood of sustained and satisfying work. Job finding is not based on a pool of jobs that are available or set aside specifically for individuals with disabilities.

- d. Initial coaching and employment support activities that enable an individual to complete initial job training, develop skills necessary to maintain employment, and transition successfully to Long-Term Follow-Along Supported Employment-Individual services. These activities typically include but are not limited to assistance in: learning job tasks (e.g. systematic instruction); learning company policies and expectations, developing skills for traveling to/from work, and getting to know/interacting effectively with supervisors and co-workers. Initial coaching and employment support activities should be expected to continue the person successfully completes any probation period that the employer may impose. Fading of initial coaching and employment support activities should begin at some level within the first month of employment and incremental fading gains should be expected to continue over time, as the person becomes more independent on the job and can rely on natural supervisors and co-workers for needed supports, until fading has been maximized and/or the person completes their probation period, at which point the person should transition to Long-Term Follow-Along Supported Employment-Individual services. Feedback regarding the performance and integration of the individual into their workplace should be obtained from the employer, through employee evaluations or other means that provide information on the level and type of coaching and support that the individual requires. The transition to Long-Term Follow-Along Supported Employment- Individual services should typically occur within one year of the individual starting competitive integrated employment.
- e. As part of Initial coaching employment support activities, consultation, technical assistance and education for the employer, including supervisors and co-workers as needed. This can include education on reasonable accommodations and other strategies that can contribute to long-term success of the competitive integrated employment situation and the satisfaction of the employer.
- f. Services to assist an individual to achieve self-employment or ownership of a micro-enterprise. This assistance consists of:
 - 1. Aiding the individual to identify potential business opportunities;
 - 2. Assistance in the development of a business plan, including potential sources of business financing and other assistance;
 - 3. Assistance, based on needs related to disability, in launching the self-employment or micro-enterprise venture;
 - 4. Identification of the long-term follow-along supports that are necessary in order for the individual to maintain self-employment or operate the micro-enterprise.

LONG TERM FOLLOW ALONG: Supported Employment- Long Term Follow Along services provide assistance, based on individual circumstances and need, to maintain, increase and/or advance in competitive integrated employment. Competitive integrated employment is an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage.

This service is available to any beneficiary ages 16 and older for whom individualized, competitive integrated employment has not been achieved, and/or has been interrupted or intermittent. Assistance

with increasing or advancing in competitive integrated employment is available to beneficiaries, ages 16 and older, for whom their current competitive integrated employment is insufficient in terms of meeting the beneficiary's goals for hours worked and income earned, or is considered underemployment in that the beneficiary desires, and could reasonably be expected to achieve, a promotion to a position with increased responsibilities and pay.

Documentation is maintained in the file of each provider agency specifying that the particular service(s) being provided under this Supported Employment-Individual service category is not otherwise available, without undue delay, to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973, or under the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

Long-Term Follow-Along Supported Employment-Individual services include:

- a. Coaching and employment support activities necessary to enable an individual to maintain competitive integrated employment, such as on-the-job supports that do not supplant or discourage natural supports, services necessary to maintain and improve skills needed to complete job tasks, supports to manage impact of disability in relation to employment. Feedback regarding the performance and integration of the individual into their workplace should be obtained from the employer at regular intervals, through employee evaluations or other means that provide information on the level and type of coaching and support that the individual requires. A focus on identifying and implementing strategies for fading should continue in Long-Term Follow-Along Supported Employment-Individual services.
- b. Ongoing assistance, counseling and guidance for an individual who is self-employed or operates a microenterprise
- c. Ongoing employer consultation, technical assistance and education, including supervisors and co-workers as needed, with the objective of ensuring long-term success of the competitive integrated employment situation and the satisfaction of the employer and supported employee. This includes proactively identifying issues and offering assistance to resolve these issues in order to prevent the supported employee's loss of employment and advising the employer regarding reasonable accommodations and other legal requirements.

The amount and duration of Long-Term Follow-Along Supported Employment-Individual services authorized should be individually determined and based on individual need. Services must involve, at minimum:

- a. Monthly face-to-face contact with the supported employee, which may or may not be at the workplace, depending on the preferences of the individual and his/her employer; Application for
- b. Monthly contact with the employer Long-Term Follow-Along Supported Employment-Individual services may be needed on an on-going basis to meet specific and well documented needs of supported employees and/or to provide for minimum contacts with the supported employee and employer as a preventative measure to avoid otherwise preventable job loss.

If Long-Term Follow-Along Supported Employment-Individual services are discontinued at some point because it is determined the supported employee no longer has a need for these services, a re-authorization of the services may be needed at a future point if the individual's job duties change, a supervisor or key co-worker leaves, the individual's disability or health creates a new need for Long-Term Follow-Along Supported Employment-Individual services, or there is an issue that must be resolved in order to ensure the job is sustained. Long-Term Follow-Along Supported Employment-Individual services that are needed to address medical, behavioral and/or physical support needs shall require documentation of such needs and accompanying narrative/documentation in the ISP supporting the need for Long-Term Follow-Along Supported Employment-Individual services as the most

appropriate and viable option for enabling the individual to maintain competitive integrated employment.

Exclusions

FFP is not to be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

- a. Incentive payments made to an employer to encourage or subsidize the employer’s participation in a supported employment program;
- b. Payments that are passed through to users of supported employment programs; or
- c. Payments for training that are not directly related to a beneficiary’s supported employment program.

While it is not prohibited to both employ a beneficiary and provide service to that same beneficiary, the use of Medicaid funds to pay for Supported Employment Services to providers that are subsidizing their participation in providing this service is improper. The following types of situations are indicative of a provider subsidizing its participation in supported employment:

- a. The job/position would not exist if the provider agency was not being paid to provide the service.
- b. The job/position would end if the beneficiary chose a different provider agency to provide service.
- c. The hours of employment have a one to one correlation with the amount of hours of service that are authorized.

For a beneficiary who is eligible for educational services under the Individuals With Disability Educational Act, Supported Employment does not include transportation to or from school settings. This includes transportation to/from the beneficiary’s home, provider home where the beneficiary may be receiving services before or after school or any other community location where the beneficiary may be receiving services before or after school.

Supported Employment services occur in integrated environments with non-disabled individuals or is a business owned by the beneficiary. Supported Employment services do not occur in licensed community day programs.

This service is not available at the same time of day as Community Networking, Day Supports, Community Living and Supports, Supported Living, Residential Supports, Respite or one of the State Plan Medicaid services that works directly with the person.

Limits on amount, frequency, or duration

The amount of Supported Employment Services is subject to the limitation on the sets of services.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input checked="" type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian

Provider Type

Employee in a beneficiary-directed arrangement

License

Certification

NC G.S. 122 C, as applicable

Other Standard

Staff that work with beneficiaries are approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice.

Agency staff that work with beneficiaries:

- a. Are at least 18 years of age
- b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- g. High school diploma or high school equivalency (GED)
- h. Qualified in alternatives to restrictive interventions
- i. For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Supervised by the Employer of Record or managing employer

State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director.

