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

PURPOSE OF THE HCBS WAIVER PROGRAM

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

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

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

1. Major Changes

Describe any significant changes to the approved waiver that are being made in this renewal application:

North Carolina Medicaid is committed to ensuring continued access to Home and Community-Based Services (HCBS) for individuals with traumatic brain injury while advancing long-term program improvements through a structured and evidence-based policy development process. The state received approval from the Centers for Medicare & Medicaid Services (CMS) to participate in a comprehensive technical assistance initiative focused on strengthening the design, delivery, and effectiveness of the Traumatic Brain Injury (TBI) Waiver. The technical assistance process extends into 2027 and includes an in-depth assessment of service design, provider qualifications, participant access, behavioral health integration, level-of-care methodologies, self-direction opportunities, and waiver expansion strategies.

North Carolina Medicaid has determined that submitting the Traumatic Brain Injury (TBI) Waiver renewal application as currently approved represents the most prudent and administratively sound approach ensuring continuity of services and compliance with federal renewal timelines.

At the time of renewal submission, the state is engaged in a multi-phased technical assistance initiative supported by the Centers for Medicare & Medicaid Services (CMS) evaluating opportunities for modernization and enhancement of the TBI waiver program. The findings and recommendations from this process have not yet been fully developed, vetted, or operationalized. As a result, incorporation of significant programmatic changes into the renewal application would be premature and could result in unintended operational, fiscal, or service delivery impacts.

The state has determined that separating the renewal process from future program redesign efforts provides several advantages:

- Ensures uninterrupted access to waiver services for current and prospective participants during the federal review process.
- Maintains compliance with federal waiver renewal requirements and established submission timelines.
- Allows completion of all phases of the CMS-supported technical assistance initiative before implementing substantial policy changes.
- Provides sufficient time for stakeholder engagement, including waiver participants, families, providers, advocacy organizations, and other interested parties.
- Supports comprehensive fiscal, operational, and systems analyses related to proposed enhancements.
- Reduces the risk of implementing multiple large-scale changes simultaneously during a renewal cycle.

Accordingly, North Carolina Medicaid is requesting CMS approval of the waiver renewal based on the currently approved program structure while reserving the ability to pursue future amendments that reflect the recommendations and outcomes of the ongoing technical assistance activities.

The state's decision to submit the waiver renewal without incorporating significant programmatic revisions should not be interpreted as a decision to forgo enhancements identified through the technical assistance process. Rather, the state intends to use the renewal period to complete the ongoing evaluation, engage stakeholders, and develop amendment proposals that are operationally feasible, fiscally sustainable, and aligned with CMS expectations for person-centered Home and Community-Based Services.

Upon approval of the renewal application, North Carolina Medicaid anticipates submitting one or more waiver amendments to address policy and programmatic changes identified through the technical assistance initiative, including potential modifications to service delivery models, provider qualifications, participant access strategies, behavioral health integration, self-direction opportunities, and other waiver enhancements.

By renewing the waiver in its current form and addressing modernization efforts through subsequent amendments, North Carolina Medicaid can ensure program stability while providing CMS with fully developed proposals supported by data analysis, stakeholder input, implementation planning, and quality oversight considerations. This phased approach promotes transparency, minimizes disruption to participants and providers, and supports thoughtful, evidence-informed program improvement consistent with the objectives of the Medicaid HCBS authorities.

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

1. Request Information (1 of 3)

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

B. Program Title (*optional - this title will be used to locate this waiver in the finder*):

TBI Waiver

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Draft ID: **NC.027.02.00**

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

Model Waiver

E. Proposed Effective Date: *(mm/dd/yy)*

04/01/27

PRA Disclosure Statement

The purpose of this application is for states to request a Medicaid Section 1915(c) home and community-based services (HCBS) waiver. Section 1915(c) of the Social Security Act authorizes the Secretary of Health and Human Services to waive certain specific Medicaid statutory requirements so that a state may voluntarily offer HCBS to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid state plan. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449 (Expires: July 31, 2027). The time required to complete this information collection is estimated to average 163 hours per response for a new waiver application and 78 hours per response for a renewal application, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Request Information (2 of 3)

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

☑ **Hospital**

Select applicable level of care

◉ **Hospital as defined in 42 CFR § 440.10**

If applicable, specify whether the state additionally limits the waiver to subcategories of the hospital level of care:

Specialty Hospital Rehabilitative Level of Care to support people with brain injury who have significant cognitive, behavioral and rehabilitative needs.

○ **Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR § 440.160**

☑ **Nursing Facility**

Select applicable level of care

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

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

Specialized nursing facility with services to support people with brain injury who have significant cognitive, behavioral and rehabilitative needs.

○ **Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR § 440.140**

☐ **Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR § 440.150)**

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

1. Request Information (3 of 3)

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

Select one:

- ○ **Not applicable**
- ● **Applicable**

Check the applicable authority or authorities:

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

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

The Waiver operates concurrently with the 1915 (b) authority for AI/AN who chose to opt out of Tailored Care Management.

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

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

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

Specify the nature of the state plan benefit and indicate whether the state plan amendment has been submitted or previously approved:

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

Specify the program:

This waiver operates concurrently with the NC Medicaid Reform Demonstration 1115 Waiver.

H. Dual Eligiblity for Medicaid and Medicare.

Check if applicable:

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

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The NC TBI waiver operates concurrently with the 1115 Waiver and 1915(b). LME/MCOs are area authorities, county programs, or consolidated human services agencies that are designated in State law as "the locus of coordination" for publicly funded mental health, intellectual/developmental disabilities and substance misuse services in their respective catchment areas. LME/MCOs function as fully capitated prepaid inpatient health plans (PIHPs) through which all State Plan MH, SA and IDD services and TBI waiver services are delivered.

Purpose: The waiver is designed to provide and array of community-based services and community alternatives for individuals with traumatic brain injuries who are currently in nursing facilities or specialty rehabilitation hospitals or who are in the community and at risk for placement in nursing facilities or specialized rehabilitation hospitals. The NC TBI Waiver is designed to provide an array of community-based rehabilitative services and supports that facilitates recovery and promotes choice, independence and community involvement. These services provide a community-based alternative to institutional care for persons who continue to require a Specialty Hospital level of care or require a Skilled Nursing Facility (SNF) level of care.

Goals of the NC TBI Waiver:

(1) Value and support waiver beneficiaries to be fully functioning members of their community.
(2) Promote rehabilitation; evidence based practices, and promising practices that result in real life outcomes for beneficiaries.
(3) Offer person centered service options that will facilitate each beneficiary's ability to live in homes of their choice, have employment or engage in a purposeful day of their choice and achieve their life goals.
(4) Provide the opportunity for all beneficiaries to contribute to the development of their services.
(5) Provide training and support to foster the development of strong natural support networks that enable beneficiaries to be less reliant on formal support systems.
(6) Ensure the well-being and safety of the people served.
(7) Maximize the beneficiary's self-determination, self-advocacy and self-sufficiency.
(8) Increase opportunities for community integration through work, life-long learning, recreation and socialization.
(9) Provide quality services and improve outcomes.

Objectives in the NC TBI waiver include:
(1) Enhancing the focus on person centered planning and aligning services and supports with those plans.
(2) Facilitating smaller community congregate living situations.
(3) Facilitating living and working in the most integrated setting.
(4) Improving outcome-based quality assurance systems.

Service Delivery Methods: Services are provided through local management entities (LMEs) operating as prepaid inpatient health plans. The LME/PIHPs are responsible for providing services to all waiver beneficiaries in their respective geographic catchment areas, most of which cover multiple counties. Enrollment in the LME/PIHP serving one's county of residence is mandatory for all TBI waiver beneficiaries and other Medicaid eligibility groups specified in the concurrent 1915(b) waiver. Within three years of contracting with the State as a prepaid health plan, the LME must be accredited by NCQA, Utilization Review Accreditation Commission (URAC) or other accreditation agencies recognized by CMS. NC TBI waiver services are authorized through the annual Individual Support Plan (ISP), which is developed using person centered planning methods. Waiver beneficiaries may select any qualified network provider to furnish authorized services.

Beneficiaries in the waiver have a Tailored Care Manager/Care Coordinator who assists them in developing an ISP, ensuring the beneficiary's health and safety needs are met, that services and supports are provided in the most integrated setting, and that the beneficiary is satisfied with the services and supports they are receiving. Services are delivered through a network of contracted community-based service providers that are charged with implementing waiver participants' ISPs by providing services and supports that enhance the beneficiary's quality of life as defined by the beneficiary. National accreditation is required of providers of waiver services.

3. Components of the Waiver Request

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

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

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver,

the number of participants that the state expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

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

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

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

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

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

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

H. Quality Improvement Strategy. Appendix H contains the quality improvement strategy for this waiver.

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

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

4. Waiver(s) Requested

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

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

- ○ **Not Applicable**
- ○ **No**
- ● **Yes**

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

- ○ **No**
- ● **Yes**

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

☑ **Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the state.
Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:

Alliance Behavioral Health (Cumberland, Durham, Harnett, Johnston, Mecklenburg, Orange, and Wake Counties).

☐ **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make

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

5. Assurances

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

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

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;

2. Assurance that the standards of any state licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and,

3. Assurance that all facilities subject to section 1616(e) of the Act where home and community-based waiver services are provided comply with the applicable state standards for board and care facilities as specified in **Appendix C**.

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

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

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

1. Informed of any feasible alternatives under the waiver; and,

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

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

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

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

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

F. FFP Limitation. In accordance with 42 CFR Part 433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. If a provider certifies that a particular legally liable third-party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The state provides the opportunity to request a Fair Hearing under 42 CFR Part 431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the state's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR § 431.210.

H. Quality Improvement. The state operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the state assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight

and (f) administrative oversight of the waiver. The state further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the state will implement the quality improvement strategy specified in **Appendix H**.

I. Public Input. Describe how the state secures public input into the development of the waiver:

NC Medicaid Tailored plans were initially scheduled to go live in December 2022, but DHHS delayed the launch to give the LME-MCOs more time to prepare. Tailored Plans were delay in 2023, to ensure beneficiaries could seamlessly receive care on day one, the North Carolina Department of Health and Human Services (NCDHHS) announced in 2024 that Tailored Plans would go live July 1, 2024.

Stakeholder engagement initiated in 2022, Public comment was included in the March 1, 2024 amendment for reference and can be reviewed below:

The following public venues have been used to provide information/obtain stakeholder input on the waiver program and transition to the 1115, specifically to the changes being requested in this TA:
- Beneficiary, advocate and provider input on the Tailored Plan exchanges through Provider and Beneficiary Listening Sessions which were held virtually on a Monthly Basis from 4/1/20 and are ongoing.

- I/DD State Stakeholder Meetings which occurred 9/22, 7/22, 4/22 and 1/22.
- Tribal officials of the Eastern Band of the Cherokee were notified of the 1115 Waiver changes and the opportunity for input on by a formal written notice. We have consulted with our federally-recognized tribe, the Eastern Band of Cherokee Indians, and incorporated their feedback to the extent possible. This document reflects the consultation process.

Beneficiary, advocate and provider input on needed TBI services and systems were obtained through meetings with the Brain Injury Advisory Association of North Carolina, the Brain Injury Advisory Council, the State Wide TBI Stakeholder group that meet quarterly, providers with in the current TBI Waiver, the TBI Specialists at the various LME-MCOs, presentations at NC TIDE and two open webinars for individuals interested in the TBI Waiver. The TBI Waiver changes were explained during an open webinar held in October of 2020.

More recent Stakeholder engagement regarding the renewal of the 1115 waiver and the transition of the 1915(c) TBI Waivers were held in 2023. Public hearing notices and listening sessions were initiated in 2023. Public comments specific to the TBI Waiver overwhelmingly supported the design and implementation of Tailored plan. Other comments requested the department ensure understanding of the Whole person integrated care, ensuring engagement Tailored Plan Care managers, supporting the TBI population to reenter their community from DOJ, and ensuring investments in technology enables TBI individuals to live more independently.
J. Notice to Tribal Governments. The state assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a

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

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

7. Contact Person(s)

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

Last Name: Ludlam

First Name: Jay

Title: Deputy Secretary for Medicaid

Agency: Division of Health Benefits, North Carolina Department of Health & Human Services

Address: 2501 Mail Service Center

Address 2:

City: Raleigh

State: **North Carolina**

Zip: 27699-2501

Phone: (919) 855-4105 **Ext:** ☐ **TTY**

Fax: (919) 733-0137

E-mail: Jay.Ludlam@dhhs.nc.gov

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

Last Name: Staton

First Name: Betty

Title: State Plan Administrator

Agency: Division of Health Benefits, North Carolina Department of Health & Human Services

Address: 2501 Mail Service Center

Address 2:

City: Raleigh

State: **North Carolina**

Zip:

27699-2501

Phone:

(919) 527-7093 **Ext:** ☐ **TTY**

Fax:

(919) 733-0137

E-mail:

Betty.Stanton@dhhs.nc.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under section 1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature:

State Medicaid Director or Designee

Submission Date:

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

Last Name:

First Name:

Title:

Agency:

Address:

Address 2:

City:

State: **North Carolina**

Zip:

Phone:

Ext: **TTY**

Fax:

E-mail:

Attachments

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- **Replacing an approved waiver with this waiver.**
- **Combining waivers.**
- **Splitting one waiver into two waivers.**
- **Eliminating a service.**
- **Adding or decreasing an individual cost limit pertaining to eligibility.**
- **Adding or decreasing limits to a service or a set of services, as specified in Appendix C.**
- **Reducing the unduplicated count of participants (Factor C).**
- **Adding new, or decreasing, a limitation on the number of participants served at any point in time.**
- **Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.**
- **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

Effective July 1, 2024, North Carolina will launch the Behavioral Health and Intellectual/Developmental Disabilities Tailored Plan on July 1, 2024. Tailored Pans are an integrated health plan for individuals with behavioral health needs and intellectual/developmental disabilities (I/DD), and will operate under the managing authority of the 1115 Waiver.

Tailored Plans will serve special populations including Innovations and Traumatic Brain Injury (TBI) waiver enrollees (and waitlist members) and will be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities and TBI services for uninsured and underinsured North Carolinians.

The plan to transition TBI Waiver beneficiaries into the Tailored Plan will occur through Tailored Care Management (TCM). Tailored Care Management (TCM) is a new care management model that began Dec. 1, 2022, for eligible NC Medicaid beneficiaries. TCM will provide eligible beneficiaries a single designated care manager, supported by a multidisciplinary team, to provide integrated care management to address the beneficiary's whole-person health needs.

Tailored Care Management includes connection to resources and other programs including assistance with locating volunteer activities that may interested the beneficiary or connection to other social service type programs that the beneficiary may be available to the beneficiary.

Tailored Care Management is available on an ongoing basis to Medicaid beneficiaries served by the LME/MCOs (and will be available ongoing by the Tailored Plans).

The Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Care Management (TCM) model reflects the goal of whole-person care management in NC Medicaid Managed Care. Provider-based care management promotes integrated care and offers beneficiaries choice in how they receive care management.
Through TCM, Behavioral Health I/DD Tailored Plan beneficiaries will have a single designated care manager supported by a multidisciplinary care team to provide whole-person care management that addresses all of their needs including physical health, behavioral health, I/DD, traumatic brain injuries (TBI), pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs. Tailored Care Management will:

- Be available throughout the entire duration of a beneficiary's enrollment in a Behavioral Health I/DD Tailored Plan.
- Be based in provider settings to the maximum extent possible, supporting integrated care and collaboration.
- Prioritize frequent in-person interactions between community-based care managers and beneficiaries.
- Place additional emphasis on outcomes and population health management.
- Effective, integrated and well-coordinated care management depends on care team members having the ability to efficiently exchange member health information and use that information to monitor and respond to medical and nonmedical issues that could impact beneficiaries.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

For 10/1 Amendment
Accepted Feedback: add home delivered meals (1 meal per day); allow some services via telehealth or virtual; allow relatives to provide up to 40 hours a week total of a Life Skills Training and/or Personal Care

Rejected Feedback:
none at this time

Accepted Feedback:

Resource Facilitation:
Added Supports the person in the person-centered planning process
Added Supports the person in coordinating financial planning.

Rejected Feedback:
Relative as Provider has not been added in the TBI Waiver renewal application and will be added in a future Appendix K submission. Adding relatives as direct support professional was rejected as this waiver is for adult beneficiaries and the State has concerns about survivors' ability to return to an independent life if they have related staff. The state is in the process of requesting this flexibility through the Appendix K to inform if relatives as providers should be included in the waiver long-term.

Maintaining the age of injury at 22 years of age as eligibility criteria. The state received limited feedback to maintain the age of injury, at 22, for access to the TBI Waiver. This feedback was rejected as the state received support from many other individuals and entities to reduce the age of injury to 18

Appendix A: Waiver Administration and Operation

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

   ◉ **The waiver is operated by the state Medicaid agency.**

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

   ◉ **The Medical Assistance Unit.**

   Specify the unit name:
   The Division of Health Benefits, NC Department of Health and Human Services
   (Do not complete item A-2)

   ○ **Another division/unit within the state Medicaid agency that is separate from the Medical Assistance Unit.**

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

   (Complete item A-2-a).

   ○ **The waiver is operated by a separate agency of the state that is not a division/unit of the Medicaid agency.**

   Specify the division/unit name:

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

Appendix A: Waiver Administration and Operation

2. Oversight of Performance.

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

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

Appendix A: Waiver Administration and Operation

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

- (●) **Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or operating agency (if applicable).**
  Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.:*

  DHB contracts with the following entities which assist with administrative and operational activities:

  An external Quality Review Organization (EQRO) for quality reviews of the PIHPs/Tailored Plans;

  An MMIS contractor which assists with recipient enrollment and payment;

  An actuarial contractor which assists with setting the capitated payments the PIHPs/Tailored Plans

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

Appendix A: Waiver Administration and Operation

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

- ( ) **Not applicable**
- (●) **Applicable** - Local/regional non-state agencies perform waiver operational and administrative functions.
  Check each that applies:

☐ **Local/Regional non-state public agencies** perform waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the state and these agencies that sets forth responsibilities and performance requirements for these agencies that is available through the Medicaid agency.

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

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

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

DHB contracts with LME-MCOs (PIHP)/Tailored Plans for the delivery of all Medicaid MH/IDD/SUS and Physical Health services, including NC TBI waiver services. PIHP/Tailored Plan conduct the following operational and administrative activities: utilization management and prior approval activities, provider network credentialing and enrollment and provider reimbursement.

The waiver responsibilities and performance requirements are set forth in a contract between the Division of Health Benefits and each LME-MCO operating under the waivers.