Agencies with Choice follow State Nursing Board Regulations Upon enrollment with the PIHP, the Agency with Choice shall have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices - The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation - The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention - The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics - The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness - The Support Professional plays a vital role in helping individuals to

- achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking - The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
 - h. Cultural Humility_- The Support Professional respects cultural differences and provides services and supports that fit with an individual’s preferences.
 - i. Education, Training and Self-Development - The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Provider Type

Provider Agencies Approved as a vendor in the PIHP provider network

License

Certification

NC G.S. 122 C

Other Standard

Agency staff that work with beneficiaries:

- a. Are at least 18 years of age
- b. If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license and a safe driving record and has an acceptable level of automobile liability insurance
- c. Criminal background check presents no health and safety risk to beneficiary
- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- g. High school diploma or high school equivalency (GED).
- h. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices - The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation - The Support Professional closely monitors an individual’s physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention - The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics - The Support Professional works in a professional and ethical

manner, maintaining confidentiality and respecting individual and family rights.

- f. Health and Wellness - The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking - The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility - The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development - The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Upon enrollment with the PIHP, the organization shall have achieved national accreditation with at least one of the designated accrediting agencies.

The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Supported Living (Level 1 – T2033, Level 2 T2033 HI, Level 3 – T2033 TF), Supported Living Periodic T2033 U1, Supported Living Transition T2033 U2

The Supported Living Periodic service is available for a beneficiary who uses four or less hours of Supported Living per day.

Supported Living provides a flexible partnership that enables a NC Innovations beneficiary to live in their own home with support from an agency that provides individualized assistance in a home that is under the control and responsibility of the beneficiary. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the beneficiary, budget management, attending appointments, and interpersonal and social skills building to enable the beneficiary to live in a home in the community. Training activities, supervision, and assistance may be provided to allow the beneficiary to participate in home life or community activities. Other activities include assistance with monitoring health status and physical condition, and assistance with transferring, ambulation and use of special mobility devices.

Transportation is an inclusive component of Supported Living to achieve goals and objectives related to these activities with the exception of transportation to and from medical services covered through the Medicaid State Plan.

This service is distinct from Residential Supports in that it provides for a variety of living arrangements for a beneficiary who chooses to live in their own home versus the home of a provider. A beneficiary's own home is defined as the place the person lives and in which the person has all of the ownership or tenancy rights afforded under the law. This home must have a separate address from any other residence located on the same property. A beneficiary living in a Supported Living arrangement shall choose who lives with him or her, are involved in the selection of direct care staff, and participate in the development of roles and responsibilities of staff. A beneficiary receiving Supported Living has the right to manage personal funds as specified in the Individual Support Plan. A formal roommate agreement, separate from the landlord lease agreement, is established and signed by individuals whose name is on the lease.

The provider of Supported Living services shall not:

- a. Own the person/s' home or have any authority to require the beneficiary to move if the beneficiary changes service providers.
- b. Own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a beneficiary if such entity requires, as a condition of renting or leasing, the beneficiary to move if the Supported Living provider changes.

The Supported Living provider shall be responsible for providing an individualized level of supports determined during the assessment process, including risk assessment, and identified and approved in the Individual Support Plan (ISP) and have 24 hour per day availability, including back-up and relief staff and in the case of emergency or crisis. Some beneficiaries receiving Supported Living services may be able to have unsupervised periods of time based on the assessment process. In these situations, a specific plan for addressing health and safety needs must be included in the ISP and the Supported Living provider shall have staffing available in the case of emergency or crisis. Requirements for the beneficiary's safety in the absence of a staff person must be addressed and may include use of tele care options. When assessed to be appropriate Assistive Technology elements may be utilized in lieu of direct care staff.

To ensure the intent of the definition to support a beneficiary to live in a home of their own and achieve independence, Supported Living must not be provided in a home where a beneficiary lives with family members unless such family members are a beneficiary receiving Supported Living, a spouse, or a minor child. Family member is defined as a parent, grandparents, siblings, grandchildren, and other extended family members. In addition, it also includes stepparents, non-minor step-children and step-siblings and non-minor adoptive relationships. All beneficiaries receiving Supported Living services who live in the same household must be on the lease unless the person is a live-in caregiver.

Reimbursement for Supported Living must not include payment for services provided by the spouse of a person or to family members as defined in this service definition or legal guardian. The Supported Living provider and provider staff shall not be a member of the beneficiary's immediate family as defined in this service definition and reimbursement must not include payment for Supported Living provided by such persons.

A Supported Living home must have no more than three residents including any live-in caregiver providing supports per SL2011-202/HB509. A live-in caregiver is defined as an individual unrelated to the beneficiary and who provides services in the beneficiary's home through the Supported Living provider agency and is not on the lease.

Reimbursement for Supported Living shall not be made for room and board with the exception of a reasonable portion that is attributed to a live-in caregiver who is unrelated to the beneficiary and who provides services in the beneficiary's home. Reimbursement cannot include the cost of maintenance of the dwelling. Residential expenses, such as phone, cable, food, rent) must be apportioned between the residents of the home, and when applicable, the live-in caregiver. Rates for Supported Living include payments of relief and back-up staff.

Homes leased under Section 8 Housing are licensed and inspected by the local housing agency and must meet the housing quality standards per 24CFR 882-109.

Staffing Plan for Supported Living Services

The provider shall develop an individualized staffing plan and schedule. The staffing plan is based on the beneficiary's preference and on the assessment and ISP process, including risk assessment. The plan must ensure staffing is adequate to protect the health and safety of the beneficiary and to carry out all activities required to meet the outcomes and goals identified in the ISP. The plan must address staff coverage for back-up and relief staff.

Supported Living levels are determined by the Individual Budget Tool and other evidence of support need. The SIS Level is only one piece of evidence that may be considered. The results of a SIS and the Individual_Base Budget are guidelines that do not constitute a binding limit that may not be exceeded on the amount of services that may be requested or authorized in a Plan of Care

Level One: Level A and B

Level one is intended to serve a beneficiary who requires minimal support to perform the activities of daily living and to remain safe and healthy. Staffing is based on the preferences and the assessed needs of the beneficiary but does not require staff to be in the home or awake at night.

Level Two: Levels C and D

Level two is intended to serve a beneficiary that requires moderate support to perform the activities of daily living and to remain safe and healthy. Staffing is based on the preferences and the assessed needs of the beneficiary. Typically, the live-in caregiver or staff shall be onsite but not awake at night or appropriate technology may be used to ensure supervision.

Level Three: Levels E, F, and G

For Level three the beneficiary requires continuous supervision, including awake overnight staff in order to remain safe and healthy. Typically, a beneficiary receiving Level Three supports include arrangements in which a person is living in his or her own home with overnight, awake staff or appropriate technology may be used to ensure supervision as identified in the ISP.

Special Needs Adjustment

A special adjustment is available for Levels 1-3. The adjustment does not change the Level designated for the beneficiary, but adjusts the Level to meet one or more of the following circumstances:

- a. The beneficiary is in circumstances that are time limited but that require support at a higher level than described by the Level and the current rate does not cover the cost. For example, the beneficiary has a serious injury or illness or behavioral or mental health crisis requiring additional support on a temporary basis. A special adjustment may be approved for up to 90 days and may be extended for an additional 90 days.
- b. The beneficiary needs a roommate and requires a special adjustment until one move in. A special adjustment may be approved for up to 90 days and may be extended for an additional 90 days.
- c. The beneficiary is transitioning from a higher level of care setting, i.e. inpatient hospital, ICF/IID, and a rate adjustment is needed to ensure success during the transition process.
- d. A beneficiary who requires a continued Special Needs Adjustment due to medical or behavioral health issues may be reassessed for appropriateness of Level.

This service is not available at the same time of day as Community Networking, Day Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the person.

The following exception applies:

Respite may be used by individuals living in a Residential or Supported Living setting when the individual is accessing a non-integrated community setting like a summer camp.

The purpose of Supported Living Transition is to provide members with the support that they need to facilitate their transition to Supported Living.

Covered transition services are:

- a. Meeting the person who is preparing to transition in an effort to get to know them and assess their support needs for Supported Living (can the person cook meal to have a healthy diet, how will they handle basic household maintenance tasks like vacuuming, cleaning appliances, bathroom; do they know how and who to call for help; are there types of technology that would support success? Does the person need help to make appointments with doctors? Do they know how to access transportation? What is the plan for their free time? Have they ever been alone overnight, or will they?)
- b. Meeting with treatment team members in an effort to gather, review and discuss information that will help to better understand that person and their support needs; assistance with finding an apartment and signing a lease; determining transportation services; gathering needed household items like furniture and supplies; learning about the surrounding community; developing a home

safety plan for fire; setting up services like phone, water, sewer, electric, cable; practicing skills needed to be safe; interviewing roommates; developing an emergency plan for disasters like hurricanes, snow, etc.

Supported Living Transition is only available only during the six-month period in advance of the beneficiary’s move to a Supported Living setting.

Exclusions

- a. Supported Living is not provided in inpatient hospitals, nursing facilities, and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIFD) or residential group homes licensed under 10A NCAC 27G .5600
- b. Supported Living is not covered for persons under age 18 since the home must be under the control and responsibility of the residents.
- c. A beneficiary who receives Supported Living may not receive: Community Living and Supports or State Plan Personal Care Services. Respite may only be provided for participation in non-integrated camps or for participation in non-integrated Support Groups.
- d. A beneficiary receiving Supported Living may only receive Home Modifications if the home is owned by the beneficiary or the beneficiary’s family. If the home is rented, only Home Modifications that are portable and can be removed once the beneficiary no longer leases the residence may be used. All requirements under the Fair Housing Act at 42 U.S.C. §§ 3601 – 3619 must be met by the landlord.
- e. This service is not available at the same time of day as Community Networking, Day Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the beneficiary.
- f. Relatives who own provider agencies may not provide Supportive Living services to family members. Other staff employed by the provider agency may provide services to the individual.

Limits on amount, frequency, or duration

The amount of Supported Living is subject to the Limits on Sets of Services.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input checked="" type="checkbox"/> Individual/Family Directed
Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian

Provider Type

Provider Agencies

License

NC G.S. 122 C

Certification

NC G.S. 122 C

Other Standard

- Staff or live-in caregiver are
- a. Are at least 18 years of age
 - b. If providing transportation, have a valid North Carolina driver’s license or other valid driver’s license and a safe driving record and has an acceptable level of automobile liability insurance
 - c. Criminal background check presents no health and safety risk to beneficiary

- d. Not listed in the North Carolina Health Care Abuse Registry
- e. Qualified in CPR and First Aid
- f. Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
- g. Qualified in alternatives to restrictive interventions
- h. High school diploma or high school equivalency (GED).
- i. Paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Professional Competency

Support Professionals have competency in the following areas:

- a. Communication - The Support Professional builds trust and productive relationships with people he/she supports, co-workers and others through respectful and clear verbal and written communication.
- b. Person-Centered Practices - The Support Professional uses person-centered practices, assisting individuals to make choices and plan goals, and provides services to help individuals achieve their goals.
- c. Evaluation and Observation - The Support Professional closely monitors an individual's physical and emotional health, gathers information about the individual, and communicates observations to guide services.
- d. Crisis Prevention and Intervention - The Support Professional identifies risk and behaviors that can lead to a crisis and uses effective strategies to prevent or intervene in the crisis in collaboration with others.
- e. Professionalism and Ethics - The Support Professional works in a professional and ethical manner, maintaining confidentiality and respecting individual and family rights.
- f. Health and Wellness - The Support Professional plays a vital role in helping individuals to achieve and maintain good physical and emotional health essential to their well-being.
- g. Community Inclusion and Networking - The Support Professional helps individuals to be a part of the community through valued roles and relationships and assists individuals with major transitions that occur in community life.
- h. Cultural Humility - The Support Professional respects cultural differences and provides services and supports that fit with an individual's preferences.
- i. Education, Training and Self-Development - The Support Professional obtains and maintains necessary certifications and seeks opportunities to improve their skills and work practices through further education and training.

Provider Qualifications:

- a. Provider Agencies in PIHP network.
- b. State Nursing Board regulations must be followed for tasks that present health and safety risks to the person/s as directed by the PIHP Medical Director or Assistant Medical Director.

Supported Living providers:

- a. Assist in finding a home that meets the individual's needs
- b. Assist in managing living in one's own home
- c. Help develop community involvement and relationships that promote full citizenship
- d. Coordinate education and assistance related to finances, healthcare, and other needs

- e. Assist with day-to-day planning and problem solving
- f. Train and support people who assist the individual
- g. Provide 24-hour flexibility in responding to the needs of an individual, including emergency situations

Vehicle Modifications: T2039

Vehicle Modifications are devices, service or controls that enable a beneficiary to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, maintenance, and training in the care and use of these items are included. The waiver beneficiary or his/her family must own or show proof of actively making payments to purchase/own the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the beneficiary. The recommendation must contain information regarding the rationale for the selected modification. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway Traffic Safety Administration guidelines. Evaluation by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications must be included with the request.

Medical necessity must be documented by the physician, physician assistant, or nurse practitioner, for every item provided/billed regardless of any requirements for approval. A letter of medical necessity written and signed by the physician, physician assistant, or nurse practitioner, or other licensed professional permitted to perform those tasks and responsibilities by their NC state licensing board, may be submitted along with the Certificate of Medical Necessity or Prescription.

Note: The Certificate of Medical Necessity or Prescription still must be completed and signed by the physician, physician assistant, or nurse practitioner.

Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.

Covered Modifications are:

- a. Door handle replacements
- b. Door modifications
- c. Installation of raised roof or related alterations to existing raised roof system to improve head clearance
- d. Lifting and/or lowering devices
- e. Devices for securing wheelchairs or scooters
- f. Adapted steering, acceleration, signaling, and breaking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel
- g. Handrails and grab bars
- h. Seating modifications
- i. Lowering of the floor of the vehicle.
- j. Modifications for accessibility

Exclusions

- a. Vehicle Modifications are only available to a beneficiary who receives Residential Supports, or who lives in licensed residential facility, when the vehicle belongs to the beneficiary and can transition to other settings with the individual.

- b. The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered.
- c. Items that are not of direct or remedial benefit to the beneficiary are excluded from this service.
- d. Vehicle modifications are not covered for leased vehicles

Limits on amount, frequency, or duration

The service is limited to expenditures of \$20,000 over the life of the waiver.

Service Delivery Method	<input checked="" type="checkbox"/> Provider Directed <input type="checkbox"/> Individual/Family Directed
--------------------------------	--

Specify whether the service may be provided by (check all that apply):	<input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> Relative <input type="checkbox"/> Legal Guardian
---	--

Provider Type

Specialized Vendors

License

Applicable state/local business license

Certification

Other Standard

Meets applicable state and local requirements for type of device that the vendor is providing.

Provider Type

Commercial/Retail Businesses

License

Applicable state/local business license

Certification

Other Standard

Meets applicable state and local requirements for type of device that the vendor is providing.