Appendix A: Waiver Administration and Operation

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

DHB, the State Medicaid Agency, is responsible for assessing the performance of the PIHPs/Tailored Plan in conducting operational and administrative functions. The DHHS Office of the MMIS and DHB oversee the performance of the MMIS contractor. DHB oversees the rate setting and external quality review contractors.

Appendix A: Waiver Administration and Operation

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Oversight and performance of the PIHPs is performed though regular data submissions related to internal quality assurance/improvement activities such as beneficiary and provider surveys, performance measures, complaints and grievances and other issues or concerns that affect service delivery. Corrective action plans as utilized as needed. Contracts with the rate setting and external quality review contractors outline specific performance expectations which the contractor must meet. DHB assesses deliverables and performance on an ongoing basis and implement corrective action plans as needed. The MMIS contract also outlines specific expectations and deliverables and performance assessment is monitored on an ongoing basis by DHB and DHHS contract managers.

Appendix A: Waiver Administration and Operation

7. **Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):
In accordance with 42 CFR § 431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. *Note: More than one box may be checked per item. Ensure that Medicaid is checked when the Single State Medicaid Agency (1) conducts the function directly; (2) supervises the delegated function; and/or (3) establishes and/or approves policies related to the function.* Note: Medicaid eligibility determinations can only be performed by the State Medicaid Agency (SMA) or a government agency delegated by the SMA in accordance with 42 CFR § 431.10. Thus, eligibility determinations for the group described in 42 CFR § 435.217 (which includes a level-of-care evaluation, because meeting a 1915(c) level of care is a factor of determining Medicaid eligibility for the group) must comply with 42 CFR § 431.10. Non-governmental entities can support administrative functions of the eligibility determination process that do not require discretion including, for example, data entry functions, IT support, and implementation of a standardized level-of-care evaluation tool. States should ensure that any use of an evaluation tool by a non-governmental entity to evaluate/determine an individual's required level-of-care involves no discretion by the non-governmental entity and that the development of the requirements, rules, and policies operationalized by the tool are overseen by the state agency.

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☑	☑	☑
Waiver enrollment managed against approved limits	☑	☐	☑
Waiver expenditures managed against approved levels	☑	☐	☑
Level of care waiver eligibility evaluation	☑	☐	☑
Review of Participant service plans	☑	☑	☑
Prior authorization of waiver services	☑	☐	☑
Utilization management	☑	☐	☑
Qualified provider enrollment	☑	☐	☑
Execution of Medicaid provider agreements	☑	☐	☑
Establishment of a statewide rate methodology	☑	☑	☐
Rules, policies, procedures and information development governing the waiver program	☑	☐	☐
Quality assurance and quality improvement activities	☑	☑	☑

Appendix A: Waiver Administration and Operation

Quality Improvement: Administrative Authority of the Single State Medicaid Agency

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

a. Methods for Discovery: Administrative Authority

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

i. Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Performance measures for administrative authority should not duplicate measures found in other appendices of the waiver application. *As necessary and applicable, performance measures should focus on:*

- Uniformity of development/execution of provider agreements throughout all geographic areas covered by

the waiver
- Equitable distribution of waiver openings in all geographic areas covered by the waiver
- Compliance with HCB settings requirements and other new regulatory components (for waiver actions submitted on or after March 17, 2014)

Where possible, include numerator/denominator.

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

Performance Measure:
Adequate capacity&choice: Outpatient services/location-based/community/mobile services(choice of 2 providers)Crisis services/inpatient services access to at least 1 provider of each type service w/i the catchment area) Num: #of PIHPs whose Network capacity studies and geo mapping show 2 available providers within a 30 min/30 mi radius through out the catchment area. Den: Total#of PIHPs

Data Source (Select one):
Other
If 'Other' is selected, specify:
Network capacity studies and geo mapping

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

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: PIHPs analyze findings in a report to DHB and DHB reviews/confirms report	☑ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
PM4 DHB ensures that LME/PIHP follow the Plan of Care Approval and Implementation Processes. Numerator: Number of LME/PIHP following the Plan of Care Approval and Implementation Processes Denominator: Total Number of LME/PIHP

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of waiver participant records and UM records maintained by the PIHP

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

☑ **Other** Specify: Contracted external quality review organization (EQRO)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM5: DHB ensures that LME-MCOs/PIHPs submit information in a complete and timely manner. Numerator: Number of LME-MCOs/PIHPs that submit performance measure information in a complete and timely manner Denominator: Total Number of LME-MCOs/PIHPs

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of PIHP and DHB documentation of submission and receipt of reporting

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Contracted external quality review organization (EQRO)	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Performance Measure: DHB ensures that LME/PIHP follow the enrollment/monitoring process for newly enrolled providers. Numerator: Number of LME/PIHPs following the enrollment/monitoring process for newly enrolled providers Denominator: Total Number of LME/PIHPs

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of provider records maintained by the PIHP

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

	Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM3 DHB ensures that LME/PIHP follow the Level of Care Approval Process. Numerator: Number of LME/PIHP following the Level of Care Approval Process Denominator: Total Number of LME/PIHP

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of waiver participant records maintained by the PIHP

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

☑ **Other** Specify: Contracted external quality review organization (EQRO)	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
PM2 DHB ensures that LME/PIHP follow the ongoing monitoring process for enrolled providers. Numerator: Number of LME/PIHP following the monitoring process for enrolled providers Denominator: Total Number of LME/PIHP

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of provider records maintained by the PIHP

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

Data Aggregation and Analysis:

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

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
Contracted external quality review organization (EQRO)	
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The PIHPs will address and correct problems identified on a case-by-case basis in accordance with their contracts with the DHB. The PIHP will notify the State immediately of any situation in which the health and safety of a beneficiary is jeopardized. DHB requires a corrective action plan for the problems identified. DHB monitors the corrective action plan with the assistance. The LME-MCO will notify the State immediately of any situation in which the health and safety of a beneficiary is jeopardized.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design

methods for discovery and remediation related to the assurance of Administrative Authority that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix B: Participant Access and Eligibility

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

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

Target Group	Included	Target Sub Group	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☐ **Aged or Disabled, or Both - General**					
	☐	**Aged**			☐
	☐	**Disabled (Physical)**			
	☐	**Disabled (Other)**			
☑ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☑	**Brain Injury**	18		☑
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

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

The NC TBI waiver targets individuals who meet Skilled Nursing Facility (SNF) and Specialty hospital eligibility. Skilled Nursing criteria is defined in the Division of Medical Assistance Clinical Coverage Policy 2B-1 on the DHB website at https://files.nc.gov/ncdma/documents/files/2B-1_1.pdf. Admission of individuals to the Specialty hospital eligibility is is guided by the general criteria for patients with the diagnosis of brain injury with persisting cognitive and behavioral impairments that necessitate 24-hour care and supervision. The beneficiary must also demonstrate the potential to benefit from specialized rehabilitation and requires specialized brain injury services and/or supports that exceed services available through the SNF eligibility.

New Beneficiaries to this waiver will live with private families or in living arrangements in 6 beds or less.

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

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

Specify:

Appendix B: Participant Access and Eligibility

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

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

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

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

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

  Specify the percentage: [ ]

- (•) **Other**

  Specify:

  $135,000.

  Assistive Technology, Home Modifications and Vehicle Modification up to the cost limits described in the service definitions may be added in addition to the maximum cost limit for beneficiaries not utilizing Supported Living Level III.

- ( ) **Institutional Cost Limit.** Pursuant to 42 CFR § 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

Complete Items B-2-b and B-2-c.

Cost Limit Lower Than Institutional Costs. The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

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

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

The following dollar amount:

Specify dollar amount:

The dollar amount *(select one)*

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

Specify the formula:

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

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

Specify percent:

Other:

Specify:

Appendix B: Participant Access and Eligibility

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

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

Individuals may apply for the NC TBI waiver by contacting the PIHP/Tailored Plan Access Center. The intake/screening process is intended to be the preliminary determination of an individual's potential eligibility for services based on the eligibility criteria and need for waiver services. The screening process consists of a comprehensive clinical review including the administration of the TBI Level of Care Form, and the NC TBI Waiver Risk/Support Needs Assessment to determine whether the waiver can meet the individual's needs. If health and/or safety risks are identified the PIHP/Tailored Plan clinical director (MD, DO, or PhD) will review the assessments and make a determination as to whether the individual's needs can be met by the waiver. Written notice of the outcome of this assessment will be provided to the individual. If an individual is terminated from the waiver, the PIHP/Tailored Plan sends a written notice explaining the reason for the adverse action, instructions on how to access a fair hearing, the time frame for making the request, information on the continuation of services during the appeal (if applicable) and contact information for questions and concerns. If entrance to the waiver is denied, the person must be given formal written notice of the denial and information about how to request a Fair Hearing to appeal the denial of entrance to the waiver.

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

☐ **The participant is referred to another waiver that can accommodate the individual's needs.**

☑ **Additional services in excess of the individual cost limit may be authorized.**

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

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

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

An individual requesting services and supports in excess of the $135,000 cost limit must make this request through his or her Individual Support Plan or Plan Update process. Services and Supports that exceed the $135,000 must be prior approved by the beneficiary's LME-MCO and must be related to the beneficiary's needs and not for the convenience of the provider agency or caregiver.

Beneficiaries not utilizing Supported Living Level III may exceed the $135,000 waiver limit, to ensure health, safety and wellbeing, through the use of Assistive Technology, Home Modifications and Vehicle Modification.

This information will be shared in an official communication. The TBI Waiver Tailored Care Manager/Care Coordinator will provide this communication to the members who fall near the cost limit or who may be in excess of the limit.

☑ **Other safeguard(s)**

Specify:

If an individual chooses not to participate in the NC TBI Waiver and is still eligible for Medicaid, other Medicaid services for which the individual met medical necessity criteria, including Skilled Nursing placement would be made available. The individual's Tailored Care Manager/Care Coordinator will inform him/her of the other state and/or local services and supports available in lieu of waiver services.

All opportunities to revise the plan of care will be explored if a beneficiary can no longer be served within the cost limit of the waiver. If services are unable to be provided within the cost limit of the waiver, the Tailored Care Manager/Care Coordinator will develop a discharge plan with the beneficiary and representative/s. If nursing facility placement is appropriate and acceptable to the beneficiary, Tailored Care Manager/Care Coordinator will provide guidance in how to locate a nursing facility in their community.

Appendix B: Participant Access and Eligibility

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

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

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	107
Year 2	107
Year 3	107
Year 4	107
Year 5	107

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

- (●) **The state does not limit the number of participants that it serves at any point in time during a waiver year.**
- ( ) **The state limits the number of participants that it serves at any point in time during a waiver year.**

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

Table: B-3-b

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

Appendix B: Participant Access and Eligibility

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

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

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

Purpose(s) the state reserves capacity for:

Purposes	
Emergencies	
Money Follows the Person	

Appendix B: Participant Access and Eligibility

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

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

Emergencies

Purpose *(describe):*

Reserved capacity is for emergency needs in which the individual is at risk of imminent, significant harm.

Describe how the amount of reserved capacity was determined:

Emergency capacity is based upon historical experience as to who were determined to be in an emergency situation requiring immediate admission to the TBI waiver.

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

Waiver Year	Capacity Reserved
Year 1	3
Year 2	3
Year 3	3
Year 4	3
Year 5	3

Appendix B: Participant Access and Eligibility

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

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

Money Follows the Person

Purpose *(describe):*

Capacity is being reserved to transition individuals using the Money Follows the Person (MFP) federal grant for participants who meet the criteria for MFP and choose to receive home and community-based services.

Describe how the amount of reserved capacity was determined:

MFP reserve capacity is based upon historial experience as to people who have chosen to enter the MFP program and anticipated related transitions.

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

Waiver Year	Capacity Reserved
Year 1	3
Year 2	3

Waiver Year	Capacity Reserved
Year 3	3
Year 4	3
Year 5	3

Appendix B: Participant Access and Eligibility

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

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

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

e. Allocation of Waiver Capacity.

Select one:

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

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

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

Individuals who seek services funded through the NC TBI waiver will be served on a first come -first serve basis.

Screening for Potential Waiver Eligibility:
Individuals make application for the NC TBI waiver by contacting the PIHP/Tailored Plan. The intake screening process is intended to be the preliminary determination of an individual's potential eligibility for services based on the waiver eligibility criteria (See B:1-b)
and need for waiver services. The screening process consists of a comprehensive clinical review inclusive of the administration of the NC TBI Risk /Support Needs Assessment, to determine whether the waiver can meet the individual's needs. If health and/or safety risks are identified, the PIHP/Tailored Plan will review the assessments and make a determination as to whether the individual's needs can be met on the waiver. Written notification of the outcome of this assessment will be provided to the individual.

Individuals determined to be potentially eligible for the waiver are placed on the TBI Waiver Registry of Unmet Needs, if waiver funding is not available.

Reserved Capacity:
When reserved capacity is available, individuals who meet the criteria for reserved capacity slots will have first access to these slots.

Reserved capacity for emergency needs:
Individuals who present with emergency needs are offered entrance to the waiver ahead of other individuals to the extent that reserved capacity is available. A clinical team, inclusive of at least one of the following: medical director (psychiatrist) or the IDD / MH clinical director and a minimum of one TBI specialist, assesses the emergency situation. A person is considered to have emergency needs when the individual meets the following eligibility criteria and no other service systems can meet the identified need:
The individual is at significant, imminent risk of serious harm which is documented by a professional and meets one or more of the following criteria:
(1) The primary caregiver(s)/support system is/are not able to provide the level of support necessary to meet the person's exceptional behavioral and exceptional medical needs and documented risk issues.
(2) The individual requires protection from confirmed abuse, neglect or exploitation as documented by the Department of Social Services.

Reserved capacity for Money Follows the Person (MFP):
When reserved capacity is available, individuals who meet the criteria for Money Follows the Person and choose to receive home and community-based services will receive priority consideration for these reserved slots. If reserved capacity is not available, individuals will be prioritized for entrance to the waiver based on non-reserved criteria.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. **1. State Classification.** The state is a *(select one)*:

- (•) **Section 1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (•) **No**
- ( ) **Yes**

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

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

- ☐ **Parents and Other Caretaker Relatives (42 CFR § 435.110)**
- ☐ **Pregnant Women (42 CFR § 435.116)**
- ☐ **Infants and Children under Age 19 (42 CFR § 435.118)**
- ☑ **SSI recipients**
- ☐ **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR § 435.121**
- ☑ **Optional state supplement recipients**
- ☑ **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

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

    Specify percentage:

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

  Specify:

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

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

  Select one and complete Appendix B-5.

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

Check each that applies:

☐ **A special income level equal to:**

Select one:

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

  Specify percentage: ☐
- ○ **A dollar amount which is lower than 300%.**

  Specify dollar amount: ☐

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR § 435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR § 435.320, § 435.322 and § 435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR § 435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

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

  Specify percentage amount: ☐

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

Specify:

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR § 441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR § 435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR § 435.217 group.

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

b. Regular Post-Eligibility Treatment of Income: Section 1634 State and SSI Criteria State after September 30, 2027

(or other date as required by law).

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

c. Regular Post-Eligibility Treatment of Income: 209(b) State or after September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time period after September 30, 2027 (or other date as required by law).

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules after September 30, 2027 (or other date as required by law)

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

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

e. Regular Post-Eligibility Treatment of Income: Section 1634 State or SSI Criteria State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

f. Regular Post-Eligibility Treatment of Income: 209(b) State - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the period beginning January 1, 2014 and extending through September 30, 2027 (or other date as required by law).

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - January 1, 2014 through September 30, 2027 (or other date as required by law).

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

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

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

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

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

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

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

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

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

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

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

Specify the entity:

Each PIHP/Tailored Plan performs the level of care evaluation for the waiver beneficiary.

Other
Specify:

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

Persons performing initial evaluations of level of care for waiver beneficiaries are psychologists, psychological associates, physicians as appropriate based on the disability of the beneficiary. All professionals must hold current licensure in the state of North Carolina. Nurse practitioners (NPs) and physicians' assistants(PAs), may complete the initial level of care only if the attending physician co-signs and dates the form.

Item a.i above specifies that the individual must require at least one service to participate in the waiver. The following exclusions to the one service are added: Assistive Technology, Vehicle Modifications, Home Modifications, Community Transition, and Respite.

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

The NC TBI waiver targets individuals who meets SNF and Specialty Hospital eligibility criteria defined in The Division of Health Benefits Clinical Coverage Policy on the DHB website at https://files.nc.gov/ncdma/documents/files/2B-1_1.pdf.

The NC TBI Level of Care Assessment tool is used to determine the initial Level Of Care (LOC)for each waiver beneficiary. Annual re-assessment of LOC is confirmed by the Tailored Care Manager/Care Coordinator.

For Nursing Facility Level of Care, the following must be met:
1. Modified Rancho Los Amigos © Level of Cognitive Functioning Level IV through VIII.

2. Cognitive support needs - One impairment in Awareness, Communication, Judgement, Memory, Planning, Problems Solving skills AND one other cognitive skill OR Impairment in three or more cognitive functions with at least two of the three functions requiring "Present / Requires frequent support" or "Present and severe, requires availability of "24-hour support" or monitoring level of intensity.

3. Behavior Assessment Grid indicates impairment in two or more of the following areas:

- Agitation
- Impulsivity
- Intrusiveness
- Legal history after brain injury
- Pica
- Socially offensive behavior
- Susceptibility to victimization
- Verbal aggression
- Wandering/ Elopement
- Withdrawal
- Damage to Property
- Inappropriate sexual activity
- Injury to others
- Injury to self
- Physical Aggression

4. Behavioral Support at one of the following levels:
- Needs and receives occasional staff intervention in the form of cues because the person is anxious, irritable, lethargic or demanding. Person responds to cues. "Occasional" is defined as less than 4 times per week.
- Needs and receives regular staff intervention in the form of redirection because the person has episodes of disorientation, hallucinates, wanders, is withdrawn or exhibits similar behaviors. Person may be resistive, but responds to redirection. "Regular" is defined as 4 or more times per week.
- Needs and receives behavior management and staff intervention because person exhibits disruptive behavior such as verbally abusing others, wandering into private areas, removing or destroying property, or
- Needs and receives behavior management and staff intervention because person is physically abusive to self and others. Person may physically resist redirection.

5. Requires level of specialized cognitive and behavioral support(s) available in a nursing facility that provided brain injury services. A person does not have to be a resident of a nursing facility to require this level of care.