Attachment D: Limits on Sets of Services

The following limits apply:

- a. An Adult beneficiary (age 22 and over) who receives residential supports: no more than 40 hours per week is authorized for any combination of community networking, day supports and supported employment services.
- b. A Child beneficiary (through age 21) who receives residential supports: during the school year, no more than 20 hours per week is authorized for any combination of community networking, day supports and supported employment services. When school is not in session, up to 40 hours per week may be authorized. If the beneficiary is age 18 or older and has graduated (graduation with a degree or occupational course of study or GED indicating a standard course of study) then the beneficiary may access the adult level of limits on sets of services.
- c. An Adult beneficiary who lives in private homes: No more than 84 hours per week is authorized for any combination of community networking, day supports, supported employment, and/or Community Living and Supports.
- d. A Child beneficiary who lives in private homes: During the school year, no more than 54 hours per week is authorized for any combination of community networking, day supports, supported employment, Community Living and Supports. When school is not in session, up to 84 hours per week may be authorized. If a beneficiary is age 18 or older and has graduated (graduation with a degree or occupational course of study or GED indicating a standard course of study) then the beneficiary may access the adult level of limits on sets of services.

Adult and child beneficiaries who live in private homes with intensive support needs: These beneficiaries may receive additional hours of Community Living and Supports to allow for 24 hours per day of support with the prior approval of the PIHP. For all services in the above sets of services in, **a** through **d**, if a beneficiary is getting only one service out of the set of services subject to a limit, the limit is applied to the one service received.

Attachment E: The Supports Intensity Scale (SIS) ®

IMPORTANT: The SIS is only one measure of an individual’s support needs. The SIS results may be considered in determining the amount of services approved but are not binding, and all other evidence of the beneficiary’s support needs must also be considered.

Overview of the SIS Assessment Tool

The SIS is an internationally recognized validated assessment tool published by American Association on Intellectual and Developmental Disability (AAIDD) that measures the level of supports for individuals with disabilities to lead typical, independent, quality lives in their home community. The SIS is designed to be used for both adults and children.

The SIS covers general, medical and behavioral areas, including:

- a. Home living
- b. Community living
- c. Lifelong learning
- d. Employment
- e. Health and wellness
- f. Social activities
- g. Protection and advocacy

All of these supports are rated for frequency (how often support is needed), daily support time (how many hours of support is needed) and type of support (verbal, gesturing, physical assistance, etc.). Rather than determining what is wrong or deficient, as conventional assessments do, the SIS helps determine what kind, amount and intensity of supports are needed for someone to succeed in the important areas of his or her life.

In addition to the questions asked on the SIS, North Carolina has adopted four Supplemental Questions (SQs) that are asked based on responses to questions in the medical and behavioral section of the SIS. The four questions pertain to:

- a. Severe Medical Risk
- b. Severe Community Safety Risk – Convicted
- c. Severe Community Safety Risk – Not Convicted
- d. Severe Risk of Injury to Self

The SQs further identify and define exceptional support needs related to medical conditions, behavioral challenges, and risks the person may pose to his/her community (convicted/non-convicted). It is important to identify supports related to any of these exceptional support needs in the Individual Support Plan (ISP). Based on responses to the SQs, beneficiaries may be considered for higher funding. Because of this, verifying responses to the questions is very important. The purpose of the verification process is to confirm the high-level need indicated by responses to the SQs. Each Local Management Entity – Managed Care Organization (LME/MCO) is responsible for forming a SQ Verification committee charged with reviewing and making decision with regard to whether the exceptional support is supported by documented needs. The SQ verification committee consists of 4-8 members that may include, but not be limited to the following staff: IDD Care Coordination, IDD Quality Review, Consumer Affairs, IDD Clinical Director, SIS Management; Utilization Management, Medical Director. Each committee will

meet at least monthly. If the committee is able to verify the responses to the SQs, the beneficiary would be considered for a higher level of support. If the committee cannot verify the SQs with the information presented, additional information may be requested. If the SQ verification still cannot verify the responses, the committee deems the review as “unable to be verified”.

Additional information on the SIS can be found on the AAIDD website- <http://www.aaid.org>.

For additional information on Supplemental Question Verification such as timelines for review; grievance process, beneficiaries should contact their LME/MCO.

The SIS Assessment in NC Innovations

The SIS is conducted in an interview format by an AAIDD trained SIS interviewer. Once the SIS is completed, the results are mailed or hand-delivered to the beneficiary and legally responsible person. The SIS interviewer, or Care Coordinator, then schedules a time to meet with the beneficiary and his/her family to review the results, if the beneficiary and his or her family would like to meet about SIS results. After the SIS results are reviewed, the beneficiary and -legally responsible person formally acknowledges the overview by signing for receipt of the SIS report. It is recommended that others (service providers; other natural supports) attend the meeting as permitted by the individual and family. The SIS interviewer or Care Coordinator will inform the beneficiary and legally responsible person of what action to take if they have questions or concerns about the SIS assessment (see below: **Re-assessments and Addendums**)

The AAIDD training is designed in three phases (Orientation, Individual Guided Practice, and Interviewer Reliability Review) to allow for adequate practice and self-study time. In order to be recognized as a SIS Interviewer, participants complete an Interviewer Reliability Quality Review (IRQR) with the AAIDD Trainer. Successful candidates must obtain an interviewer reliability coefficient of .85 (85 percent) or higher.

An NC Innovations Wavier beneficiary is required to have a SIS assessment. Failure to comply with this requirement may result in the beneficiary’s termination from the waiver. The assessment is completed using the following two age-based tools:

- a. For a beneficiary aged 16 and older, the Supports Intensity Scale for Adults is utilized
- b. For a beneficiary aged 5 through 15, the Supports Intensity Scale for Children is utilized.

A beneficiary new to the NC Innovations waiver receives a SIS prior to their initial NC Innovations waiver plan.

A routine assessment occurs every two years for beneficiaries aged 5-15 years of age and every three years for beneficiaries 16 years of age and older.

A new assessment does not occur when a beneficiary transfers to a new Managed Care Organization (MCO) service area. A copy of the SIS is transferred to the new MCO per established procedures.

Using the SIS for Planning

Once the results are reviewed, the Individual Support Plan (ISP) meeting is scheduled. The planning meeting includes the beneficiary, his/her family, Care Coordinator, Community Navigator, all providers of services and any other individual that the beneficiary would like to attend. The ISP is developed through a person-centered planning process and is led by the beneficiary and legally responsible person to the extent they desire. It focuses on supporting beneficiaries to realize their own vision for their lives. The planning process should identify the beneficiary’s unique gifts, skills and capacities, and focuses on

listening for what is really important to the person. Although the SIS is used to assess the types and levels of supports a person needs, not all areas of the SIS are included in the ISP. The beneficiary and legally responsible person prioritize needs that are developed into long-range outcomes in the ISP. The Care Coordinator documents the long-range outcomes developed by the planning team. Long-range outcomes must be:

- a. broad in nature;
- b. address life areas;
- c. relate to support needs identified; and
- d. address needs gathered in the assessment process.

Once the long-range outcomes are identified, providers, Agencies with Choice and Employers of Record along with the planning team are responsible for the development of the short-range goals. The short-range goals are measurable and help to achieve the long-range outcomes. Short-range goals are:

- a. statements defining where the beneficiary would like to be in his/her life;
- b. based on wants or needs of the beneficiary; and
- c. should make sense to support the beneficiary to live a life of their choosing.

A beneficiary works towards achieving his or her short-range goals based on the information in the ISP, the SIS, and other information gathered in the plan year. Some goals may need to be modified based on progress or lack thereof.

For additional information on ISP development, each beneficiary should refer questions to his or her Care Coordinator.

Re-assessments and Addendums

A request for a re-assessment may occur when the beneficiary experiences a major life change. This means a change in the health or safety of a beneficiary that merits examination of the types of supports that the beneficiary may need. This may occur prior to the regularly scheduled re-assessment date. Major life changes may include, but are limited to:

- a. An emergency or crisis in the beneficiary's living situation, including the loss of the current living situation or primary caregiver;
- b. Repeated incidents relating to the beneficiary's or other persons' health and safety;
- c. A new diagnosis of a serious mental health condition; or development of new co-morbid conditions; and
- d. Transitional change including a life and age-appropriate transition from the family home or group home setting into a more independent setting.

If a beneficiary or legally responsible person has questions or concerns about the SIS results, the following process occurs:

- a. The beneficiary or legally responsible person contacts the LME/MCO within 30 calendar days of receipt of the SIS score;
- b. Within three (3) business days of notifying the LME/MCO of questions or concerns, the SIS Interviewer will contact the beneficiary and legally responsible person (requester) by phone to review the SIS summary and answer any questions. At the conclusion of this call, the SIS Interviewer will specifically ask if the beneficiary and legally responsible person would like to meet to further discuss the results and possibly request a new SIS;

- c. If the beneficiary or legally responsible person expresses a desire to meet or requests a new SIS, the SIS Interviewer meets with the beneficiary or legally responsible person face-to-face within two (2) weeks, ensuring that a second SIS Interviewer or Care Coordinator is present at this meeting;
- d. At the face-to-face meeting with the beneficiary or legally responsible person, the SIS Interviewer reviews the SIS Report and provide needed interpretation;
- e. Requests for a new SIS must be scheduled as soon as possible but no longer than ninety (90) days from the date of the request and a new SIS will be administered at that time. Additionally, the second SIS assessment must be conducted by a different SIS Interviewer whenever possible;
- f. The beneficiary or legally responsible person also has an opportunity to file a grievance (42 C.F.R. § 438.400; N.C.G.S. § 108D-12); and
- g. Failure to grieve a SIS evaluation does not constitute a waiver of the beneficiary's right to challenge the correctness of the SIS evaluation when requesting services or during a service appeal.

Addendums to the SIS may occur if one or more of the ratings on the SIS do not accurately capture the individual's supports needs. The SIS Interviewer or Care Coordinator can provide assistance, as needed, in documenting the beneficiary or legally responsible person's concerns. If it is determined, through the review of the results and the additional information provided, that the SIS results do not adequately capture the beneficiary's support needs in one or more areas, the following steps are taken:

- a. SIS Interviewer or Care Coordinator meets in person or via phone with all respondents;
- b. An addendum to the SIS is prepared and serves as an addendum to the reviewed SIS. However, the original document may not be altered;
- c. A written notification is mailed to the beneficiary or legally responsible person that an addendum has been approved. A copy of the SIS and addendum are included in the mailing; and
- d. Reasonable efforts are made to inform and provide the addendum within a reasonable time to those identified by the beneficiary or legally responsible person and to those individuals who participated in the SIS interview.

The SIS Interviewer or Care Coordinator shall document all contacts, telephone or face-to-face, with the beneficiary or legally responsible person related to the SIS.

Attachment F: Individual Budgets

The Individual Budgeting Tool is a guideline to assist in developing the plan of care. It is not a binding limit on the amount of services that can be requested or approved. Services should be requested and approved if they are medically necessary regardless of the amount of the individual budget. No beneficiary may be required to show that the beneficiary needs additional support compared to other individuals in the same budget category in order to receive services in excess of the individual budget. A beneficiary and his or her team should submit requests for Innovation services they feel are needed with supporting documentation.

All beneficiaries funded through the NC Innovations wavier are assigned to one of four categories on the Individual Budgeting Tool. All persons supported through the NC Innovations Waiver have an Individual Budget as a guideline in developing their Individual Support Plan (ISP). The Individual Budget does NOT represent the maximum cost of waiver services authorized in the Individual Support Plan. Again, the base budget is a guideline that does **not** constitute a binding limit on the amount of services that may be requested or authorized, and if the LME/MCO determines services to be medically necessary, they will be authorized, regardless of the base budget. If any request for authorization of services is denied, the LME/MCO notifies the individual of the reasons for the decision and how to appeal.

Calculation of Individual Budgets and Beneficiaries' Right to Information

The individual budgets are calculated in a uniform manner for all beneficiaries in the waiver. Budget methodology is open to public review through the clinical policy of the waiver. Reviews of budgets occurs no less frequently than one time annually. The Letter notifying the family of the individual budget explains the methodology for budget development, total dollar value of the budget and mechanisms available to the beneficiary to modify their Individual Budget. Upon entry to the NC Innovations Waiver, the beneficiary also receives written information from the PIHP that explains the budgeting methodology.

Determination of the Initial Individual Budget

All beneficiaries supported through the NC Innovations Waiver have an Individual Budget as a guideline in developing their Individual Support Plan (ISP). The Individual Budget Tool does not represent the maximum cost of waiver services authorized in the Individual Support Plan.

The Individual Budget Tool is based on living arrangement, age, and assessment derived categories of need as these factors most closely align with the cost of service. The Non-Residential Support Category is applied to those individuals that do not require residential services. The Residential/Supported Living Category is applied to those individuals that require residential services or supported living services. Children are defined as younger than twenty-two (22) and adults are age twenty-two (22) and older. Please note that completion of high school (graduation with a degree or occupational course of study or GED indicating a standard course of study) can prompt movement from the child category to the adult category.

Both the Residential Support and Supported Living Category and the Non-Residential Support Categories are collectively referred to as the "Individual Budget Tool." The four categories that make up the Individual Budget Tool are:

- a. Non-Residential Child (under age 22 and living in a private home);

- b. Residential / Supported Living (per diem) Child (under 22 years old and living in a group home, an Alternative Family Living (“AFL”) setting or a Supported Living setting.);
- c. Non-Residential Adult (age 22 and older and living in a private home); and
- d. Residential / Supported Living (per diem) Adult (age 22 and older and living in a group home, an AFL, or Supported Living Setting).

Each category has seven levels, which are clinical descriptions representative of groupings of individuals who have similar support needs. The funding assigned to each level is derived from a package of available services, validated to ensure their clinical appropriateness, that are assigned to each category. The seven levels are A, B, C, D, E, F, and G.

Components of the Individual Budgeting Tool

The Individual Budget is only one measure of a beneficiary’s likely current needs and is not a binding limit on the amount of funding for any period of time. The Individual Budget is reviewed no less frequently than annually by the PIHP. The Individual Budget includes only Base Budget Services. Non-Base Budget services are not included. Base Budget services are the core habilitation and support services in the waiver. Non-Base Budget services are preventative services, and equipment. Combined these services may not total more than the \$135,000 cost limit within the waiver unless the follow criteria is met:

An individual may exceed the \$135,000 waiver limit, to ensure health, safety and wellbeing, if the following criteria is met:

- a. Beneficiaries utilizing Supported Living Level III:
 - 1. lives independently without his or her family in a home that s/he owns, rents or leases, and
 - 2. receives Supported Living Level III, and
 - 3. requires 24 hour support.

Base Budget Services are:

- a. Community Networking Services;
- b. Day Supports;
- c. Community Living and Supports;
- d. Respite; and
- e. Supported Employment.