For Specialty Hospital Level of Care, the following must be met:
1. Behavior Assessment Grid indicates impairment that is present and severe AND requires the availability of intensive behavior intervention in two or more of the following areas:
- Damage to property,
- Inappropriate sexual activity,
- Injury to others, Injury to self,
- Physical aggression

2. Behavioral Support at one of the following levels:
- Needs and receives occasional staff intervention in the form of cues because the person is anxious, irritable, lethargic

or demanding. Person responds to cues. "Occasional" is defined as less than 4 times per week and Needs and receives regular staff intervention in the form of redirection because the person has episodes of disorientation, hallucinates, wanders, is withdrawn or exhibits similar behaviors. Person may be resistive, but responds to redirection. "Regular" is defined as 4 or more times per week.

- Needs and receives behavior management and staff intervention because person exhibits disruptive behavior such as verbally abusing others, wandering into private areas, removing or destroying property, or acting in a sexually aggressive manner. Person may be resistant to redirection.
- Needs and receives behavior management and staff intervention because person is physically abusive to self and others. Person may physically resist redirection.

3. Requires services and/or supports that exceed services in TBIW-NF.

4. Requires a 24-hour plan of care that includes a formal behavioral support plan.

5. Requires level of care and behavioral support available in a neurobehavioral hospital; available intensive behavior intervention. A person does not have to be a resident of a neurobehavioral hospital to require this level of care.

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

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

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

The NC TBI Level of Level of Care form integrates information from the FL-2 (SNF) level of care are well as including information appropriate for Specialty Hospital Level of Care. While the TBI waiver level of care tool is similar to the FL-2 level of care tool for nursing facilities, the TBI Waiver level of care tool is designed to more specifically to obtain information related to the unique needs of the TBI population as many survivor's of TBI have cognitive and behavioral support needs that are not captured in the traditional medical model.

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

Initial Level of Care Criteria:

Evaluations are completed by a psychologist, licensed psychological associate or physician, as defined in NC General Statutes 122C-3 and as appropriate based on the individual's specific clinical issue. The form used to document the initial LOC determination is called the NC TBI Level of Care Assessment.

Re-evaluation of LOC:
Re-evaluation of LOC is completed annually during or up to 30 days prior to the birth month of the beneficiary. Re-evaluations are completed by qualified professionals who are Tailored Care Managers/ Care Coordinators employed by or contracted with the PIHP/tailored Plan, using the annual recommendation for LOC, a component of the ISP.

Annual assessments include the completion of an assessment of risks and support needs and review of the LOC form. The findings are addressed in the Individual Support Plan and recommendations.

If the beneficiary's condition and/or life circumstances have changed significantly during the past twelve months and continued eligibility is questionable, the beneficiary is referred to the full evaluation process to verify continued eligibility.

g. Reevaluation Schedule. Per 42 CFR § 441.303(c)(4), reevaluations of the level of care required by a participant are

conducted no less frequently than annually according to the following schedule *(select one)*:

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

Reevaluations of the level of care take place at least annually for each waiver beneficiary according to the following schedule: during or up to 30 days prior to the birth month of the waiver beneficiary. If there is a change in the beneficiary's condition per the LOC, a re-evaluation is performed within 30-days of the identification of the change in condition.

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

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

Annual re-evaluations will be completed by a qualified professional who is a Tailored Care Manager/ Care Coordinator within the PIHP/Tailored Plan or in the community.

The QP conducting the annual re-determination of LOC is performed by a QP as defined in NC General Statutes 122C-3 Definitions or 10A NCAC 27G .0104 :

"Qualified Professional means any individual with appropriate training or experience as specified by the General Statutes or by rule of the Commission 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 Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, section 10A NCAC 27G.0103 18 (a)-(d) describe requirements for qualified professionals.

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

The PIHP maintains a computerized tracking system of all level of care evaluations with their annual reevaluation due date. The Individual Support Plans and LOC Reevaluations are tied to the beneficiaries' birthdays and the PIHP system is capable of generating reports based on when the reevaluations are due. The data is reviewed monthly by the LME-MCO. The Tailored Care Manager/ Care Coordinator is notified if the evaluation is received outside the approved timeline.

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

Records of each LOC evaluation must be maintained by the PIHP/Tailored Plan for a minimum period of five years for those beneficiaries over the age of 18.

Level of care documents are maintained in the beneficiary's record by a Tailored Care Manager who is with the PIHP/Tailored Plan or in
the community or a Care Coordinator who is with the PIHP/Tailored Plan if the beneficiary opts out of TCM.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

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

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

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and percent of new waiver applicants that received a LOC evaluation as part of the enrollment process. Numerator: Number of new waiver applicants that received a LOC evaluation as part of the enrollment process. Denominator: Number of new waiver applicants that were part of the waiver enrollment process.

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

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

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

Data Aggregation and Analysis:

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

Performance Measure:
PM1: Number and percent of new waiver enrollees who have a LOC evaluation prior to receipt of services. Numerator: Number of new waiver enrollees who received an initial LOC evaluation Denominator: Total number of new waiver enrollees

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

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

Data Aggregation and Analysis:

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

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

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of Level of Care evaluations completed at least annually for enrolled beneficiaries Numerator: Number of waiver beneficiaries who received an annual LOC re-evaluation Denominator: Total number of waiver beneficiaries with annual plans (not including new enrollees)

Data Source (Select one):
Other
If 'Other' is selected, specify:
Care Coordinator/ Care Manager's Signature in the NC TBI Waiver / Level of Care Re-Determination box located on the Individual Service Plan

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

		Interval =
☑ **Other** Specify: PIHP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi-annually	

Data Aggregation and Analysis:

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

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

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of New Level of Care evaluations completed using approved processes and instrument. Numerator: Number of new waiver participants who received an initial LOC evaluation using approved LOC instrument/process Denominator: Total number of new waiver participants

Data Source (Select one):
Other
If 'Other' is selected, specify:
LOC tracking and or Case Record

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

At the annual site review, DHB reviews a sample of charts to ensure LOC is met.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The PIHPs/Tailored Plan will address and correct problems identified on a case by case basis and include the information in the reports to DHB. DHB may require a corrective action plan(s) if problems are identified. DHB monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team. The EQR annual technical report provides detailed information on the regulatory compliance of the PIHPs/Tailored Plan, as well as results of performance improvement projects (PIPs) and performance measures (PMs). The report provides information about the quality, timeliness and accessibility of care furnished by the PIHPs/Tailored Plan, assesses strengths and weaknesses and identifies opportunities for improvement.

ii. Remediation Data Aggregation

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

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

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☑ **Other** Specify: The PIHPs/Tailored Plan	☑ **Annually**
	☐ **Continuously and Ongoing**
	☑ **Other** Specify: Semi-Annually

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- ● **No**
- ○ **Yes**

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

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

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

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

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

When a waiver slot is available, prospective beneficiaries are informed of their feasible alternatives under the waiver and their option to choose of institutional care or waiver services. Freedom of Choice is provided to potential waiver beneficiaries at the time a waiver slot becomes available. This decision is documented on the Individual Support Plan (ISP) signature page. Annually, thereafter, the freedom of choice option is reviewed with the beneficiary or the legally responsible person and the decision documented in the ISP.

Individuals are assigned to a Tailored Care Manager/Care Coordinator once they become eligible for the TBI Waiver. If an individual feels that the Tailored Care Manager is not the right fit, s/he can request a different Tailored Care Manager or Care Coordinator. Freedom of Choice for a Tailored Care Manager/ Care Coordinator is waived as this waiver runs concurrent with an 1115 and 1915(b) waiver.

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

The Freedom of Choice statement is maintained in written form as a component of the ISP and is found in the administrative files of the PIHP/Tailored Plan. PIHP/Tailored Plan inform members of their freedom of choice of providers at during the member's annual ISP Meeting.

Appendix B: Participant Access and Eligibility

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

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

The PIHP/Tailored Plan makes available, to beneficiaries with limited English proficiency and their legally responsible representatives, materials that are translated into the prevalent non-English languages of the state. The PIHP/Tailored Plan makes interpreter services available to individuals with limited English proficiency.

The PIHP/Tailored must comply with the DHHS Title VI Language Access Policy which ensures that individuals with limited English proficiency (LEP) have equal access to benefits and services for which they may qualify from entities receiving federal financial assistance. The policy applies to the North Carolina DHHS, all divisions/institutions within DHHS and all programs and services administered, established or funded by the Department, including subcontractors, vendors and sub-recipients.

The policy requires all divisions and institutions within DHHS and all local entities, including LME/MCOs participating in the waiver as PIHPs/Tailored Plan, to draft and maintain a Language Access Plan. The plan must include a system for assessing the language needs of LEP populations and individual LEP applicants/recipients; securing resources for language services; providing language access services; assessing and providing staff training; and monitoring the quality and effectiveness of language access services. Local entities must ensure that effective bilingual/interpretive services are provided to serve the needs of the non-English speaking populations at no cost to the recipient. Local entities must also provide written materials, in languages other than English, where a significant number or percentage of the population eligible to be served, or likely to be directly affected by the program, needs services or information in a language other than English to communicate effectively.

Appendix C: Participant Services

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

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

Service Type	Service		
Statutory Service	**Day Supports**		
Statutory Service	**Personal Care**		
Statutory Service	**Residential Supports**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Extended State Plan Service	**Occupational Therapy**		
Extended State Plan Service	**Physical Therapy**		
Extended State Plan Service	**Speech and Language Therapy**		
Other Service	**Assistive Technology**		
Other Service	**Cognitive Rehabilitation (CR)**		
Other Service	**Community Networking**		
Other Service	**Community Transition**		
Other Service	**Crisis Supports Services**		
Other Service	**Home Delivered Meals**		
Other Service	**Home Modifications**		

Service Type	Service		
Other Service	In Home Intensive Support		
Other Service	Life Skills Training		
Other Service	Natural Supports Education		
Other Service	Remote Supports		
Other Service	Specialized Consultation		
Other Service	Supported Living		
Other Service	Vehicle Modifications		

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Day Habilitation

Alternate Service Title (if any):

Day Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Day Supports is typically group, facility-based service that provides assistance to the beneficiary with rehabilitation, retention, or modification of socialization and daily living skills and is one option for a meaningful day as specified in the Person Centered Plan.

Facility-Based" means that beneficiaries who receive this service are often in a licensed Day Supports provider facility that

serves individuals with TBI. Beneficiaries 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.
For individuals who are aging, Day Supports can provide a structured day program of service and support with nursing supervision in an Adult Day Care Program. Additionally, Adult Day Health services similar to adult day care programs in that they 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 beneficiary to attain or maintain their 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, beneficiaries new to the service 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 beneficiaries must be appropriate to the age and preferences of the person.
For working-age individuals (ages 18 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, including 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.
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 Traumatic Brain Injury.
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. 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 / 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 individual resides. Individuals 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.
NC TBI Day Supports Group can be provided in a group setting that includes State-funded Day Supports / Activity as long as the NC TBI Waiver definition is met and the staff meet the qualifications of NC TBI 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.
When appropriate, Day Supports can be provided via real time two-way interactive audio and video telehealth.

Exclusions:
This service may not duplicate services provided under Adult Day Health, Community Networking, Cognitive Rehabilitation, In-Home Intensive Supports, Life Skills Training, Personal Care, Supported Employment Residential Supports, Supported Employment and/or one of the State Plan Medicaid Services that works directly with the beneficiary.

Beneficiaries may not utilize Day Supports to attend transitional sheltered workshops.

This service shall not be furnished/billed at the same time of day as Community Networking, Life Skills Training, Personal Care, Residential Supports, Respite, Supported Employment and/or one of the State Plan Medicaid services that works directly with the person.

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

The amount of Day Supports is subject to the "Limit on Sets of Services" specified in appendix C-4.
Individuals may not utilize Day Supports to attend transitional sheltered workshops.
Prevocational services must not include services that are available under Section 110 of the Rehabilitation Act of 1973 (20

U.S.C 1401 et seq.)

This waiver service is only provided to individuals age 21 and over. All medically necessary Day Support services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Programs
Agency	Provider Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Adult Day Care Programs

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Certified by NC Division of Aging in accordance with NC General Statute 10A, chapter 6, subchapters Q, R, and X.

Other Standard *(specify):*

Professional Competency

Approved as a provider in the PIHP provider network:

- Are at least 18 years old
- 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
- Criminal background check presents no health nor safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with participants must be qualified in CPR and First Aid
- Staff that work with participants must have a high school diploma or high school equivalency (GED)
- Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP.
- 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.

Verification of Provider Qualifications

Entity Responsible for Verification:

Adult Day Care Programs
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Day Supports

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

NC G.S. 122 C-3 and NC Administrative Code Title 10A, subchapters 26B, 26C, 27C, 27D, 27E, and 27G. Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:
- Are at least 18 years old
- 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
- Criminal background check presents no health nor safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with participants must be qualified in CPR and First Aid
- Staff that work with participants must have a high school diploma or high school equivalency (GED)
- Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP.
- 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.
- To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Personal Care Services under North Carolina State Medicaid Plan differs in service definition and provider type from the services offered under the waiver. Personal Care Services under the waiver include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living as specified in the Person Centered Plan. Support and engaging the beneficiary describes the flexibility of activities that may encourage the beneficiary to maintain skills gained during rehabilitation while also providing supervision for independent activities. This service may include preparation of meals, but does not include the cost of the meals themselves.

When specified in the ISP, this service may also include housekeeping chores such as bed making, dusting and vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the beneficiary, rather than the beneficiary's family. Personal care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation, and use of special mobility devices.

Personal Care Services may be provided outside of the private home as long as the outcomes are consistent with the support described in the ISP. Services may be allowed in the private home of the provider / staff if there is documentation in the ISP that the beneficiary's needs cannot be met in the beneficiary's private home or another community location. The provider agency must complete a site assessment of the private home of the provider / staff every 6 months to ensure health and

safety.

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

Personal care services do not include medical transportation and may not be provided during medical transportation and medical appointments. Beneficiaries who live in licensed residential facilities, licensed AFL homes, licensed foster care homes or unlicensed alternative family living homes serving one adult, may not receive any aspect of this service nor any other state plan personal care service.

This service may not be provided on the same day that the benefeciary receives regular Medicaid personal care, a home health aide visit, residential supports or another substantially equivalent service.

This service may not be provided at the same time of day that a beneficiary receives: Adult Day Health, Day supports, Life Skills Training, community networking, respite care, supported employment, or in-home intensive supports.

Personal Care cannot be provided in a licensed program.

This service does not cover the staff member completing home maintenance, housekeeping for areas that are used by other members of the household and/or meal preparation when the same meal is being prepared for other family members.

The amount of personal care is subject to the "Limits on Sets of Services" specified in Appendix C-4.

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Personal Care Service Provider
Agency	Home Care Agency

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Personal Care Service Provider

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network in accordance with requirements for services in NC General Statute 122-C.

Staff Qualifications:

- Are at least 18 years old
- 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
- Criminal background check presents no health nor safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with participants must be qualified in CPR and First Aid
- Staff that work with participants must have a high school diploma or high school equivalency (GED)
- Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP.
- 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 participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however.
- To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid..
- Services provided in private home of the direct service employee are subject to the checklist and monthly monitoring by the provider agency qualified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP
Provider Agency

Frequency of Verification:

Prior to initial enrollment and at least every three years thereafter

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Personal Care

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Licensed by the NC DHHS Division of Health Service Regulation as a Home Care Agency in accordance with NC General Statute 131-E and NC Administrative Code 13J, chapter 13, subchapter J.
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network

Agency staff that work with participants:
- Are at least 18 years old
- 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
- Criminal background check presents no health nor safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with participants must be qualified in CPR and First Aid
- Staff that work with participants must have a high school diploma or high school equivalency (GED)
- Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP.
- 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 participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however.
- To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.
- Services provided in private home of the direct service employee are subject to the checklist and monthly monitoring by the provider agency qualified professional.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP
Provider

Frequency of Verification:

Prior to initial enrollment and at least every three years thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Residential Habilitation

Alternate Service Title (if any):

Residential Supports

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02011 group living, residential habilitation
Category 2:	**Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

Residential Supports provides individualized services and supports to enable a person to live successfully in a Group Home or Alternate Family Living setting of their choice and be an active participant in his/her community as specified in the Person Centered Plan. The intended outcome of the service is to increase, regain, or maintain the person'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 consist of an integrated array of individually designed training activities which may be rehabilitative or maintenance, assistance and supervision.

Residential Supports include:
1. Rehabilitation Services aimed at assisting the beneficiary to reacquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas. Rehabilitation and/or maintenance training outcomes focus on allowing the beneficiary to improve his/her ability to reside as independently as possible in the community.
2. Assistance in activities of daily living when the beneficiary is dependent on others to ensure health and safety.
3. Rehabilitation and/or maintenance services that allow the beneficiary to participate in home life or community activities. 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 Supports are provided to individuals who live in a community residential setting that meets the home and community based characteristics as outlined in Appendix C of the TBI Waiver document.
1. Facility capacity for all newly developed facilities, approved within the PIHP network and that meet the home and community based characteristics is five beds or less.
2. Facility capacity for existing facilities approved within the PIHP network and meeting the home and community based characteristics, is six beds or less.
3. Facilities that meet the home and community based characteristics, and currently serve a waiver beneficiary, larger than six beds which meet HCBS characteristics as defined in this waiver will be allowed to continue to provide Residential Supports until the waiver beneficiary is discharged from the facility.

No new waiver beneficiaries will be admitted to a facility larger than 6 beds.

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 AFL sites will be reviewed using the PIHP AFL checklist for health and safety related issues.

Home and community environment is described in the Location of Services.

NC TBI Waiver respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs.

Residential Support Levels are determined using the process below:

Level 1 requires a minimum of 1:3 staff to beneficiary ratio during day and evening shifts and non-awake supervision during overnight shift or an awake staff person covering more than one site during the overnight shift.

Level 2 requires a minimum of 1:3 staff to beneficiary ratio during day and evening shifts and awake, on-site supervision during overnight shift.

Level 3 requires a minimum of 1:1 staff to beneficiary ratio during the day and evening shifts and awake, on-site supervision during overnight shift.

Exclusions:
Transportation to/from medical appointments is billed to State Medicaid Plan Transportation rather than Residential Supports.

Beneficiaries who receive Residential Supports may not receive Home Modifications, In-Home Intensive Supports, Life Skills Training, Personal Care Services, Respite, Vehicle Modifications, or State Plan Personal Care Services.

This service is not available at the same time of day as Adult Day Health, Community Networking, Day Supports, In-Home Intensive Services, Life Skills Training, Personal Care Services, Residential Supports, Respite, Supported Living, Supported Employment, Cognitive Rehabilitation or one of the State Plan Medicaid services that works directly with the person.

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

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

The amount of Residential Supports is subject to the "Limits on sets of services"

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Unlicensed Supervised Living Facilities
Individual	Supervised Living Facility, Type C
Agency	Supervised Living Facilities, Type F

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Supports

Provider Category:

Agency

Provider Type:

Unlicensed Supervised Living Facilities

Provider Qualifications

License *(specify):*

N/A

Certificate *(specify):*

Other Standard *(specify):*

Unlicensed Supervised Living Facilities may serve only one adult in accordance with State Rule at 10A NCAC 27 G.5601(b)(1)(2).

Unlicensed Supervised Living Facilities must be approved as a provider in the PIHP provider network and meet the following qualifications:

- Are at least 18 years old
- 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
- Criminal background check presents no health or safety risk to beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with beneficiaries must be qualified in CPR and First Aid
- Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
- Staff that work with beneficiaries must be qualified in the customized needs of the TBI beneficiary as described in the ISP.
- 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 however.
- To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP
Provider Agency

Frequency of Verification:

The facility is monitored by the PIHP according to the requirements of the DHHS Monitoring Process.
Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Supports

Provider Category:

Individual

Provider Type:

Supervised Living Facility, Type C

Provider Qualifications

License *(specify):*

10 A NCAC 27G.5600, statutory authority: NC General Statute 143B-147
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Supervised Living facilities, type C, serve adults whose primary diagnosis is a developmental disability and may be licensed for 6 beds or less.

Supervised Living Facilities, type C, must be approved as a provider in the provider network and meet the following qualifications:

- Are at least 18 years old
- 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
- Criminal background check presents no health or safety risk to beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with beneficiaries must be qualified in CPR and First Aid
- Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
- Staff that work with beneficiaries must be qualified in the customized needs of the TBI beneficiary as described in the ISP.
- 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 participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however.
- To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

The North Carolina Department of Health and Human Services, Division of Health Services Regulation (DHSR) inspects and licenses supervised living homes. The facility verifies employee qualifications. The PIHP re-verifies agency credentials, including a sample of employee qualifications upon initial review and no less than every three years.

Frequency of Verification:

DHSR: Facility is relicensed annually.
Facility employee verification of employee qualifications: upon hiring
Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Residential Supports

Provider Category:

Agency

Provider Type:

Supervised Living Facilities, Type F

Provider Qualifications

License *(specify):*

NC Administrative Code 10 A 27G.560; statutory authority: NC General Statute 143B-147

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Supervised Living Facilities, type F, serve no more than 3 minors or 3 adults with a developmental disability.

Supervised Living Facilities, type F, must be approved as a provider in the PIHP provider network and meet the following qualifications:

- Are at least 18 years old
- 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
- Criminal background check presents no health or safety risk to beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with beneficiaries must be qualified in CPR and First Aid
- Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
- Staff that work with beneficiaries must be qualified in the customized needs of the TBI beneficiary as described in the ISP.
- 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 however.
- To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

The DHHS Division of Health Service Regulation (DHSR)licenses Supervised Living Facilities, type F.
Facility employee verification of employee qualifications is conducted upon hiring.
Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years
Provider Agency

Frequency of Verification:

DHSR licensure: Annually
The facility verifies employee qualifications upon hiring.
PIHP credentialing is conducted no less than every 3 years.

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
09 Caregiver Support	09012 respite, in-home
Category 2:	**Sub-Category 2:**
09 Caregiver Support	09011 respite, out-of-home
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Respite services provide periodic or scheduled support and relief to the primary caregiver(s) from the responsibility and stress of caring for the beneficiary as specified in the Person-Centered Service Plan. This service may also be used to provide temporary relief to beneficiaries who reside in Licensed and Unlicensed AFLs, 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. This service also enables the beneficiary 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.

- The cost of 24 hours of respite care cannot exceed the per diem rate for the average community SNF facility.
- 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.
- Respite services are only provided for the beneficiary, other family members, such as children of the beneficiary, may not receive care from the provider while Respite Care is being provided/billed for the beneficiary.
- Respite Care is not provided by any person who resides in the beneficiary's primary place of residence.
- 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.

- Respite may not be used for beneficiaries who are living alone or with a roommate; unless it is for a beneficiary individual to attend a camp or support group where there is no other appropriate service.
- 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.
- This service may be used as a planned respite stay for individuals who have a history of crisis/high behavioral health needs
- This service is not available at the same time of day as Community Networking, Day Supports, Life Skills Training, Personal Care, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.

- Residential Support AFL cannot be billed on the same day as Per Diem Respite for the same beneficiary.

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

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies who operate private respite homes
Agency	Home Care Agencies
Agency	Provider Agencies, Nursing Respite
Agency	Provider Agencies, facility based and in home services

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Provider Agencies who operate private respite homes

Provider Qualifications

License *(specify):*

Private home respite services serving individuals outside their private home 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.

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Professional Competency

1. At least 18 years old
2. 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
3. Criminal background check presents no health and safety risk to beneficiary
4. Supervised by the employer of record or managing employer
5. Not listed in the North Carolina Health Care Abuse Registry

6. Qualified in CPR and First Aid
7. Staff that work with beneficiaries must be qualified in the customized needs of the TBI beneficiary as described in the ISP
8. Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
9. 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
10. If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina
11. Services provided in the home of the direct service employees are subject to the checklist and monthly monitoring by the qualified professional

To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies, Private Respite Homes
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Care Agencies

Provider Qualifications

License *(specify):*

Licensed by the NC DHHS, Division of Health Services Regulation in accordance with NCGS 131E, Article 6,Part C, and North Carolina Administrative Code 10A, Chapter 13-J

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Professional Competency

NC G.S. 122C, as applicable
Approved as a provider in the PIHP provider network:
1. At least 18 years old
2. 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
3. Criminal background check presents no health and safety risk to beneficiary
4. Supervised by the employer of record or managing employer
5. Not listed in the North Carolina Health Care Abuse Registry

6. Qualified in CPR and First Aid
7. Staff that work with beneficiaries must be qualified in the customized needs of the TBI beneficiary as described in the ISP
8. Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
9. 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
10. If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina
11. Services provided in the home of the direct service employees are subject to the checklist and monthly monitoring by the qualified professional

12. To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Home Care Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Provider Agencies, Nursing Respite

Provider Qualifications

License *(specify):*

Licensed by the NC DHHS, Division of Health Services Regulation in accordance with NC General Statute 131E,Article 6, Part C and, as applicable, NC General Statute 122C

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network
1. At least 18 years old
2. 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
3. Criminal background check presents no health and safety risk to beneficiary
4. Supervised by the employer of record or managing employer
5. Not listed in the North Carolina Health Care Abuse Registry
6. Qualified in CPR and First Aid
7. Staff that work with beneficiaries must be qualified in the customized needs of the TBI beneficiary as described in the ISP
8. Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
9. 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
10. If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina
11. Services provided in the home of the direct service employees are subject to the checklist and monthly monitoring by the qualified professional

12. To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Nursing Respite Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Provider Agencies, facility based and in home services

Provider Qualifications

License *(specify):*

NC General Statute 122C
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved by the PIHP Network
1. At least 18 years old
2. 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
3. Criminal background check presents no health and safety risk to beneficiary
4. Supervised by the employer of record or managing employer
5. Not listed in the North Carolina Health Care Abuse Registry
6. Qualified in CPR and First Aid
7. Staff that work with beneficiaries must be qualified in the customized needs of the TBI beneficiary as described in the ISP
8. Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
9. 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
10. If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina
11. Services provided in the home of the direct service employees are subject to the checklist and monthly monitoring by the qualified professional

12. To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired
PProvider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Supported Employment Services provide assistance with choosing, acquiring, and maintaining a job for individuals for whom competitive employment has not been achieved and /or has been interrupted or intermittent as specified in the Person-Centered Service Plan.

The intent of Initial Supported Employment is to assist individuals with developing skills to seek, obtain and maintain competitive employment or develop and operate a micro-enterprise. The employment positions are found based on individual preferences, strengths, and experiences. Job finding is not based on a pool of jobs that are available or set aside specifically for individuals with disabilities.

The transition to long-term supported employment should occur within one year of successful competitive employment, at this time it is expected that staff time will reduce as the individual becomes more independent in her/his job duties. Supported Employment may be needed if the individual's job duties change or if a new job is acquired. Feedback regarding the success and integration of the individual into their position should be obtained from the employer, through employee evaluations that provide information on the level of supervision and oversight that the individual requires on a daily basis.

Long-term follow-up may be used on a regular basis to meet specific and well documented needs. Long-Term follow-up related to medical / behavioral / physical support needs shall require medical behavioral records and accompanying documentation in the ISP supporting the need for individual services as the most appropriate and viable option.

Initial Supported Employment services include:
1. Pre-job training/education and development activities to prepare a person to engage in meaningful work-related activities which may include career/educational counseling, active job searching, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, assistance in learning skills necessary for job retention.

2. Assisting an individual to develop and operate a micro-enterprise. This assistance consists of:
a. Aiding the individual to identify potential business opportunities;
b. Assistance in the development of a business plan, including potential sources of business financing and other assistance; and
c. Identification of the supports that are necessary in order for the individual to operate the business.
3. Coaching and employment support activities that enable an individual to complete initial job training or develop skills necessary to maintain employment is completed through activities such as: assistance in job tasks, work adjustment training and counseling.
4. Providing technical support to potential employers regarding Federal ADA accommodations and requirements.

The service includes transportation from the individual's residence and to and from the job site. The provider agency's payment for transportation from the individual's residence and the individual's job site is authorized service time.

Long term follow-up supports include:
1. Coaching and employment support activities that enable an individual to maintain employment is completed through at least monthly face-to-face activities such as monitoring, supervision, maintaining skills necessary for job tasks, work adjustment training and counseling;
2. Ongoing assistance, counseling and guidance for an individual who operates a microenterprise once the business has been launched;
3. Employer consultation with the objective of identifying work related needs of the individual and proactively engaging in supportive activities to address the problem or need.
4. Providing ongoing technical support to potential employers regarding Federal ADA accommodations and requirements.
5. Transportation when the individual's job does not include staffing support. Payments for transportation are an established as a per trip charge or mileage.

Documentation will be maintained in the file of each provider agency specifying that this service is not otherwise available under a program funded under Section 110 of the Rehabilitation Act of 1973, or Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) for this beneficiary. The provider agency is responsible for obtaining this documentation.

When appropriate, Supported Employment can be provided via real time two-way interactive audio and video telehealth.

Exclusions:
FFP is not to be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or
3. Payments for training that are not directly related to a beneficiary's supported employment program.

While it is not prohibited to both employ an individual and provide service to that same individual, 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:
1. The job/position would not exist if the provider agency was not being paid to provide the service.
2. The job/position would end if the individual chose a different provider agency to provide service.
3. The hours of employment have a one to one correlation with the amount of hours of service that are authorized.

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 Adult Day Health, Community Networking, Day Supports, In-Home Intensive Services, Life Skills Training, Personal Care Services, Residential Supports, Respite, Supported Living, Cognitive Rehabilitation or one of the State Plan Medicaid services that works directly with the person.

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

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

Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in supported employment; or 2. Payments that are passed through to users of supported employment services."

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:
• Are at least 18 years old
• 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
• Criminal background check presents no health nor safety risk to participant
• Not listed in the North Carolina Health Care Abuse Registry
• Staff that work with beneficiaries must be qualified in CPR and First Aid
• Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
• Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP.
• 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.
•To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Occupational Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11080 occupational therapy

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

Occupational Therapy is a treatment and assessment approach that addresses the functional needs of the Individual related to the effects of the injury on adaptive functioning, adaptive behavior and sensory, motor, posture, and perceptual, and/or cognitive abilities as specified in the Person Centered Plan. The goal of Occupational therapy is to assist individual with TBI achieve greater independence by regaining physical, perceptual, and cognitive skills through exercises and other related activities.

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

maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other TBI Waiver rehabilitation therapy (Physical Therapy / Occupational Therapy / Speech and Language Pathology)

Occupational Therapy waiver services are provided when the limits of the approved Occupational Therapy State Plan service are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the beneficiaries needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver.

To avoid any overlap of services, Occupational Therapy, Physical Therapy, and Speech and Language Therapy is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. HCBS/TBI waiver funding is used as the funding source of last resort and requires prior authorization from the MCO.

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency
Individual	Occupational Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

-Staff must hold appropriate NC license for occupational therapy
-Criminal background check presents no health or safety risk to beneficiary
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the beneficiaries as described in the Individual Support Plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Occupational Therapy

Provider Category:

Individual

Provider Type:

Occupational Therapist

Provider Qualifications

License *(specify):*

These services must be provided by an Occupational Therapist as defined in 42 CFR 440.110 and be licensed pursuant to North Carolina State law or by a licensed Occupational Therapy Assistant under the supervision of a licensed Occupational Therapist

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Certification or registration specific to discipline, if applicable
May be provided by an individual under the supervision of an enrolled licensed provider.

Other Standard *(specify):*

- Staff must hold appropriate NC license for Occupational Therapy,
- Criminal background check presents no health or safety risk to the beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in the customized need of the TBI beneficiaries as described in the Individual Support Plan

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of initial review and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Physical Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11090 physical therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Physical Therapy is a treatment and assessment approach that addresses the promotion of sensor motor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptationas specified in the Person Centered Plan. It includes evaluation to identify movement dysfunction, obtaining, interpreting and integrating information for program planning and treatment to prevent or compensate for functional problems. Through Physical Therapy, people with TBI receive treatment to move and perform functional activities in their daily lives and to help prevent conditions associated with loss of mobility through fitness and wellness programs that achieve healthy and active lifestyles.

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

maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other TBI Waiver rehabilitation therapy (Physical Therapy / Occupational Therapy / Speech and Language Pathology)

Physical Therapy waiver services are provided when the limits of the approved Physical Therapy State Plan service are exhausted. Therapeutic treatments provided over and above the amount allowed in the State Plan are provided according to the beneficiaries needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver.

To avoid any overlap of services, Occupational Therapy, Physical Therapy, and Speech and Language Therapy is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. HCBS/TBI waiver funding is used as the funding source of last resort and requires prior authorization from the MCO.

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency
Individual	Physical Therapist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

-Staff must hold appropriate NC license for Physical Therapy
-Criminal background check presents no health or safety risk to beneficiary
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the beneficiaries as described in the Individual Support Plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Physical Therapy

Provider Category:

Individual

Provider Type:

Physical Therapist

Provider Qualifications

License *(specify):*

These services must be provided by an Physical Therapist as defined in 42 CFR 440.110 and be licensed pursuant to North Carolina State law or by a licensed Physical Therapy Assistant under the supervision of a licensed Physical Therapist

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Certification or registration specific to discipline, if applicable
May be provided by an individual under the supervision of an enrolled licensed provider.

Other Standard *(specify):*

- Staff must hold appropriate NC license for Phyical Therapy,
- Criminal background check presents no health or safety risk to the beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in the customized need of the TBI beneficiaries as described in the Individual Support Plan

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of initial review and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Extended State Plan Service

Service Title:

Speech and Language Therapy

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Speech-Language Therapy is the treatment and assessment of speech and/or language disorders. Assessment and treatment of persons with TBI may include the areas of language (listening, talking, reading, writing), cognition (attention, memory, sequencing, planning, time management, problem solving), motor speech skills and articulation, and conversational skills as specified in the Person Centered Plan. Speech-language therapy also addresses issues related to swallowing and respiration. The intent of Speech-Language Therapy is to regain lost skills and/or achieve a greater level of independence though the development compensatory strategies for skills that have permanently changed.

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

Maximum of 3,120 units per year (1 unit=15 minutes) either alone or in combination with any other TBI Waiver rehabilitation therapy (Physical Therapy / Occupational Therapy / Speech and Language Pathology)

Speech-Language Therapy waiver services are provided when the limits of the approved Speech-Language Therapy State Plan service are exhausted. Therapeutic treatments provided over the amount allowed in the State Plan are provided according to the beneficiaries needs as identified by the licensed provider and in keeping with the rehabilitative intent of the waiver.

To avoid any overlap of services, Occupational Therapy, Physical Therapy, and Speech and Language Therapy is limited to those services not covered through regular State Plan Medicaid and which cannot be procured from other formal or informal resources. HCBS/TBI waiver funding is used as the funding source of last resort and requires prior authorization from the MCO.

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including

EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency
Individual	Speech and Language Pathologist

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Language Therapy

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

-Staff must hold appropriate NC license for Speech and Language Therapy
-Criminal background check presents no health or safety risk to beneficiary
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the beneficiaries as described in the Individual Support Plan

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Extended State Plan Service
Service Name: Speech and Language Therapy

Provider Category:

Individual

Provider Type:

Speech and Language Pathologist

Provider Qualifications

License *(specify):*

These services must be provided by a Speech Pathologist as defined in 42 CFR 440.110 and be licensed pursuant to North Carolina State law or by a licensed Speech Language Pathologist Assistant under the supervision of a licensed Speech Pathologist
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Certification or registration specific to discipline, if applicable
May be provided by an individual under the supervision of an enrolled licensed provider.

Other Standard *(specify):*

- Staff must hold appropriate NC license for Speech and Language Therapy,
- Criminal background check presents no health or safety risk to the beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in the customized need of the TBI beneficiaries as described in the Individual Support Plan

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of initial review and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Assistive Technology

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)

Category 2:	**Sub-Category 2:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 3:	**Sub-Category 3:**
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 4:	**Sub-Category 4:**
14 Equipment, Technology, and Modifications	14032 supplies

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

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

Service Definition *(Scope):*

Assistive Technology, Equipment and Supplies 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 as specified in the Person Centered Plan. 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 monitoring charges may be covered when it is required for the functioning of the item / 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.

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. 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 professional AND write the prescription.

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

- Aids For Daily Living or Aids to increase Independent Living
- Aids For Gross Motor Development or Fine Motor Skill Development
- Environmental Controls and Modifications
- Positioning Systems or Devices to aid with Positioning
- Alert and Monitoring Systems
- Sensory Aids
- Technology to enhance a beneficiary's ability to recall or be prompted to complete tasks
- Communication Aids not covered by regular Medicaid State Plan
- Mobility Aids not covered by DME

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

- a plan for how the person and family will be trained when needed on the use of the equipment;
- 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
- shipping costs must be itemized in the request to be included, taxes are not coverable;
- other information as required for the specific equipment or supply request;
- quote(s) (PIHP determines how many quotes are required.)

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

- 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.

For individuals under the age of 21, all State Plan and EPSDT benefits must be exhausted prior to ATES supplying Medical Supplements not covered through the Durable Medical Equipment program.

Exclusions:

Items that are not of direct or remedial benefit to the person are excluded from this service.