Non-Base Budget, are:

- a. Assistive Technology Equipment and Supplies;
- b. Community Navigator Services;
- c. Community Transition Services;
- d. Crisis Services;
- e. Financial Support Services;
- f. Home Modifications;
- g. Individual Goods and Services;
- h. Natural Supports Education;
- i. Specialized Consultation Services;
- j. Vehicle Modifications;
- k. Residential Supports; and
- l. Supported Living.
- m.

Category Assignment and Individual Budget Changes

A Level is assigned every person on the NC Innovations Waiver. This level is based on the Support Intensity Scale (“SIS”) which is the assessment instrument used to measure individual support needs.

The SIS scores are uploaded to SIS On-line with AAIDD. Within 15 calendar days of receiving notice that the SIS has been uploaded, NC Medicaid, or their designee, applies the algorithm and assigns an initial level and individual budget. If a SIS is updated, the results of the SIS may indicate a change in the level of support needs. This may result in a new Individual Budget Tool Level and base budget being assigned. Within thirty (30) calendar days of a SIS being performed and NC Medicaid, or their designee’s notification, NC Medicaid, or their designee will determine if there has been a Level change and the LME/MCO will notify the beneficiary in writing within 15 days of receiving notice from NC Medicaid, or their designee. The beneficiary will also be notified if there is not a Level change. A Level change may not always result in a change in the beneficiary’s base budget, but the beneficiary will always be notified if there is a Level change and budget change.

If the beneficiary’s level change has resulted in an increase in budget, that budget increase can take effect sixty (60) calendar days from the date on the letter. During that sixty (60) calendar day period, the individual can develop an update to his/her Individual Support Plan (“ISP”) with the planning team allowing for the increased services, if they choose. The Care Coordinator will submit an updated ISP to UM for approval. If the beneficiary’s Level change has resulted in a decrease in budget, the budget decrease will take effect at the end of the individual’s most recently approved Annual ISP. No currently authorized services will be reduced as a result of the budget change. The letters notifying the individual of the decrease in budget will notify the individual of the following:

- a. He or she may request services that cost in excess of his or her base budget if he or she believes his or her needs cannot be met within his or her base budget; and
- b. The results of the SIS and the base budget are guidelines that do not constitute a binding limit on the amount of services that may be requested or authorized, and if the LME/MCO determines services to be medically necessary, they will be authorized, regardless of the base budget.
- c. If any request for authorization of services is denied, the LME/MCO will notify the individual of the reasons for the decision and how to appeal
- d. How to file a grievance regarding the base budget if he or she wishes to do so.

Changes within the Individual Budget Tool

Sometimes, an individual’s support needs may not be met in his or her assigned level base budget. If Utilization Management determines requested services to be medically necessary, they will be authorized.

There are a variety of ways for a beneficiary’s base budget to be modified. However, no change in the amount of the budget is needed in order to approve services in excess of the budget.

Temporary Change

A temporary change in support needs is an unexpected need that is expected to resolve in six months or less. A temporary change in budget request may be considered when a need arises that the team has not previously identified. There is not a budget assigned to the temporary change, but the total cost of services cannot exceed the NC Innovations waiver cost limit of \$135,000.00 set by NC Medicaid.

If a temporary increase in budget is needed, the individual’s Care Coordinator shall submit information to UM either the individual’s annual ISP or an update to his/her ISP. UM shall review the request

within 14 days. If a temporary change is approved and results in a change in budget, UM will notify the individual in writing.

If the request is expedited (meaning the beneficiary's health and safety are at risk if the service does not begin immediately or within the next 24 hours, for example, if the beneficiary has been evicted from his/her apartment or the primary care giver, for an individual who lives with family, is suddenly hospitalized), the Care Coordinator should make verbal contact with a Care Manager in UM. The UM Care Manager can also recommend a temporary change if a clinical need that is not addressed in the submitted ISP is identified.

Permanent Change

A permanent change is a change in support needs expected to last longer than six months. This type of change results when there is a category change or a confirmed level change (as described in the previous section). When the living situation of an individual results in a change of category, the change will be implemented immediately upon notification to UM. The change from a child category to an adult category occurs within the context of the annual plan on the beneficiary's twenty second (22nd) birthday. If there is a change that would dictate a permanent change in his/her category, the beneficiary's Care Coordinator should submit the *Criteria for Permanent, Temporary, and Intensive Review Form* to UM with either the individual's annual plan or an update to his/her ISP. UM will review the request within fourteen (14) days. If the permanent change is approved and results in a change in budget, UM will notify the individual in writing. If the request is expedited, (meaning the individual's health and safety are at risk if the service does not begin immediately or within the next 24 hours, for example, if the individual has been evicted from his/her apartment or the primary care giver, for a beneficiary who lives with family, is suddenly hospitalized) the Care Coordinator should make verbal contact with a Care Manager in UM.

Intensive Review –

Under no circumstances may an individual be required to request Intensive Review if they have needs that cannot be met with their current service array, or to obtain services in excess of the amount of the individual budget. However, if a beneficiary wishes to pursue an Intensive Review, the beneficiary or legal guardian may do so. There is no limit to the amount of times an individual can go through Intensive Review. A beneficiary may be in Intensive Review so long as criteria are met. There is no limit to the amount of times a beneficiary can go through Intensive Review. An individual may be in Intensive Review so long as criteria are met.

Intensive Review may not result in funds (the total cost of services including base-budget services, enhanced rates, and add-on services) exceeding \$135,000. Regardless of the outcome of Intensive Review, as long as services in excess of the beneficiary's individual base budget are medically necessary, they will be authorized. An Intensive Review request may be submitted at any time during a beneficiary's plan year by the individual's Care Coordinator. If a clinical need is not addressed in the submitted ISP, the UM Care Manager should request additional information. All requests for services, including those submitted in excess of an assigned base budget, will be reviewed to determine whether or not the requested service array is medically necessary.

There are four primary types of requests for the Intensive Review; however, other types of requests for Intensive Review may be made and may be appropriate. It is important to note that some individual's Intensive Review requests may touch more than one of the primary types of requests for Intensive Review.

- a. Behavioral needs – The individual’s behavioral support needs (Intensity, type, duration, or frequency) differ from the behavioral component defined in her/his level description.
- b. Medical needs – The individuals medical support needs (Intensity, type, duration, or frequency) differ from the medical component defined in her/his level description.
- c. Post-Secondary Services Approved Curriculum (these are specialized programs designed to build independence and increase community participation that require funding beyond the assigned Individual Budget Tool)
- d. Enhanced Rate – Enhanced Rate requests should be made through a service request or by the provider, not through Intensive Review.

The following is a list of core documents that are needed for the Intensive review (Other documents may be requested as needed):

- a. Updated Evaluations (if relevant to the request);
- b. Positive Behavior Support Plan and Date specific to the Request (within the six (6) months prior to the request) (if relevant to the request)
- c. Medical Records (if relevant to the request);
- d. Post-Secondary Services Approved Curriculum (if relevant to the request; and
- e. Letter of intent to enroll or to continue enrollment (if relevant to the request).

Attachment G: Relative as Provider

This policy applies to waiver beneficiaries' ages 18 and older who live with a relative or legal guardian who is employed by a waiver provider agency.

Relatives are defined as individuals related by blood or marriage to the waiver beneficiary. The relative must live in the home of the waiver beneficiary. Excluded from this policy are the following relatives: biological or adoptive parents of a minor child, stepparents of a minor child or the spouse of a waiver beneficiary. A waiver beneficiary under the age of 18 may not receive services provided by a relative who resides in their home.

Community living and Support is the only waiver service that may be provided by a relative who resides in the home of the beneficiary (age 18 and older). It is recommended that a relative residing in the home of the beneficiary provide no more 40 hours per week of service to the person. This must be reported to the PIHP but does not require approval by the PIHP.

If more than 40 hours are requested to be provided by relatives residing in the home of the beneficiary, then approval must be obtained by the PIHP. Justification needs to be provided as to why there is no other qualified provider to provide Community living and Support and assurances of provider choice and that the beneficiary shall not be isolated from their community. In exceptional situations, up to 56 hours per week may be approved. This is the total number of hours that one relative may provide regardless of the number of beneficiaries residing in the home.

****Relatives who were providing more than 56 hours of services on 12/31/15 may exceed the 56 hour limit and be approved to provide the amount of services that they were authorized to provide as of 12/31/15 as long as the beneficiary continues to choose the relative as the staff member, there are no health and safety issues, and the beneficiary is not isolated from their community.**

The PIHP ensures compliance with the conditions of this policy through a prior approval process. The PIHP provides an increased level of monitoring for services delivered by relatives or legal guardians. Services delivered by relatives or legal guardians are monitored monthly. Care Coordinators monitor through on-site monitoring and documentation review to ensure that payment is made only for services rendered and that the services are furnished in the best interest of the beneficiary. Monitoring should typically take place in the primary residence of the person; while services are being provided. If the relative regularly provides the community-based component of Community Living and Supports; a maximum of once per quarter monitoring can occur while the beneficiary is receiving services in the community.

The ISP must contain documentation that the waiver beneficiary is in agreement with the employment of the relative and has been given the opportunity to fully consider all options for employment of non-related staff for waiver service provision.

The relative or legal guardian will not be reimbursed for any activity that would be provided to a person without a disability of the same age.

Employers of Record and Managing Employers participating in the Individual Family Directed option may not be employed to provide waiver services.

Provider agencies, Employers of Record and Agency with Choice in conjunction with the Managing Employer must monitor the relative or legal guardian's provision of the service on site and at a minimum of one time per month.

Attachment H: Individual and Family Directed Services

The NC Innovations waiver offers beneficiaries both agency directed and beneficiary directed supports options. Beneficiary directed services are known as Individual and Family Directed Services (IFDS). There are two options for Individual and Family Directed Services under the Innovations waiver:

- a. Employer of Record
- b. Agency With Choice

All waiver beneficiaries are offered the opportunity to direct one or more of the following services:

- a. Community Networking Services
- b. Community Living and Supports
- c. Individual Goods and Services (in conjunction with at least one other self-directed services)
- d. Natural Supports Education
- e. Respite Services
- f. Supported Employment
- g. Supported Living

The beneficiary may direct one or all of these services and may receive additional provider directed services that the beneficiary does not choose to self-direct. Of the services that the beneficiary chooses to self-direct; all hours of that service must be self-directed.

Beneficiaries are offered an opportunity to receive an orientation to Individual and Family Directed Services from the Community Navigator at the time of the initial or annual plan. The orientation is provided by the Community Navigator. The Community Navigator also provides the beneficiary and legally responsible person with a copy of an employer handbook and other educational materials. The training and educational materials provide sufficient information to ensure that the beneficiary and legally responsible person make informed choices about the degree they wish to self-direct services. After the training, the beneficiary and a legally responsible person meets with a Care Coordinator. The Employer of Record, or managing employer, is identified. The Employer of Record, or managing employer, is:

- a. the adult beneficiary,
- b. the parent of a minor beneficiary, or
- c. the guardian of the beneficiary.

The Employer of Record may not be an LLC. The Employer of Record may not provide paid supports to the beneficiary.

If the Managing Employer desires assistance, a representative is chosen. If the Managing Employer requires assistance, a representative is appointed. In either scenario, the representative must meet certain guidelines to ensure that the representative functions in the best interests of the beneficiary. The representative may be a family member, friend, someone who has power of attorney, income payee, or another person who willingly accepts responsibility for performing tasks that the Managing Employer is unable to perform or needs assistance with completing.

The representative shall meet all the following requirements:

- a. Demonstrate knowledge and understanding of the beneficiary's needs and preferences and respect these preferences;
- b. Demonstrate evidence of a personal commitment to the beneficiary and be willing to follow the beneficiary's wishes while using sound judgment to act on the beneficiary's behalf;

- c. Agree to a predetermined level of contact with the beneficiary;
- d. Be at least 18 years of age; and
- e. Be willing and able to comply with program requirements and be approved by the beneficiary_or his/her legal representative to act in this capacity.

The representative shall not:

- a. Be paid for being the representative or provide paid supports to the beneficiary; Provide paid trainings to their beneficiary or their staff
- b. Provide paid services to the beneficiary, including employees of agencies providing services, with the exception of guardianship services; and
- c. Have a history of physical, mental or financial abuse.

If a representative is identified, the representative shall be asked to sign the “Representative Agreement”. This agreement outlines the requirements and expectations of the representative in the IFDS option and explains that the representative may be removed for not complying with the agreement. The representative receives training from the Community Navigator in the IFDS option.

The Care Coordinator assesses the Employer of Record, managing employer, and representative, if applicable, to determine the areas of support needed to self-direct services. Standard assessment tools are used with each Employer of Record, managing employer and/or representative. The beneficiary and/or legally responsible person direct the Care Coordinator to add the requested model of Individual and Family Directed Services, either Employer of Record or Agency With Choice, to the ISP and select the services that are to be self-directed. Services are directed to the extent that the beneficiary and/or legally responsible person desire.

The beneficiary, legally responsible person, and Care Coordinator work collaboratively to include supports for self-direction in the ISP including Community Navigator Services. The Community Navigator service will be mandated until the Employer of Record can demonstrate competency in all employer functions. The beneficiary and legally responsible person also choose either a Financial Supports Agency (for the Employer of Record Model) or Agency With Choice Provider, depending on the model of Individual and Family Directed Services elected. The completed ISP is submitted to the PIHP for approval. Emergency and back-up staffing plans are included.

Once the ISP is approved, a referral is made to a Financial Supports Agency for beneficiaries who have elected the Employer of Record model. The Financial Supports Agency assists by assuring that services are managed, and funds distributed as required. The Financial Supports Agency also ensures the required paperwork that is submitted to the Internal and State Revenue Services and facilitates the employment of support staff.

The employer of record:

- a. screens, hires, and trains staff;
- b. manages the individual and family directed budget by setting employee pay rates and benefits through the use of a computer-based auto calculator (Community Navigators are able to assist employers who do not have access to computers or need assistance with the auto calculator and other web-based resources);
- c. provides the supervision of the staff in lieu of supervision that would normally be provided by a qualified professional in a provider directed employment arrangement
- d. submits Incident Reports to the PIHP; and

- e. dismisses employees when necessary.

EOR Background Check

The EOR requests the Financial Support Services (FSS) agency complete the criminal background checks, driver's license checks, and health care registry checks for prospective new employees. The FSS agency will assist with reviewing the background check to ensure the prospective new employee does not have any convictions on the convictions barring employment list. If the employee has a conviction listed in § 108C-4 but not on the Convictions Baring Employment list below, the EOR may elect to hire the employee if the EOR feels the employee can perform the duties of their job while also maintaining the beneficiary's health and safety. The EOR must complete the FSS background check acknowledgement form and maintain a copy of the FSS background check acknowledgement form in the staff's personnel file. The EOR must notify the LME/MCO that they have hired a staff that required completion of the background check acknowledgement form.