- Recreational items that would normally be purchased by a family are excluded from this service.
- Non-adaptive Computer desks and other furniture items are not covered.
- Service and maintenance contracts and extended warranties; and equipment or supplies purchased for exclusive use at the school/home school are not covered.
- Computer hardware will not be authorized solely to improve socialization or educational skills, to provide recreation or diversion activities, or to be used by any person other than the beneficiary.
- Hot tubs, Jacuzzis, and pools, are not covered.
- Items utilized as restraints are not coverable under the waiver.

Exclusions:

1. Items that are not of direct or remedial benefit to the person are excluded from this service.
2. Computer desks and other furniture items are not covered.
3. Service and maintenance contracts and extended warranties;
4. Computer hardware will not be authorized solely to improve socialization or educational skills, to provide recreation or diversion activities, or to be used by any person other than the beneficiary.
5. Hot tubs, Jacuzzis, pools, are not covered.
6.Ongoing/connectivity Internet services are not covered and are not permitted to be paid for.

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

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

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Durable Medical Equipment Providers
Agency	Alert Response Centers
Individual	Specialized Vendors
Agency	Commercial/Retail Businesses
Agency	Home Care Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Durable Medical Equipment Providers

Provider Qualifications

License *(specify):*

Applicable state/local business license
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

DHB enrolled vendor

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Alert Response Centers

Provider Qualifications

License *(specify):*

Applicable state/local business license
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Response centers must be staffed by 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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Individual

Provider Type:

Specialized Vendors

Provider Qualifications

License *(specify):*

Applicable state/local business license
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License *(specify):*

Applicable state/local business license
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Assistive Technology

Provider Category:

Agency

Provider Type:

Home Care Agencies

Provider Qualifications

License *(specify):*

Licensed by the NC DHHS, Division of Health Services Regulation, in accordance with NCGS 131E, Article 6,Part C
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

DHB enrolled vendor

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Cognitive Rehabilitation (CR)

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
11 Other Health and Therapeutic Services	11120 cognitive rehabilitative therapy
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Cognitive Rehabilitation is an one-on-one therapy, utilized for the development of cognitive (thinking) skills to improve functional abilities including but not limited to: attention, memory, problem solving, and to help identify impaired thinking as specified in the Person Centered Plan. The initial goal of therapy is to improve cognitive functioning to the full extent possible. Compensatory strategies will be introduced as progress slows. This phase will assist to achieve an awareness of the ongoing cognitive limitations, maintain skills learned and teach functional strategies necessary to increase the quality of life and enhance their ability to live successfully in the community of their choice. Compensatory strategies also include the training of significant individuals in the person's life.

Cognitive Rehabilitation includes a traditional approach which focuses on the individual cognitive impairment and tries to remediate or teach compensatory strategies if restorative objectives are unsuccessful. This approach is most often provided

in an office setting.

Cognitive Rehabilitation also includes a contextual approach that helps individuals achieve their real-world participation in their chosen real-world activities that are blocked by cognitive impairment. This approach is most often provided in the community or in the home.

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

Cognitive Rehabilitation (CR) is limited to 192, 15-minute units annually.

This service may not duplicate services provided under Specialized Consultation Services or Natural Supports Education. This service may not duplicate services provided to family members through natural supports education or specialized consultative services.

This waiver service is only provided to individuals age 21 and over. All medically necessary Cognitive Rehabilitation services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies
Individual	Individual Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation (CR)

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

-NC G.S.122C, as appropriate

- Cognitive Rehabilitation (CR) must be provided by independent Physicians, Neuropsychologists, Psychologists, LPC, LCSW, Special Education Teachers, Occupational Therapists and Speech-Language Pathologists, licensed to practice in the State of North Carolina.

Requirements:

Degree in behavioral science field or other appropriate field with appropriate licensure and/or certification for that particular field i.e. Psychology, SW, Special Education, Speech-Language Pathology, Occupational Therapy or Counseling and; PhD and Master's degree must have 40 hours of training in brain injury and one year of experience working with persons with brain injury; bachelor's degree must have 40 hours of training in brain injury and three years of experience working in brain injury

May be provided under the supervision of an enrolled licensed provider.-
Staff must hold appropriate NC license for occupational therapy, speech therapy, psychology, behavioral analysis (licensure subject to psychology board implementation date), Social Work, Counseling; and

PhD and Master's degree must have 40 hours of training in brain injury and one year of experience working with persons with brain injury;

bachelor's degree must have 40 hours of training in brain injury and three years of experience working in brain injury
May be provided under the supervision of an enrolled licensed provider.

Criminal background check presents no health or safety risk to beneficiary
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the TBI beneficiaries as described in the Individual Support Plan
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 PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Cognitive Rehabilitation (CR)

Provider Category:

Individual

Provider Type:

Individual Practitioner

Provider Qualifications

License *(specify):*

Licensure specific to discipline, if applicable
Cognitive Rehabilitation (CR) must be provided by independent Physicians, Neuropsychologists, Psychologists, LPC, LCSW, Special Education Teachers, Occupational Therapists and Speech-Language Pathologists, licensed to practice in the State of North Carolina.

Requirements:

Degree in behavioral science field or other appropriate field with appropriate licensure and/or certification for that

particular field i.e. Psychology, SW, Special Education, Speech-Language Pathology, Occupational Therapy or Counseling and; PhD and Master's degree must have 40 hours of training in brain injury and one year of experience working with persons with brain injury; bachelor's degree must have 40 hours of training in brain injury and three years of experience working in brain injury

May be provided under the supervision of an enrolled licensed provider.

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Certification or registration specific to discipline, if applicable

Other Standard *(specify):*

-NC G.S.122C, as appropriate
Cognitive Rehabilitation (CR) must be provided by independent Physicians, Neuropsychologists, Psychologists, LPC, LCSW, Special Education Teachers, Occupational Therapists and Speech-Language Pathologists, licensed to practice in the State of North Carolina.

Requirements:

Degree in behavioral science field or other appropriate field with appropriate licensure and/or certification for that particular field i.e. Psychology, SW, Special Education, Speech-Language Pathology, Occupational Therapy or Counseling and; PhD and Master's degree must have 40 hours of training in brain injury and one year of experience working with persons with brain injury; bachelor's degree must have 40 hours of training in brain injury and three years of experience working in brain injury

May be provided under the supervision of an enrolled licensed provider.
-Staff must hold appropriate NC license for occupational therapy, speech therapy, psychology, behavioral analysis (licensure subject to psychology board implementation date), Social Work, Counseling; and

PhD and Master's degree must have 40 hours of training in brain injury and one year of experience working with persons with brain injury;

bachelor's degree must have 40 hours of training in brain injury and three years of experience working in brain injury
May be provided under the supervision of an enrolled licensed provider.

Criminal background check presents no health or safety risk to beneficiary
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the TBI beneficiaries as described in the Individual Support Plan

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of initial review and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Networking

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Community Networking services provide individualized day activities that support the beneficiary's definition of a meaningful day in an integrated community setting, with persons who are not disabled as specified in the Person Centered Plan. This service is provided separate and apart from the beneficiary's 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 beneficiaries gain skills and increase community connections, service hours should fade; however a formal fading plan is not required.

Community Networking services consist of:
1. Participation in adult education (College, Vocational Studies, and other educational opportunities);
2. Development of community based time management skills;
3. Community based classes for the development of hobbies or leisure/cultural interests;
4. Volunteer work;
5. Participation in formal/informal associations and/or community groups;
6. Training and education in self-determination and self-advocacy;
7. Using public transportation;
8. Inclusion in a broad range of community settings that allow the beneficiary to make community connections;
9. 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.

This service includes a combination of rehabilitation/maintenance for personal assistance and supports as needed by the beneficiary during activities. Transportation to/from the beneficiary's residence and the training site(s) is included.

When appropriate, Community Networking can be provided via real time two-way interactive audio and video telehealth.

The waiver beneficiary can access up to $1000, per year, to pay for classes at an integrated class that may occur in the community or at a college, university, or vocational school. These funds cannot be used to pay for books/materials.

This does not include the cost of hotels, meals, materials or transportation while attending conferences.
This service does not include activities that would normally be a component of a beneficiary's home/residential life or services.
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 (i.e. hair salon, florist, etc.) 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 Adult Day Health, Day Supports, Life Skills Training, Personal Care, Cognitive Rehabilitation, Residential
Supports, Respite, Supported Employment or one of the state plan Medicaid services that works directly with the beneficiary.

This service does not pay for overnight programs of any kind.
Classes that offer one-to-one instruction and are in a nonintegrated
community setting are not covered.

The $1000 for Classes and Conferences is provided directly to the provider and not to the beneficiary.

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

Payment for attendance at classes and conferences will not exceed $1000/ per participant plan year. The amount of community networking services is subject to the "Limits on Sets of Services" specified in Appendix C-4.

This waiver service is only provided to individuals age 21 and over. All medically necessary Community Networking services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Networking

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:
- Are at least 18 years old
- 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
- Criminal background check presents no health or safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with participants must be qualified in CPR and First Aid
- Staff that work with participants must have a high school diploma or high school equivalency (GED)
- Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP
- 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.
- To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Community Transition

HCBS Taxonomy:

Category 1:	Sub-Category 1:
16 Community Transition Services	16010 community transition services

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

The purpose of Community Transition is to provide initial set-up expenses for adults to facilitate their transition from a Rehabilitation or Specialty Hospital), Psychiatric Hospital, skilled nursing facility or another licensed living arrangement (group home, alternative family living arrangement), or a family home / one person AFL to a living arrangement where the individual is directly responsible for his or her own living expenses as specified in the Person Centered Plan This service may be provided only in a private home or apartment with a lease in the individual's/legal guardian's/representative's name or a home owned by the individual. In situations where an individual lives with a roommate, Community Transition cannot duplicate items that are currently available.

Covered transition services are:
1. Security deposits that are required to obtain a lease on an apartment or home;
2. Essential furnishings, including furniture, window coverings, food preparation items, bed/bath linens;
3. Moving expenses required to occupy and use a community domicile;
4. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; and/or
5. Service necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

Community Transition expenses are furnished only to the extent that the individual is unable to meet such expense or when the support cannot be obtained from other sources. These supports may be provided only once during the life of the waiver. These services are available only during the three-month period that commences one month in advance of the individual'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 service.

Exclusions:

Community Transition does not include monthly rental or mortgage expense; regular utility charges; and/or household appliances rented or leased or diversional/recreational/entertainment items such as televisions, DVD players, computers, and other recreational components. Service and maintenance contracts and extended warranties are not covered. Cars and other vehicles are not covered. Community Transition services can be accessed only one time over the life of the waiver.

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

The cost of Community Transition has a limit of $5000.00 per individual per life of the waiver.

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

Community Transition includes the actual cost of services and does not include provider overhead charges.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Specialized Vendor Supplies
Agency	Commercial/Retail Businesses
Agency	Agencies that provide Resource Facilitation Services

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Individual

Provider Type:

Specialized Vendor Supplies

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable state and local regulations for type of service that the provider/supplier is providing as approved by PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At the time of first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License *(specify):*

Applicable state/local business license
Tribal providers are not subject to licensure but substantial equivalency.

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At the time of first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Transition

Provider Category:

Agency

Provider Type:

Agencies that provide Resource Facilitation Services

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon initial credentialing; PIHP re-verifies agency credentials at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Crisis Supports Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10030 crisis intervention
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Crisis Supports provides intervention and stabilization for individuals experiencing a crisis. Crisis Supports are for individuals who
experience acute crises and who present a threat to the person's health
and safety or the health and safety of others. These behaviors may
result in the person 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 individual 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 (5) 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 individual'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 include:

- 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
- Determine and contact agencies needed to secure higher level intervention or out-of-home services
- 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.
- Contact the Tailored Care Manager/Care Coordinator 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, including direct intervention to de-escalate behavior or protect others during behavioral episodes. This may include enhanced staffing provided by a QP to provide one additional staff person in settings where the participant may be receiving other services.

Out-of-Home Crisis Supports

- 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 providers and staff for out of home crisis have increased training surrounding behavioral support needs/crisis. 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/or all other approaches to insure health and safety have failed. In addition, the service may be used as a planned respite stay for individuals who have a history of crisis/high behavioral health needs as this service allows a planned respite stay with crisis/behavioral supports as a component

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

Crisis Consultation

- Crisis consultation is for individuals that have significant, intensive, or challenging behaviors 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 CMS 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 TBI and behavioral health needs.
- 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 person'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 Tailored Care Manager/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.
4. referral for medication evaluation if appropriate.

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

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

Crisis Support Services will not occur at the same time of day as Respite Services.

The services under the TBI Waiver are limited to additional services not otherwise covered under the state plan, including EPSDT, but consistent with waiver objectives of avoiding institutionalization.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Practitioners
Agency	Provider Agencies who operate licensed facilities
Agency	Provider Agencies who operate licensed facilities

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Supports Services

Provider Category:

Agency

Provider Type:

Independent Practitioners

Provider Qualifications

License *(specify):*

Licensure specific to discipline, if applicable
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

Staff that work with individuals:

Are at least 18 years old

Criminal background check presents no health and safety risk to individual

Not listed in the North Carolina Health Care Abuse Registry

Staff holds NC license for psychologist or psychological associate

Meets Crisis Services Competencies specified by the PIHP.

Qualified in customized needs of the individual as described in the ISP

The organization must 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 must meet all applicable competency requirements including crisis prevention, intervention and resolution
techniques and trauma-informed care.
Crisis Services staff must 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 TBI and mental health needs OR a physician assistant with a minimum of one year of experience
serving individuals with TBI 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 TBI.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Supports Services

Provider Category:

Agency

Provider Type:

Provider Agencies who operate licensed facilities

Provider Qualifications

License *(specify):*

North Carolina General Statute 122C

Must be licensed according to NC Administrative Code 10A 27G.5100 or have waiver of licensure granted by licensing agency

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:
- Are at least 18 years old
- 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
- Criminal background check presents no health or safety risk to beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with beneficiaries must be qualified in CPR and First Aid
- Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
- Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP
- 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.

• To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.
Staff providing Crisis Services, including first response activities, shall demonstrate strong clinical skills, professional qualifications, experience, and competency. Staff must meet all applicable competency requirements including crisis prevention, intervention and resolution
techniques and trauma-informed care.
Crisis Services staff must 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 TBI and mental health needs OR a physician assistant with a minimum of one year of experience
serving individuals with TBI 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 TBI.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Supports Services

Provider Category:

Agency

Provider Type:

Provider Agencies who operate licensed facilities

Provider Qualifications

License *(specify):*

North Carolina General Statute 122C

Must be licensed according to NC Administrative Code 10A 27G.5100 or have waiver of licensure granted by licensing agency

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:
- Are at least 18 years old
- 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
- Criminal background check presents no health or safety risk to beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with beneficiaries must be qualified in CPR and First Aid
- Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
- Staff that work with beneficiaries must be qualified in the customized needs of the beneficiary as described in the ISP

• 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.
• To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.
Staff providing Crisis Services, including first response activities, shall demonstrate strong clinical skills, professional qualifications, experience, and competency. Staff must meet all applicable competency requirements including crisis prevention, intervention and resolution
techniques and trauma-informed care.
Crisis Services staff must 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 TBI and mental health needs OR a physician assistant with a minimum of one year of experience
serving individuals with TBI 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 TBI.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Delivered Meals

HCBS Taxonomy:

Category 1:	Sub-Category 1:
06 Home Delivered Meals	06010 home delivered meals
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

Home delivered meals is a meal delivery service based on an individual's need for assistance with nutritional planning, in order to safely prepare meals, or ensure meals are prepared to meet the individual's dietary or specialized nutritional needs as ordered by a licensed professional within his or her scope of practice.
The vendor is responsible for preparation, packaging, and delivery of a safe and nutritious meal(s) to an individual at his or her home. This may include a single ready-to-eat meal, or multiple single-serving meals that are frozen, vacuum packed, modified-atmosphere-packed meal, or shelf-stable meal.
Specialized meals include, specialized diets due medical conditions (i.e. reduced sodium, diabetic diet), or specialized textures, therapeutic or kosher meals.

Add home delivered meal services provide up to one meal a day and does not constitute a full nutritional regimen.

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

The service includes no more than 1 meal per day. Planned multiple meal delivery may include meals for up to seven days that are compliant with food storage and safety requirements.

This waiver service is only provided to individuals age 21 and over. All medically necessary Home Delivered Meal services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Independent Provider of Home Delivered Meals
Agency	Agency Provider of Home Delivered Meals

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Individual

Provider Type:

Independent Provider of Home Delivered Meals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable state and local requirements for Home Delivered Meals

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meals

Provider Category:

Agency

Provider Type:

Agency Provider of Home Delivered Meals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable state and local requirements for Home Delivered Meals

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Home Modifications

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

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 beneficiary's level of independence as specified in the Person Centered Plan. A private residence is a home owned by the beneficiary or his/her family (natural or adoptive). 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 beneficiaries 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 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 waiver beneficiary or his/her family must own any equipment that is repaired.

1. Ramps and Portable Ramps
2. Grab Bars
3. Handrails
4. Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside an individual's home
5. Porch stair lifts
6. Modifications and/or additions to bathroom facilities
a. Roll in shower
b. Sink modifications
c. Bathtub modifications/grab bars
d. Toilet modifications
e. Water faucet controls
f. Floor urinal and bidet adaptations
g. Plumbing modifications
7. 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 an individual's rights
8. The following specific specialized adaptations:
a. Shatterproof windows
b. Floor coverings for ease of ambulation for individuals with mobility limitations
c. Modifications to meet egress regulations directly related to the modification requested
d. Automatic door openers/doorbells
e. Voice activated, light activated, touch activated, motion activated electronic devices to control the individual's home environment
f. Medically necessary portable heating and/or cooling adaptation to be limited to one unit per individual
g. Installation of rounded counter tops
h. Lowering of shelves / closet dowel rods / cabinets
i. Protective covering for ramp
j. Wall coverings to prevent damage

Exclusions:
Individuals who receive Residential Supports may not receive this service.
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).
Central air conditioning; general plumbing; swimming pools; Jacuzzis; service and maintenance contracts and extended warranties are not covered.
Locks that are used to restrict an individual's rights are not a covered modification.
Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.
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.
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.

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

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

This waiver service is only provided to individuals age 21 and over. All medically necessary Home Modifications for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Specialized Vendors
Agency	Commercial/Retail Businesses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Individual

Provider Type:

Specialized Vendors

Provider Qualifications

License *(specify):*

Applicable state/local business license

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Modifications

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License *(specify):*

Applicable state/local business license
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

All services are provided in accordance with applicable state or local building codes and other regulations.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

In Home Intensive Support

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ◉ **Service is included in approved waiver. The service specifications have been modified.**

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

Service Definition *(Scope):*

In- Home Intensive support is available to support beneficiaries in their private home, when the beneficiary needs extensive support and supervision as specified in the Person Centered Plan. Rehabilitation, maintenance support and/or supervision are provided to assist with positioning, intensive medical needs, elopement and/or behaviors that would result in injury to self or other people. Staff implements interventions and assistance as defined in the ISP. The ISP includes an assessment and a fading plan or plan for obtaining assistive technology to reduce the amount of intensive support needed by the beneficiary.