All EOR staff must:

- a. Be at least 18 years of age;
- b. If providing transportation, have a valid North Carolina driver's license or other valid driver's license and a safe driving record and has an acceptable level of automobile liability insurance;
- c. Criminal background check presents no health and safety risk to beneficiary;
- d. Not be listed in the North Carolina Health Care Abuse Registry;
- e. Become Qualified in CPR and First Aid;
- f. Become Qualified in the customized needs of the beneficiary as described in the ISP;
- g. Have High school diploma or high school equivalency (GED); and
- h. Be absent of a history of abuse, neglect, exploitation or violent crimes against children or vulnerable adults

Convictions Baring Employment:

A Lifetime hiring ban is place on any individual who has any of the following findings on his or her background check:

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

For beneficiaries who elect the Agency With Choice model, a referral is made to an Agency With Choice. The Agency With Choice serves as the common law employer for employees providing services to the beneficiary.

The managing employer:

- a. screens, interviews and recommends applicants for hire;

- b. ensures that employees are trained (jointly with the Agency With Choice);
- c. provides supervision of staff (with oversight by a qualified professional employed by the Agency With Choice; and
- d. Recommends dismissal, of employees to the agency with choice provider, when necessary.

Agency With Choice are provider agencies who meet the qualifications for service delivery of all NC Innovations services that may be directed under the individual and family supports option. The PIHP requires specific assurances that are included in each provider agency's contract that require the Agency With Choice to maintain policies and procedures that support the control and oversight by beneficiaries and managing employers over employees. These policies and procedures are subject to approval by the PIHP. Agency With Choice must attend PIHP-sponsored trainings and beneficiary/family meetings in Individual and Family Directed Services.

In both models, agreements with the PIHP, the Financial Supports Agency, Agency With Choice and employees outline responsibilities of all parties. Community Navigators assist the Employer of Record, or managing employer, with employer duties and responsibilities, as requested or needed. Beneficiaries in either model of Individual and Family Directed Services have access to Individual Goods and Services when employees begin to provide at least one service to the beneficiary. Beneficiaries in Employer of Record model have access to Employer Equipment and Supplies.

The PIHP provides ongoing support for Individual and Family Directed Services by maintaining a website with information about Individual and Family Directed Services. The PIHP also arrange periodic meetings for employers and managing employers that provide opportunities for meetings with key support agencies, including Care Coordinators, Community Navigators, Agency With Choice and Financial Supports Agencies.

The PIHP monitors Employers of Record annually and provides any needed technical assistance to comply with Individual Family Directed policies and processes. Community Navigator agencies, Financial Supports Agencies, and Agency With Choice providers are monitored at least once every three years at a frequency determined by the PIHP.

The Care Coordinator monitors the delivery of services monthly and reports any concerns regarding the representative to the PIHP. In addition, any concerns about the well-being of a beneficiary may be reported to the PIHP by any party at any time.

Withdrawing from Individual and Family Directed Services

A beneficiary in Individual and Family Directed Services may withdraw from the option at any time by notifying the Care Coordinator. The Care Coordinator prepares a revision to the ISP, and submits the revision to the PIHP, so that provider directed services are authorized for the beneficiary with no service lapse. The following steps are followed when Employer or managing employer requests that the Care Coordinator terminate Individual and Family Directed Services option and return the beneficiary to provider-directed services:

- a. Care Coordinator asks the employer or managing employer to select a provider and updates the ISP to reflect termination of Individual and Family Directed Services and the provider agency selected by the employer or managing employer to provide provider-directed services.
- b. The legally responsible person signs the ISP, and the Care Coordinator submits it to the PIHP for approval.
- c. The PIHP approves the ISP, authorizes provider-directed services and terminates Financial Supports Services.

- d. The PIHP sends a letter to the legally responsible person, Financial Supports Agency, Community Navigator and Agency With Choice notifying them of the termination of Individual and Family Directed Services per the legally responsible person's request the date of the termination of payroll to employees. The letter is copied to the Care Coordinator and NC Medicaid.
- e. The Employer of Record or Agency With Choice notifies staff that they are no longer employed under the Individual and Family Directed Services option.
- f. The finance department reconciles the individual budget with the Financial Supports Agency. Any non-used funds are returned to the PIHP by the Financial Supports Agency.

Note the above steps will also be followed if the Employer of Record becomes incapacitated and an appropriate alternate EOR or representative is not immediately identified

Involuntary Termination from Individual and Family Directed Services

A beneficiary in Individual and Family Directed Services may be removed from Individual and Family Directed Services involuntarily under any one of the following circumstances:

- a. Immediate health and safety concern, including maltreatment of the beneficiary;
- b. Repeated unapproved expenditures/misuse of NC Innovations funds;
- c. No approved representative available when the Employer of Record managing employer in the Agency With Choice Option is determined to need one;
- d. Refusal to accept the necessary Community Navigator services;
- e. Refusal to allow Care Coordinator to monitor services;
- f. Refusal to participate in PIHP, state or federal monitoring;
- g. Non-compliance with individual and family supports, Financial Supports Agency, Agency With Choice and/or employee support agreements; ~~or~~
- h. Inability to implement the approved ISP or comply with NC Innovations requirements, despite reasonable efforts to provide additional technical assistance and support (for event requiring additional technical assistance/corrective action plan in twelve months).

The PIHP may remove a beneficiary from Individual and Family Supports, after consultation with NC Medicaid, in instances when the beneficiary's health and safety are compromised, or after an employer or managing employer has made the same major mistake three different times in one year. A major mistake includes:

- a. the inability to implement the Individual Support Plan and/or
- b. the inability to comply with NC Innovations requirements.

The PIHP shall make reasonable efforts to provide the beneficiary with technical assistance and/or support prior to terminating the Beneficiary Directed Option. The rationale is that each beneficiary should be given every opportunity to be successful in the Beneficiary Directed Service option should he/she desire to participate.

Termination of the Beneficiary Directed Option will occur immediately in the following circumstances:

- a. the individual's health and/or safety are compromised,
- b. misuse of Innovations Waiver funds,
- c. suspected fraud or abuse of funds,
- d. no approved representative when one is required,

- e. refusal to accept required Community Navigator services,
- f. refusal to allow Care Coordination monitoring, and
- g. refusal to participate in PHIP, State, or federal monitoring.

If it is determined at any point in the PIHP investigation that the person immediately needs to be returned to the provider directed option to ensure their health and safety, this can be recommended. The following steps are followed:

- a. Concerns and/or allegations of major problems with the implementation of Individual and Family Directed Services are reported to each PIHP.
- b. The PIHP consultant investigates the concerns or allegations of major problems. The consultant will review all available plans of correction and documentation.
- c. Depending on results of the investigation, the consultant may recommend termination of Individual and Family Directed Services. If the removal is an emergency, the PIHP or the Care Coordinator, contacts the Office of the Medical Director and obtains a decision regarding removal. This decision is reported to NC Medicaid the first working day following the removal.
- d. Termination from the Individual and Family Directed Services option is normally at the end of a month; however, when the termination is due to a threat to the beneficiary's health and safety, such as physical abuse, termination occurs immediately, and provider-directed services resumes immediately.
- e. If the employer/Agency With Choice disagrees with the decision of the PIHP/NC Medicaid, the employer/Agency With Choice may file a reconsideration request or a grievance.
- f. Steps b through g of the voluntary termination procedure are followed to return the beneficiary to the provider-directed supports option.