Authorization Process:
Long-Term follow-up related to for individual services as the most appropriate and viable option.
1. In-Home Intensive Supports may only be provided to beneficiaries who have documented exceptional medical, behavioral, or physical support needs. Medical / behavioral / physical support needs shall require medical / behavioral records with accompanying documentation in the ISP supporting the need for this services

2. In-Home Intensive Support requires prior authorization by PIHP

3. In-Home Intensive Support requires approval by PIHP at a minimum of every 90 days.

This service is provided in the beneficiary's private home, not in the home of the direct service employee. This service is not provided in the home or office of a staff person or agency.

Exclusions
This service is not provided to participants who receive Residential Supports. This service may not be furnished / billed at the same time of day as Adult Day Health, Cognitive Rehab., Day Supports, Community Networking, Life Skills Training, Personal Care, Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person.

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

The amount of in-home intensive support is subject to the "Limits on Sets of Services" specified in Appendix C-4.

This waiver service is only provided to individuals age 21 and over. All medically necessary In- Home Intensive support services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

☐ **Participant-directed as specified in Appendix E**
☑ **Provider managed**
☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: In Home Intensive Support

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:
• Are at least 18 years old
• 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
• Criminal background check presents no health and safety risk to participant
• Not listed in the North Carolina Health Care Abuse Registry
• Staff that work with beneficiaries must be qualified in CPR and First Aid
• Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
• Staff that work with beneficiaries must be qualified in the customized needs of the TBI beneficiary as described in the ISP 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 however
• To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Frequency of Verification:
Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Life Skills Training

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
13 Participant Training	13010 participant training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Life Skills Training provides rehabilitation and skill building to enable the beneficiary to acquire and maintain skills, which support more independence as specified in the Person Centered Plan. Life Skills Training offers rehabilitative and skill building supports to individuals that are supported in their own home and do not receive residential supports. Life Skills Training augments the family and natural supports of the beneficiary and consists of an array of services that are required to maintain and assist the beneficiary to live in community settings. Life Skill Training does not stem from a licensed facility like Day Supports, nor does it focus on prevocational training.

Life Skills Training consists of:
1. Training in interpersonal skills and development and maintenance of personal relationships
2. Skill building to support the beneficiary in increasing community living skills, such as shopping, recreation, personal banking, grocery shopping and other community activities
3. Training with therapeutic exercises, supervision of self-administration of medication and other services essential to healthcare at home, including transferring, ambulation and use of special mobility devices
4. Transportation to support implementation of Life Skills Training

Life Skills Training may be provided when a primary caregiver is home or when that primary caregiver is regularly scheduled to be absent. Life Skills Training is individualized, specific, and consistent with the beneficiary's assessed disability specific needs and is not provided in excess of those needs. Life Skills Training is furnished in a manner not primarily intended for the convenience of the beneficiary, primary caregiver, the provider, or the provider/ employer of record. This service is distinctive from personal care by the presence of rehabilitation. The mixture of Life Skills Training and personal care must be specified in the Individual Support Plan. It is anticipated that the presence of Life Skills Training will result in a gradual reduction in hours as the beneficiary is trained to take on additional tasks and masters skills (fading plan). A formal fading plan is not required.

These services are provided in the beneficiary's private home and not in the home of the direct service employee. Life Skills Training Services must start and/or end at the home of the beneficiary. When appropriate, Life Skills Training can be provided via real time two-way interactive audio and video telehealth.

Exclusions
This service is not provided to beneficiaries who receive Residential Supports. This service is not provided to participants who receive Residential Supports. This service may not be furnished / billed at the same time of day as Cognitive Rehab., Day Supports, Community Networking, In Home Intensive Supports, Personal Care, Respite, Supported Employment or one

of the State Plan Medicaid services that works directly with the person. Through the review of service documentation, the care coordinator will confirm that Life Skills Training is not being billed at the same time of day as to determine that services are not being billed at the same time of day as Cognitive Rehab., Day Supports, Community Networking, In Home Intensive Supports, Personal Care, Respite, Supported Employment

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

The amount of Life Skills Training is subject to the "Limits on Sets of Services" specified in Appendix C-4.

This waiver service is only provided to individuals age 21 and over. All medically necessary Life Skills Training services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Payments for Life Skills Training is made directly from the LME-MCO to the service provider. Life Skills Training Payments are not made to the beneficiary.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Life Skills Training

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

- Are at least 18 years old
- 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
- Criminal background check presents no health or safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with beneficiaries must be qualified in CPR and First Aid
- Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)

• Staff that work with TBI beneficiaries must be qualified in the customized needs of the participant as described in the ISP
• 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 participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however
• To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Natural Supports Education

HCBS Taxonomy:

Category 1:	Sub-Category 1:
09 Caregiver Support	09020 caregiver counseling and/or training
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Natural Supports Education provides training to families (who are not paid to provide support) 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 TBI and its co-occurring disabilities upon the beneficiary, provide education and training on rehabilitation and/or compensatory intervention/strategies, and provide education and training in the use of specialized equipment and supplies as specified in the Person Centered Plan. 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 or Cognitive Rehabilitation.

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.

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

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

This waiver service is only provided to individuals age 21 and over. All medically necessary Natural Supports Education services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Natural Supports Education

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

- Are at least 18 years old
- 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
- Criminal background check presents no health or safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Staff that work with beneficiaries must be qualified in CPR and First Aid
- Staff that work with beneficiaries must have a high school diploma or high school equivalency (GED)
- Staff that work with TBI beneficiaries must be qualified in the customized needs of the participant as described in the ISP
- 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 participant crisis situations. The participant may select any enrolled crisis services provider in lieu of this provider however
- To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Has expertise as appropriate in the field in which the training is provided in the ISP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Verifies employee qualifications at the time employee is hired
Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Remote Supports

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17990 other
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

Remote support is a service delivery for beneficiaries, 18 and older, who are able to follow verbal prompts, have a desire to enhance their independent living skills and who are selecting an alternative option to increase their independence. Remote support means the support of a beneficiary through staff working from a remote location using one or more modes of remote support equipment systems. The purpose of remote supports is to enable beneficiaries to exercise greater independence over their lives and promote community inclusion. All Remote Support systems shall utilize assistive technology that can engage in live two-way communication with or without real-time video observation of the beneficiary. Any specific needs related to ongoing remote supervision should be outlined within the beneficiary's Individual Support Plan (ISP). The ISP should contain all coverage needs to include the hours of remote support coverage.

Remote support equipment is used to operate systems such as live video feed, live audio feed, motion sensing system, radio frequency identification, web-based support systems, or another approved assistive technology device. All remote support systems must have the ability to engage in live two-way communication with the beneficiary being remotely supervised based on their support needs identified during the person-centered planning process. The physical location of a provider's support base cannot be located at the home of the beneficiary nor their family member who receives remote support service.

Expected Outcomes
Remote Support allows beneficiaries to remain safely in their homes. Remote Support helps to promote self-determination, enhances privacy through providing services in the less restrictive level of care, and permits supervision as needed by remote observation. The goal of this service is to allow the flexibility of remote supervision when direction supervision is not required, thus encouraging independence while still providing a safe environment for the beneficiary.

The intended outcome of Remote Support is the following:
A. To increase or maintain the beneficiary's level of independence,
B. Provide the supervision needed,
C. Maximize self-sufficiency,
D. Increase self-determination, and
E. Ensure the beneficiary's opportunity to have full membership in his/her community.

Service Type and Setting
Remote Support is a 24-hour a day service. This service is provided through the use of remote support technology in the beneficiary's home and/or community. Through the use of remote support technology, direct support professionals provide live support as outlined within the ISP. It is important to note that Remote support service is done in real time (not via a

recording) by awake staff at a support base using the appropriate connection. While remote support is being provided, the remote support staff are not to have duties other than remote support. Provider agencies and vendors are required to meet all service type and setting requirements outlined under program requirements.

Program Requirements
Remote Support is designed to be a supportive therapeutic relationship between the provider and the beneficiary which addresses and/or implements interventions outlined in the ISP. The beneficiary's or ISP shall be amended to include remote supports:
A. A statement in the ISP to justify the rationale for remote support, such as how it benefits the beneficiary, assures health and safety and/or promotes independence.
B. Updated risk assessment specific to remote support shall be attached to the support plan.
C. A description of the remote support equipment being used which includes the function/purpose of any assistive technology devices or software, identifies the general location of equipment and addresses the beneficiary's and family's knowledge of how to use.
D. A detailed back-up plan in the event of system failure or power outage should outline the responsibilities of both the remote support vendor and the provider agency.
E. The following shall also be in place:
1. There must be a written response protocol listed in the ISP which outlines the remote support vendor's procedure and provider agency's procedures for when the beneficiary triggers an event for assistance, or an alert is received.
2. The remote support vendor shall have an effective system for notifying emergency personnel such as mental health crisis response entities, fire, and police.
3. There must be a written emergency response protocol that outlines the responsibilities of the remote support vendor, as well as the responder.
4. The emergency plan can include natural supports or paid supports.
F. Updated emergency response plan shall include, at a minimum, a description of:
1. The types of responses that are deemed to be in person/face-to-face, telehealth or telephonic
2. The number and type of back-up responder (natural supports and/or staff).
3. The expected response time of the back-up responders to respond

In situations not included in the ISP or Emergency Plan, the remote support staff or vendor who receives the alert should determine how to best respond to the beneficiary's support needs at that time to ensure health and safety. The beneficiary and guardian/family should be notified immediately of any decisions made outside of the ISP. The ISP should be updated within 30 days to include a protocol to address similar situations in the future.

G. When a beneficiary needs assistance but the situation is not an emergency, the remote support staff shall:
1. Address the situation as specified in the beneficiary's beneficiary support plan for a beneficiary who receives remote support with unpaid backup support; OR
Contact the paid back-up support for a beneficiary who receives remote support with paid backup supports.
2. The remote support staff shall have detailed and current written protocols for responding to a beneficiary's needs as specified in the ISP, including contact information for the backup support person or direct support professional to provide assistance if deemed appropriate.
3. The beneficiary's ISP shall describe steps to be followed should the beneficiary request that the equipment used for delivery of remote support be turned off.
F. When overnight support staff is needed, the ISP specifies the need for overnight support staff. It should address how the service would ensure the beneficiary's service needs are being met and that health and welfare are being addressed adequately.

INFORMED CONSENT:
A. To address potential issues of privacy, informed consent for using this service versus traditional service options. Informed consent shall be documented in the ISP.
B. Live video feed cameras will only be set up in common areas; never in a location where there is an expectation of privacy, such as a bedroom or bathroom. If for health and safety reasons, supervision is required in the bedroom or bathroom, alternative assistive technology shall be utilized to protect the privacy and dignity of the beneficiary requesting or needing supervision.
C. When Remote Support involves the use of audio or video equipment that enables Remote Support staff to view or listen in on activities within the home, a notice shall be prominently displayed within the entry way of the residence and near each camera or listening device. This notice shall include accessible language that advises occupants and visitors that the home is equipped with audio and/or video equipment that permits others to view activities and/or listen to conversations.
D. The beneficiary who receives the service and each beneficiary who lives in the home is to provide consent in writing,

after being fully informed of what Remote Support entails including; but not limited to, that the Remote Support staff has the ability to and will observe their activities and/or listen to their conversations within the home, where within the residence the Remote Support will take place, and whether or not recordings will be made. If the beneficiary receiving Remote Support or another beneficiary who lives in the home, has a guardian, the guardian must also consent in writing.

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

endor or Provider Safeguards:

A. In the event of electrical outages or failure, the provider of the assistive technology or Remote Support must have a backup power system. The provider must also have other backup systems and additional safeguards in place which include, but are not limited to, contacting the backup support responder to provide in-person support in the event the assistive technology and/or Remote Support equipment stops working for any reason.

B. If the beneficiary receiving the service indicates s/he wants the Remote Support equipment turned off or disabled; temporarily or permanently, the following protocol is to be implemented:

1. The Remote Support staff is to contact the backup support responder and request in-person assistance at the beneficiary's current home as notated in the beneficiary's person-centered plan/beneficiary support plan.
2. The Remote Support equipment shall remain in operation until the backup support responders arrives.
3. If no one else at the location is receiving Remote Support, the Remote Support staff will turn off the system once the backup support responder arrives at the location and is briefed on the situation. The ISP should be updated accordingly.

C. Remote support service vendors shall maintain record of monitoring services for seven years.

D. A secure network system requiring authentication, authorization, and encryption of data that complies with HIPAA requirements.

E. Monthly testing of the assistive technology shall be completed to ensure it is in good working condition and used appropriately by the beneficiary receiving the service. For Remote Support equipment that is in daily use, there shall be a means to continuously monitor the functioning of the equipment and a policy or plan in place to address malfunctions.

F. If the evaluation identifies a need for Remote Support, ensure the Remote Support equipment meets the following criteria:

1. Includes an indicator that lets the beneficiary using the equipment know that it is on and operating. The indicator shall be appropriate to meet the beneficiary's needs;
2. Is designed so that it can be turned off only by the beneficiary (s) indicated in the beneficiary support plan;
3. Has 99% system uptime that includes adequate redundancy;
4. Has adequate redundancy that ensures critical system functions are restored within three hours of a failure. If a service is not available, the beneficiary and provider must be alerted within ten minutes.

G. If the evaluation identifies the need for a staffed call center, a backup plan must be in place that meets the beneficiary's needs. In the most demanding situations, that may mean there is another call center that is part of a network. In less demanding situations, it may be an alternate location that can become operational within a timeframe that meets the beneficiary's needs and is specified within the plan. In any event, an adequate "system down" plan must be in place.

H. There shall be a mechanism to alert staff when a power outage occurs that provides a low battery alert, and an alert if the system may go or goes down so that back-up support, if required, is in place until service is restored.

I. A main hub, if required, must be able to connect to the internet via one or more different methods; hard-wired, wireless, or cellular. The main hub must also be able to send via one or more different modes of notification (i.e. text, email, or audio), as well as the ability, to connect to an automated or customer support call center that is staffed 24 hours a day, 7 days a week. The provider/vendor determines main hub location. The location cannot be within a beneficiary's residence.

J. Has a latency of no more than 10 minutes from when an event occurs to when the notification is sent via text, email or audio contingent upon the beneficiary's needs.

K. Has the capability to include environmental controls that can be added on and controlled by the identified beneficiary in the support plan.

L. Have a battery life expectancy lasting six months or longer, has a low battery notification and have a battery replacement policy.

M. Response timeframes are beneficiary-specific and outlined within their support plan and not to exceed 1 hour.

N. The vendor of the remote support system must have an effective means for notifying emergency personnel, such as fire, emergency medical services, and mental health crisis response entities, police as soon as possible.

O. If an emergency arises at a beneficiary's residence, the remote support staff will immediately assess the situation and call emergency personnel first, if it is deemed necessary, and then contact the backup responder to notify of the emergency event. The Remote Support staff will stay engaged with the beneficiary during an emergency until emergency personnel or the backup support arrives.

P. The backup responder is to acknowledge receipt of a request for assistance from the Remote Support staff.

Q. The backup support responder must arrive at the beneficiary's home within a reasonable amount of time (to be specified in the ISP but not to exceed 1hr) when a request for beneficiary assistance for non-urgent issues is made.

This waiver service is only provided to individuals age 21 and over. All medically necessary Remote Support services for

children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Exclusions:
a. Items that are not of direct or remedial benefit to the person are excluded from this service
b. Remote Supports is not intended for convenience of the beneficiary's caretake or the provider.
c. Remote supports shall not be utilized for individuals where remote supports is contraindicated.

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

☐ **Participant-directed as specified in Appendix E**

☑ **Provider managed**

☐ **Remote/via Telehealth**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Alert Response Centers
Agency	Specialized Vendors

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Alert Response Centers

Provider Qualifications

License *(specify):*

Applicable state/local business license

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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.
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.
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.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Remote Supports

Provider Category:

Agency

Provider Type:

Specialized Vendors

Provider Qualifications

License *(specify):*

Applicable state/local business license

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

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.
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.

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Specialized Consultation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10040 behavior support
Category 2:	**Sub-Category 2:**
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11080 occupational therapy
Category 4:	**Sub-Category 4:**
11 Other Health and Therapeutic Services	11100 speech, hearing, and language therapy

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

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

Service Definition *(Scope):*

Specialized Consultation Services provide expertise, training and technical assistance in a specialty area (neuro/psychology, behavior intervention, therapeutic recreation, augmentative communication, assistive technology equipment, nutrition, and other licensed professionals who possess experience with individuals with traumatic brain injury) to assist family members, support staff and other natural supports in assisting individuals with traumatic brain injury as specified in the Person

Centered Plan. 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:
• Observing the individual to determine needs;
• Assessing any current interventions for effectiveness;
• 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;
• 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;
• Training and technical assistance of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan;
• Observe, record data and monitor implementation of therapeutic interventions/support strategies;
• Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan;
• Revision of the intervention plan as needed to assure progress toward achievement of outcomes
• Participating in team meetings; and/or
• 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.

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

This service may not duplicate services provided to family members through natural supports education, cognitive rehabilitation, extended state plan OT, PT, SLP, or crisis services.

This waiver service is only provided to individuals age 21 and over. All medically necessary Specialized Consultative services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Provider Agencies
Individual	Independent Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Consultation

Provider Category:

Individual

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

NC G.S.122C, as appropriate
-Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology, behavioral analysis (licensure subject to psychology board implementation date) and nutrition; state certification for recreational therapy; board certified behavior analyst-MA; master's degree and expertise in augmentative communication; national certification in assistive technology
-Criminal background check presents no health or safety risk to beneficiary
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the beneficiaries as described in the Individual Support Plan

• To enroll as a provider of 1915(c) Innovations Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Consultation

Provider Category:

Individual

Provider Type:

Independent Practitioner

Provider Qualifications

License *(specify):*

Licensure specific to discipline, if applicable
Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Certification or registration specific to discipline, if applicable

Other Standard *(specify):*

• Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology, behavioral analysis (licensure subject to psychology board implementation date) and nutrition; board certified behavior

analyst-MA; master's degree and expertise in augmentative communication; national certification in assistive technology and state certification in recreation therapy

- Criminal background check presents no health or safety risk to beneficiary
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in the customized need of the beneficiaries as described in the Individual Support Plan

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

At time of initial review and annually thereafter

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Supported Living

HCBS Taxonomy:

Category 1:	Sub-Category 1:
02 Round-the-Clock Services	02021 shared living, residential habilitation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

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

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

Service Definition *(Scope):*

The 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 TBI Waiver 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 as specified in the Person Centered Plan. 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; however, must not be used for the convenience of 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 by family members as defined in this service definition. 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 Individuals support needs.

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
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 person 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 person 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 person 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.

When appropriate, Supported Living can be provided via real time two-way interactive audio and video telehealth.

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

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

This service is not available on the same day as the TBI Waiver Personal Care or State Plan Personal Care.

The following exception applies:
Respite may be used by individuals living in a Residential or Supported Living setting when the individual is accessing a summer camp or support group. The Residential and Supported Living will not be billed on days when an individual is utilizing respite to access an overnight summer camp.Respite may be used by individuals living in a Residential or Supported Living setting when the individual is accessing a summer camp or support group. The Residential and Supported Living will not be billed on days when an individual is utilizing respite to access an overnight summer camp.The amount of Supported Living is subject to the Limits on Sets of Services. A. To ensure the intent of the definition to support persons to live in a home of their own and achieve independence, Supported Living shall not be provided in a home where a person lives with family members unless such family members are a person receiving Supported Living, the family member is

receiving other disability specific services, a spouse, or a minor child. Family member is defined as a parent, grandparents, siblings, grandchildren, and other extended family members.

This waiver service is only provided to individuals age 21 and over. All medically necessary Supported Living services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency.

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Staff or live-in caregiver are at least 18 years of age and meet the following requirements:

- If providing transportation, have valid NC driver's license or other valid driver's license, a safe driving record an acceptable level of automobile liability insurance
- Criminal background check presents no health and safety risk to person/s
- Not listed in NC Health Care Abuse Registry
- Qualified in CPR and First Aid
- Qualified in the customized needs and TBI needs of the person/s as described in the ISP
- High school diploma or equivalency (GED).
- Paraprofessionals providing this service must also be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) and (f) and according to licensure or certification requirements of the appropriate discipline.

Provider Qualifications: Provider Agencies in PIHP network. 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. To enroll as a provider of 1915(c) TBI Waiver services in NC Medicaid, 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 enrollment requirements for NC Medicaid.

Supported Living providers:
• Assist in finding a home that meets the individual's needs
• Assist in managing living in one's own home
• Help develop community involvement and relationships that promote full citizenship
• Coordinate education and assistance related to finances, healthcare, and other needs
• Assist with day-to-day planning and problem solving
• Train and support people who assist the individual
• Provide 24 hour availability to respond to the needs of the individual, including emergency situations.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing by the State.
PIHP verifies credentials upon initial review and re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Vehicle Modifications

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

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

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

Service Definition *(Scope):*

Vehicle Modifications are devices, services or controls that enable individuals to increase their independence or physical safety by enabling their safe transport in and around the community as specified in the Person Centered Plan. The installation, repair, maintenance, and training in the care and use of these items are included. The individual or his/her family must 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 individual. 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 and/or Traffic Safety Administration guidelines. The adapted vehicle supplier should conduct an evaluation that has an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications.".

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.

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:
1. Door handle replacements
2. Door modifications
3. Installation of raised roof or related alterations to existing raised roof system to approve head clearance
4. Lifting and/or lowering devices
5. Devices for securing wheelchairs or scooters
6. 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
7. Handrails and grab bars
8. Seating modifications
9. Lowering of the floor of the vehicle
10. Modifications for accessibility

Exclusions:
1. Vehicle Modifications are not available to individuals who receive Residential Supports or who live in licensed residential facilities.
2. 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.
3. Items that are not of direct or remedial benefit to the individual are excluded from this service.

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

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

This waiver service is only provided to individuals age 21 and over. All medically necessary Vehicle Modifications services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

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

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**
- ☐ **Remote/via Telehealth**

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Specialized Vendors
Agency	Commercial/Retail Businesses

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Individual

Provider Type:

Specialized Vendors

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Vehicle Modifications

Provider Category:

Agency

Provider Type:

Commercial/Retail Businesses

Provider Qualifications

License *(specify):*

Tribal Provides may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Prior to first use

Appendix C: Participant Services

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

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

- ○ **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- ◉ **Applicable** - Case management is furnished as a distinct activity to waiver participants.

Check each that applies:

- ☐ **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☑ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under section 1945 and/or section 1945A of the Act (Health Homes Comprehensive Care Management).** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants and the requirements for their training on the HCBS settings regulation and person-centered planning requirements:

Under the 1915(b)/1915(c) concurrent waivers, the case management functions compliant with managed care treatment planning requirements at 42 CFR 438.208(c) are conducted by the PIHP/Tailored Plan, community based provider or Tribal Care Coordination.

d. Remote/Telehealth Delivery of Waiver Services. Specify whether each waiver service that is specified in Appendix C-1/C-3 can be delivered remotely/via telehealth.

No services selected for remote delivery

Appendix C: Participant Services

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

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

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

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

Section 1.13 of the contract, in accordance with 42 CFR § 455.106, requires the PIHPs/Tailored Plan to require all providers to disclose any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The PIHP/Tailored Plan must report such disclosures to DHB within 20 working days from the date the PIHP/Tailored Plan receives such disclosures. Pursuant to 42 CFR § 455.106(b)(1), DHB will report such disclosures to HHS-OIG within 20 working days after notification by the LME-MCOs.

Criminal background checks must be conducted prior to hiring the employee in all situations described below. As provided by NC G.S. 122C-80, criminal background checks must be conducted on all prospective employees of licensed MH/DD/SAS provider agencies who may have direct access to individuals served. PIHP/Tailored Plan licensed contract agencies must comply with this law. This includes direct care positions, administrative positions and other support positions that have contact with individuals served. When prospective employees have lived in North Carolina for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.

As required by the North Carolina TBI Waiver service provider qualifications, unlicensed provider agencies who contract to provide North Carolina TBI Waiver services must also conduct criminal background checks on all prospective employees who may have direct access to individuals served. The PIHP/Tailored Plan conducts criminal background checks on independent practitioners. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. National criminal record checks may be completed by private entities (defined as a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency in each of the States) while State criminal history record checks may be completed by a county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank. In addition, a State criminal history record check may be completed by a private entity (defined as a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency). A provider of unlicensed services shall not employ an applicant who refuses to consent to a criminal history record check required by this waiver.

The State reviews the provider agency's criminal record check policy at the time of initial credentialing of the agency and re-verifies agency credentials, including a sample of criminal background checks, at a frequency determined by the State, no less than every three years.

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

○ **No. The state does not conduct abuse registry screening.**

● **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

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

G.S. 131E-256, 10 A NCAC, requires the PIHP/Tailored Plan to require providers to perform a Health Care Registry screen at the time that the apply or renew their applications for Medicaid participation or at any time on request. The PIHP/Tailored Plan must report such disclosures to DHB within 20 working days from the date the PIHP/Tailored Plan receives such disclosures. DHB will report such disclosures to the HHS-OIG within 20 working days of notification by the PIHP/Tailored Plan.

Abuse registry screenings must be conducted prior to hiring the employee in all situations discussed below.

As provided by NC General Statute 131E-256, the DHHS Division of Health Service Regulation maintains an abuse registry, called the Health Care Personnel Registry. As required by NCGS 131-E-256, licensed agencies and unlicensed providers of community based services for persons with TBI who contract with the PIHP/Tailored Plan must conduct abuse registry screenings of prospective employees for positions who have direct access to individuals receiving services. Information from both the Nurse Aide Registry and the Health Care Personnel Registry is available to the general public and all health care providers via the Internet and through a 24 hour telephone voice response system through the Division of Health Service Regulation at https://www.ncnar.org/verify_listings1.jsp

The PIHP/Tailored Plan reviews the provider agency's abuse registry screening policy at the time of initial credentialing and re-verifies agency credentials, including a sample of Abuse Registry screenings, at a frequency determined by the PIHP/Tailored Plan, no less than every three years. The PIHP/Tailored Plan reviews employer of record personnel practices annually to ensure that necessary screenings have been performed prior to employment.

Appendix C: Participant Services

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

Note: Required information from this page is contained in response to C-5.

Appendix C: Participant Services

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

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law or regulations to care for another person (e.g., the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child). At the option of the state and under extraordinary circumstances specified by the state, payment may be made to a legally responsible individual for the provision of personal care or similar services. *Select one*:

○ **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**

● **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the types of legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) the method for determining that the amount of personal care or similar services provided by a legally responsible individual is ***"extraordinary care"***, exceeding the ordinary care that would be provided to a person without a disability or chronic illness of the same age, and which are necessary to assure the health and

welfare of the participant and avoid institutionalization; (c) the state policies to determine that the provision of services by a legally responsible individual is in the best interest of the participant; (d) the state processes to ensure that legally responsible individuals who have decision-making authority over the selection of waiver service providers use substituted judgement on behalf of the individual; (e) any limitations on the circumstances under which payment will be authorized or the amount of personal care or similar services for which payment may be made; (f) any additional safeguards the state implements when legally responsible individuals provide personal care or similar services; and, (g) the procedures that are used to implement required state oversight, such as ensuring that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

Legally Responsible Individuals or Individuals who reside in the same home of a TBI Waiver Beneficiary are permitted to provider Life Skills Training and/or Personal Care Services.

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 spouse of a waiver beneficiary.
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.
Justification needs to be provided as to why there is no other qualified provider to provide Personal Care and/or Life Skills Training and assurances of provider choice and that the individual will not be 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/legal guardians. Services delivered by relatives/legal guardians are monitored monthly. Care Managers 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 individual. 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.

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- (●) **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- ( ) **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

  Specify the types of relatives/legal guardians to whom payment may be made, the services for which payment may be made, the specific circumstances under which payment is made, and the method of determining that such circumstances apply. Also specify any limitations on the amount of services that may be furnished by a relative or legal guardian, and any additional safeguards the state implements when relatives/legal guardians provide waiver services. Specify the state policies to determine that that the provision of services by a relative/legal guardian is in the best interests of the individual. When the relative/legal guardian has decision-making authority over the selection of providers of waiver services, specify the state's process for ensuring that the relative/legal guardian uses substituted judgement on behalf of the individual. Specify the procedures that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

- ( ) **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

  Specify the controls that are employed to ensure that payments are made only for services rendered.

○ **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR § 431.51:

Under its risk contract with DHB, the PIHP must establish policies and procedures to monitor the adequacy, accessibility and availability of its provider network to meet the needs of individuals served through the concurrent §1915 (b)/ §1915(c) waivers. As this is a new waiver, the PIHP will open provider its provider network for willing and qualified TBI Providers. The provider will make an application to the PIHP and the PIHP will review to determine if the provider is qualified.

The PIHP will continually analyze its provider network and demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access by beneficiaries to practitioners and facilities. The analysis is reviewed by DHB at the beginning of Application for 1915(c) HCBS Waiver: each contract period; at any time, there has been a significant change in PIHP operations that may affect the adequacy of capacity and services, including changes in services, benefits, geographic service areas or payments or enrollment of a new population in the concurrent waivers; and annually thereafter during the annual site visits by the EQRO. Whenever network gaps are noted, the PIHP submits to DHB a network development strategy or plan to fill the gaps, as well as periodically reports to DHB on the implementation plan or strategy.

g. State Option to Provide HCBS in Acute Care Hospitals in accordance with Section 1902(h)(1) of the Act. Specify whether the state chooses the option to provide waiver HCBS in acute care hospitals. *Select one*:

○ **No, the state does not choose the option to provide HCBS in acute care hospitals.**

○ **Yes, the state chooses the option to provide HCBS in acute care hospitals under the following conditions.** *By checking the boxes below, the state assures:*

☐ **The HCBS are provided to meet the needs of the individual that are not met through the provision of acute care hospital services;**

☐ **The HCBS are in addition to, and may not substitute for, the services the acute care hospital is obligated to provide;**

☐ **The HCBS must be identified in the individual's person-centered service plan; and**

☐ **The HCBS will be used to ensure smooth transitions between acute care setting and community-based settings and to preserve the individual's functional abilities.**

*And specify:***(a) The 1915(c) HCBS in this waiver that can be provided by the 1915(c) HCBS provider that are not duplicative of services available in the acute care hospital setting;(b) How the 1915(c) HCBS will assist the individual in returning to the community; and(c) Whether there is any difference from the typically billed rate for these HCBS provided during a hospitalization. If yes, please specify the rate methodology in Appendix I-2-a.**

Appendix C: Participant Services

Quality Improvement: Qualified Providers

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

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services Numerator: Number of new providers who meet licensure, certification, and/or other standards prior to furnishing waiver services Denominator: Total number of new providers

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider credentialing documentation.

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

☑ **Other** Specify: PIHP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☑ **Other** Specify: Semi Annually	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PIHP monitoring schedule. Numerator: Number of C waiver providers who had a review completed and were found to be compliant Denominator: Total number of C waiver providers scheduled for a review who had a review completed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring Review Protocol and Tools

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level with +/-5% margin of error
☑ **Other** Specify: PIHPs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Proportion of new licensed providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services Numerator: Number of new licensed providers reviewed who meet the requirements to furnish waiver services Denominator: Total number of new licensed providers reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider applications and evidence of licensure/certification

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level with +/-5% margin of error

☑ **Other** Specify: PIHPs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

b. ***Sub-Assurance: The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of monitored non-licensed, non-certified providers that are compliant with waiver requirements. Numerator: Number of monitored non-licensed, non-certified providers that are compliant with waiver requirements. Denominator: Number of non-licensed, non-certified providers reviewed.

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Provider Monitoring Protocol and Tools

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

Data Aggregation and Analysis:

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

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the state will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of monitored providers wherein all staff completed all mandated training, excluding restrictive interventions, within the required timeframe. Numerator: Number of provider agencies monitored wherein all staff have completed all mandated training, excluding restrictive interventions, within the required timeframe Denominator: Number of provider agencies monitored

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring Protocol and Tools

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

Agency		
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: PIHPs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Proportion of monitored providers where all staff completed restrictive intervention training within the required timeframe for beneficiaries with restrictive interventions approved in their ISPs. Numerator: # of provider agencies monitored where applicable staff have completed all restrictive interventions training within the required timeframe Denominator: # of provider agencies monitored.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Provider Monitoring Protocol and Tools

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The PIHPs address and correct problems identified on a case by case basis and include the information in reports to DHB. Issues with providers are often identified through consumer complaints/grievances which are reported to the DHB quarterly by the PIHPs. The PIHPs may require the provider to implement a corrective action plan. Depending on the seriousness of the provider issue and/or the results of the corrective action plan, the PIHPs may terminate the provider from the network.

The state periodically reviews the accuracy of the PIHP reporting during the annual EQRO as well.

ii. Remediation Data Aggregation

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ● **No**
- ○ **Yes**

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

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ● **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
Furnish the information specified above.

The following limits apply:

Nursing Facility Level of Care:

(1) Adult beneficiaries who receive residential supports or supported living supports: No more than 30 hours per week is authorized for any combination of community networking, adult day health, day supports and/or supported employment services.

Nursing Facility Level of Care:
(1) Adult beneficiaries who live in private homes: No more than 49 hours per week is authorized for any combination of community networking, adult day health, day supports, supported employment, personal care and/or Life Skills Training.

Specialty Hospital Level of Care:
(1) Adult beneficiaries who receive residential supports or supported living supports: No more than 40 hours per week is authorized for any combination of community networking, Adult Health, day supports and/or supported employment services.

(1) Adult participants who live in private homes: No more than 84 hours per week is authorized for any combination of for any combination of community networking, Adult Day Health, day supports, supported employment, personal care and/or Life Skills Training.

Once the level of care has been approved, the individual will be made aware of the limits that apply. If the individual's needs exceed the limits on sets of services, the individual may be authorized for In Home Intensive Supports. This service can exceed the limits on sets of services. Waiver limits are applied for the 5-year waiver cycle.

☐ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
Furnish the information specified above.

☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
Furnish the information specified above.

☐ **Other Type of Limit.** The state employs another type of limit.
Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 §§ CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings in which 1915(c) HCBS are recieved. *(Specify and describe the types of settings in which waiver services are received.)*

2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and in the future as part of ongoing monitoring. *(Describe the process that the state will use to assess each setting including a detailed explanation of how the state will perform on-going monitoring across residential and non-residential settings in which waiver HCBS are received.)*

3. *By checking each box below, the state assures that the process will ensure that each setting will meet each requirement:*

- ☐ **The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.**
- ☐ **The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board. *(see Appendix D-1-d-ii)***
- ☐ **Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.**
- ☐ **Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.**
- ☐ **Facilitates individual choice regarding services and supports, and who provides them.**
- ☐ **Home and community-based settings do not include a nursing facility, an institution for mental diseases, an intermediate care facility for individuals with intellectual disabilities, a hospital; or any other locations that have qualities of an institutional setting.**

Provider-owned or controlled residential settings. (*Specify whether the waiver includes provider-owned or controlled settings*.)

- ○ **No, the waiver does not include provider-owned or controlled settings.**
- ○ **Yes, the waiver includes provider-owned or controlled settings.** (By checking each box below, the state assures that each setting, *in addition to meeting the above requirements, will meet the following additional conditions*):
  - ☐ **The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the state, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, the state must ensure that a lease, residency agreement or other form of written agreement will be in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.**
  - ☐ **Each individual has privacy in their sleeping or living unit:**

- ☐ **Units have entrance doors lockable by the individual.**
- ☐ **Only appropriate staff have keys to unit entrance doors.**
- ☐ **Individuals sharing units have a choice of roommates in that setting.**
- ☐ **Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement.**

☐ **Individuals have the freedom and support to control their own schedules and activities.**

☐ **Individuals have access to food at any time.**

☐ **Individuals are able to have visitors of their choosing at any time.**

☐ **The setting is physically accessible to the individual.**

☐ **Any modification of these additional conditions for provider-owned or controlled settings, under § 441.301(c)(4)(vi)(A) through (D), must be supported by a specific assessed need and justified in the person-centered service plan*(see Appendix D-1-d-ii of this waiver application).***

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

Individual Service Plan (ISP)

a. Responsibility for Service Plan Development. Per 42 CFR § 441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals. Given the importance of the role of the person-centered service plan in HCBS provision, the qualifications should include the training or competency requirements for the HCBS settings criteria and person-centered service plan development. *(Select each that applies):*

☐ **Registered nurse, licensed to practice in the state**

☐ **Licensed practical or vocational nurse, acting within the scope of practice under state law**

☐ **Licensed physician (M.D. or D.O)**

☐ **Case Manager** (qualifications specified in Appendix C-1/C-3)

☑ **Case Manager** (qualifications not specified in Appendix C-1/C-3).

Specify qualifications:

"Qualified professional" means,

(a) an individual who holds a license, provisional license, certificate, registration or permit issued by the governing board regulating a human service profession, except a registered nurse who is licensed to practice in the State of North Carolina by the North Carolina Board of Nursing who also has four years of full-time accumulated experience in mh/dd/sa with the population served; or

(b) a graduate of a college or university with a Masters degree in a human service field and has one year of full-time, accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; or

(c) a graduate of a college or university with a bachelor's degree in a human service field and has two years of full-time, accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has two years of full-time, accumulated supervised experience in alcoholism and drug abuse counseling; or

(d) a graduate of a college or university with a bachelor's degree in a field other than human services and has four years of full-time, accumulated mh/dd/sa experience with the population served, or a substance abuse professional who has four years of full-time, accumulated supervised experience in alcoholism and drug abuse counseling.

☐ **Social Worker**

Specify qualifications:

☐ **Other**
Specify the individuals and their qualifications:

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (2 of 8)

b. Service Plan Development Safeguards. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for service plan development except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.** ***Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can develop the service plan:***

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in service plan development. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (3 of 8)

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) A variety of person centered tool kits are available to gather information and enable the beneficiaries 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 Tailored Care Manager or support providers as needed. Based on the unique needs of the beneficiary, a decision can be made to use one toolkit, multiple tool kits or none at all.

(b) The beneficiary and Tailored Care Manager/Care Coordinator review the team composition to make sure that people the beneficiary would like to have at the meeting are invited. If the beneficiary has a legally responsible person, the Tailored Care Manager will ensure that the person is invited to the ISP meeting as well.

Care Coordinators will perform PCP when the individual declines Tailored Care Management. Wherever Tailored Care Management is noted, this may be a Care Coordinator if the individual declines Care Management.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. i. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; (g) how and when the plan is updated, including when the participant's needs changed; (h) how the participant engages in and/or directs the planning process; and (i) how the state documents consent of the person-centered service plan from the waiver participant or their legal representative. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Individual Support Plan (ISP):
The timing of service plan is specific to the type of service plan (initial plan of care, annual updates, or revisions). The following outlines the type of service plan and the timelines associated with them:

Initial Plan of Care - Any person entering the NC TBI Waiver must have an initial level of care determination completed prior to the start of the care planning process. Once the level of care determination is complete, the Initial service plan must be completed within 60 calendar days. Once the initial plan of care is complete, the beneficiaries annual plan due date is identified.

Annual Updates - 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 would be 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 may not extend beyond 365 days.

Revisions to the Individual Support Plan - Revisions are made to the Individual Support Plan whenever the beneficiary's life circumstances change. This may occur often or rarely, depending on the individual. This includes 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. For example, if the beneficiary goes on vacation and needs to suspend Supported Employment services for two weeks, a revision is not needed. 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 individual's record. Revisions are also made to the Individual Support Plan when the cost of a service changes.

The Individual Support Plan (ISP) is updated at least annually, and revisions are made as often as necessary to reflect changes in the beneficiary's life circumstances or service needs. Revisions may be made frequently or rarely, depending on the beneficiary and individual life circumstances. Examples of changes that may necessitate a revision include accomplishment of a goal, lack of progress on a goal, change in living arrangement, increased medical needs, change in employment status, change in educational status, increased or decreased supervision needs, behavioral changes, etc.
Relevant assessments are also updated at this time, as appropriate. For example, if the beneficiary wants to change employment, a vocational assessment update may need to be completed.

Changes in short term goals and intervention strategies do not require an ISP update or revision.

Any member of the person centered planning team may suggest that the ISP be updated or revised. The Tailored Care Manager/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 individual. The Tailored Care Manager/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.

Tailored Care Management/Care Coordination:
Each NC TBI Waiver beneficiary is assigned a Tailored Care Manager at the PIHP. Tailored Care Manager/Care Coordinator are Qualified Professionals under the North Carolina credentialing system and are competent in the person centered planning process. The Care Coordinator will perform PCP when the individual declines Tailored Care Management.
The Tailored Care Manager/Care Coordinator is responsible for facilitating the person centered planning process and is responsible for the preparation of the Individual Support Plan. The Tailored Care Manager/Care Coordinator determines with the beneficiary and/or the legally responsible person the degree to which the beneficiary and/or legally responsible person desires to lead the planning team and to identify its membership. The beneficiary may choose additional members for the person centered planning team. The Tailored Care Manager/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. Tailored Care Managers/Care Coordinators are assigned to the Waiver Beneficiary by the PIHP as the NC TBI Waiver runs concurrent with an 1115 and a 1915(b) Waiver.

ISP Development -
The ISP is developed through a person centered planning process led by the beneficiary and/or legally responsible person for the beneficiary to the extent they desire. Person--centered planning is about supporting beneficiaries to realize their own vision for their lives. It is a process of building effective and collaborative partnerships with beneficiaries and working in partnership with them to create a road map for the ISP for reaching the beneficiary's goals. When applicable, the Tailored Care Manager/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 planning process is directed by the beneficiary and identifies strengths and capabilities, desires and support needs. A good ISP 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 also ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to access the quality of services being provided. The PIHP's ISP Manual provides detailed information about how ISPs are developed.

At the time the beneficiary enters the waiver, information is shared with the beneficiary regarding the NC TBI waiver. The beneficiary's Tailored Care Manager is available to answer any questions that the beneficiary/family may have regarding available services. The Tailored Care Manager/Care Coordinator works with the beneficiary/family to develop the ISP. The Tailored Care Manager/Care Coordinator determines with the beneficiary and/or legally responsible person 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 Tailored Care Manager, additional planning team members may include: support providers, family friends, acquaintances and other community members.

The ISP is developed face to face with the waiver beneficiary and legally responsible person as clinically indicated. Face to face meetings are clinically indicated when the individual cannot participate fully in a planning meeting via teleconference due to hearing impairment or other communication challenges. Beneficiaries will continue to have the option for a face to face meeting versus a teleconference.

The initial ISP, with an authorized signature(s), is completed and submitted to the PIHP for approval no later than 60 days from the approval of the NC TBI Waiver Level of Care tool. Waiver enrollment begins the latest of the following dates:

- Date of Medicaid Application;
- Level of Care Approval Date; or
- Date of De-institutionalization

Annual plans, with an authorized signature(s), are developed to be effective the first day of the month following the beneficiary's birth month.

Assessments-
A variety of assessments are completed to support the planning process including:

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 process. A variety of person centered tool kits are available to assist in getting to know the beneficiary. These tool kits include worksheets, workbooks and exercises that can be completed by the beneficiary, with the assistance of the Tailored Care Manager or other support persons as needed.

NC TBI Waiver Risk/Support Needs Assessment: 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.

Information about Support Needs: This information assists in assuring that the beneficiary receives needed services, and at the same time, that beneficiaries do not receive services that are unnecessary, ineffective and/or do not

effectively address the beneficiary's identified needs. This can include information from the health/support assessment and/or other formal assessment of the beneficiary's support needs.

Additional Formal Evaluations: These are evaluations by professionals and can include physical therapy, occupational therapy, speech therapy, vocational, behavioral, rehabilitative testing, physician recommendations, psychological testing, neuropsychological testing, adaptive behavior scales or other evaluations as needed.

Prior to the Person Centered Planning Meeting: The Tailored Care Manager offers the beneficiary/legally responsible person information about Individual Family Supports. If the beneficiary/legally responsible person is interested in learning more about individual/family directed supports, the Tailored Care Manager arranges for them to receive additional training and information.

The Tailored Care Manager supports the beneficiary to schedule the meeting and invite team members to the meeting at a time and location that is desirable for the beneficiary.

The Individual Support Planning Meeting:
The beneficiary and Tailored Care Manager/Care Coordinator review with the team all issues that were identified during the assessment processes. Information is presented in draft plan form. 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. The planning meeting also includes a discussion about monitoring the beneficiary's services, supports and health/safety issues. During the planning meeting decisions are made regarding team members responsibilities for service implementation and monitoring. While the Tailored Care Manager/Care Coordinator is responsible for overall monitoring of the ISP and the beneficiary's situation, other team members, including the beneficiary and community supports, may be assigned monitoring responsibilities.

Individual Support Plan Development:
A written ISP will be 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 TBI to exercise choice and responsibility in the development and implementation of their support plan. A good ISP generates actions, positive steps that the person can take towards realizing a better and more complete life. 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 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 beneficiaries with long-term services and supports, intended to identify the strengths, capacities, preferences, needs and desired outcomes of the beneficiary. The process includes people, freely chosen by the 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 will assist him/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. The identified personally defined 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 shall be completed and submitted to the PIHP utilization management for approval. The Tailored Care Manager reassesses each beneficiary's needs at least annually and develops an updated PCP/ISP continued need review (CNR), based on that reassessment. The Tailored Care Manager/Care Coordinator will follow-up and resolve any issues related to the beneficiary's health, safety or service delivery. Unresolved issues will be brought to the attention of the PIHP and provider agency by the Tailored Care Manager/Care Coordinator to resolve these issues.

The Tailored Care Manager/Care Coordinator will provide information to waiver beneficiaries about their rights, protections and responsibilities, including the right to change providers. In the event the ISP developed results in denial of services, the Tailored Care Manager/Care Coordinator will inform the beneficiary of the right to request a fair hearing. The Tailored Care Manager/Care Coordinator will assist the beneficiary and the family through the Fair Hearing process. The Tailored Care Manager will inform the beneficiaries of grievance and complaint resolution processes. This information will be provided on an annual basis during the annual ISP process.

Also as part of the annual review, the Tailored Care Manager/Care Coordinator, in consultation with the beneficiary and the team, will identify the Most Integrated Setting appropriate in which to provide the individual for supports and services. If the Most Integrated Setting is not available, the Tailored Care Manager/Care Coordinator will document in the individual'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 will describe the services and supports (regardless of funding source) to be furnished, their projected frequency, and type of provider who will furnish each service or support. A Crisis Prevention Plan is incorporated within the ISP. The Crisis Prevention Plan includes supports/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 will be considered a "crisis", and how to stay calm and to lend that strength to others in handling the situation capably. The Crisis Prevention Plan should include what positive skills the beneficiary has which can be elicited and increased at times of crisis; how to implement redirection of energies towards exercising these skills that can prevent crisis escalation; how to implement positive behavioral supports that may be relied upon as a crisis response. The Crisis Prevention Plan is an active and living document that is to be used in the event of a crisis. After crisis, the beneficiary and staff should meet to discuss how well the plan worked and make changes as indicated.

The ISP also includes other formal and informal services and supports that the beneficiary wants and/or needs. The ISP provides for supports and coordination for the beneficiary to access educational services, generic community resources and Medicaid state plan services. The Tailored Care Manager makes sure that the ISP contains a plan for coordinating services, including the Tailored Care Manager's responsibility for overall plan coordination of waiver and other services.

The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as beneficiary needs change. Tailored Care Manager/Care Coordinator will work with beneficiaries to identify potential sources of services and support; paid and non paid natural supports within their catchment areas. Also, the PIHP will ensure that beneficiaries eligible for Medicaid will have freedom of choice of qualified providers. The process for review and approval/authorization of beneficiary ISPs is a primary function of the PIHP. All initial/annual/plan updates require an authorized signature(s) and will be signed by relevant providers.

Plan Approval:
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 Tailored Care Manager notifies the beneficiary/legally responsible person of the approval, the services that will be provided and the start date of services. The beneficiary/legally responsible person is given a copy of the approved ISP and individual budget, including crisis plan as applicable.

The TCM/CC developing the plan are employees of the PIHP in a separate unit from the individuals authorizing the plan if employed by the PIHP. The TCM/CC may not exercise prior authorization authority over the individual support plan. The PIHP will not approve an ISP that exceeds the limitations in any individual service definition, for the sets of services found at C-4.

Updates/Changes to the ISP:
The TCM/CC works 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/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. Examples of updates/revisions include adding an outcome, addressing needs related to the back-up staffing plan and adding new information when the beneficiary's needs change.

Implementation: The responsibility for implement the Individual Service 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 works to reach the goals identified in the ISP. Service providers are responsible for developing intervention strategies

and monitoring progress at the service delivery level. The service provider ensures that staff are appropriately qualified and trained to deliver the interventions necessary to support the accomplishment of goals. The provider is also responsible for clinical supervision of staff. Other team members are responsible to the extent identified in the ISP. The Tailored Care Manager is ultimately responsible for monitoring and overseeing the implementation of the ISP. The TCM/CC monitors the provision of services through observation of service provision, review of documentation and verbal reports. The Tailored Care Manager maintains close contact with members of the person centered planning team to ensure that the ISP is implemented as intended. The TTCM/CC provides a copy of the approved ISP and individual budget, including the crisis prevention plan to the beneficiary/legally responsible person as applicable.

ii. HCBS Settings Requirements for the Service Plan. *By checking these boxes, the state assures that the following will be included in the service plan:*

☐ **The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.**

☐ **For provider owned or controlled settings, any modification of the additional 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 and the following will be documented in the person-centered service plan:**

- ☐ **A specific and individualized assessed need for the modification.**
- ☐ **Positive interventions and supports used prior to any modifications to the person-centered service plan.**
- ☐ **Less intrusive methods of meeting the need that have been tried but did not work.**
- ☐ **A clear description of the condition that is directly proportionate to the specific assessed need.**
- ☐ **Regular collection and review of data to measure the ongoing effectiveness of the modification.**
- ☐ **Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**
- ☐ **Informed consent of the individual.**
- ☐ **An assurance that interventions and supports will cause no harm to the individual.**

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (5 of 8)

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The NC TBI Waiver Risk/ Support Needs Assessment is completed prior to the development of the ISP and updated as significant changes occur with the beneficiary at least annually. The Tailored Care Manager/Care Coordinator works with the beneficiary, family and other team members to complete the assessment.

1. The NC TBI Risk/Support needs assessment includes: health and wellness screening to include the primary care physician to act as the locus of coordination for all health care issues, medication management, nutrition, preventive screenings, as appropriate, and any relevant information obtained from other supports needs assessments.

2. Risk screening to include behavioral supports, potential mental health issues, personal safety and environmental community risk issues. Support needs and potential risks that are identified during the assessment process are addressed in the ISP, which includes a crisis plan as applicable. Strategies to mitigate the risk reflect beneficiary needs and include consideration of the beneficiary preferences. Strategies to mitigate risk may include the use of risk agreements. The ISP states how risks will be monitored and by whom, including the paid providers, natural and community supports, beneficiaries and their family and the Tailored Care Manager/Care Coordinator .

A backup staffing plan is included in the ISP and designed to meet the needs of beneficiaries to make sure that their health and safety is ensured. It outlines who (whether natural or paid) is available, contact numbers, at least two levels of backup staffing are identified for each waiver service provided.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (6 of 8)

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Tailored Care Management/Care Coordination, following the PIHP policy, assists the beneficiary/legally responsible person in choosing a qualified provider to implement each service in the ISP. The Tailored Care Manager/Care Coordinator meets with the beneficiary/legally responsible person and provides them with a provider listing of each qualified provider within the PIHP provider network and encourages the individual/legally responsible person to select providers that they would like to meet to obtain further information. The Tailored Care Manager/Care Coordinator provides any additional information that may be helpful in assisting them to choose a provider. Arranging provider interviews is facilitated by the Tailored Care Manager/Care Coordinator on behalf of the beneficiary. Once the beneficiary has selected a provider, their choice of provider is documented in the service record.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (7 of 8)

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR § 441.301(b)(1)(i):

The PIHP approves ISPs following a process approved by the DHB, the State Medicaid agency. The Tailored Care Manager/Care Coordinator developing the plan is in a separate unit from the individuals authorizing the plan if employed by the PIHP. ISP approval occurs locally at the PIHP. DHB authorizes the PIHP to approve ISPs through routine monitoring of the plan of care approval process. DHB 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 plan of care approval would be carried out by DHB or DHB designee.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (8 of 8)

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update, when the individual's circumstances or needs change significantly, or at the request of the individual, to assess the appropriateness and adequacy of the services as participant needs change. Specify the minimum schedule for the review and update of the

service plan:

- ○ **Every three months or more frequently when necessary**
- ○ **Every six months or more frequently when necessary**
- ◉ **Every twelve months or more frequently when necessary**
- ○ **Other schedule**

Specify the other schedule:

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR § 92.42. Service plans are maintained by the following *(check each that applies):*

- ☐ **Medicaid agency**
- ☐ **Operating agency**
- ☑ **Case manager**
- ☑ **Other**

Specify:

PIHP

Appendix D: Participant-Centered Planning and Service Delivery

D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan, participant health and welfare, and adherence to the HCBS settings requirements under 42 CFR §§ 441.301(c)(4)-(5); (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The PIHP Tailored Care Manager/Care Coordinator is responsible for monitoring the implementation of the ISP. Services are implemented within 45 days of ISP approval. The Tailored Care Manager/Care Coordinator is responsible for the monitoring of activities. Monitoring will take place in all service settings and on a schedule outlined in the ISP.

Monitoring methods also include 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:
(1) Verification that services are provided as outlined in the ISP
(2) Beneficiaries have access to services and identification of any problems that may arise
(3) The services meet the needs of the beneficiaries, that the back-up staffing plans are documented
(4) Issues of health and welfare (rights restrictions, medical care, abuse/neglect/exploitation, behavior support plan) are addressed and that beneficiaries are offered a free choice of providers and that non-waiver services needs have been addressed

Tailored Care Manager/Care Coordinator monitoring occurs monthly to include the following:
(1) Beneficiaries that are new to the waiver receive 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.
(2) Beneficiaries who live in residential programs receive face-to-face monitoring visits monthly.
(3) For months that beneficiaries do not receive face-to-face monitoring, the Tailored Care Manager/Care Coordinator has telephone contact to ensure that there are no issues that need to be addressed.
(4) At least one service is utilized monthly, per waiver eligibility requirements.
(7) That services utilized do not exceed authorization. If there is an emergency, the Tailored Care Manager/Care Coordinator should ensure that the enrollee's needs are met and ensure that any updates to the LOC and ISP, based upon the changes in needs of the individual, are processed in a timely manner.

b. Monitoring Safeguard. Providers of HCBS for the individual, or those who have interest in or are employed by a provider of HCBS; are not permitted to have responsibility for monitoring the implementation of the service plan except, at the option of the state, when providers are given this responsibility because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may not provide other direct waiver services to the participant.**
- ● **Entities and/or individuals that have responsibility to monitor service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements may provide other direct waiver services to the participant because they are the only the only willing and qualified entity in a geographic area who can monitor service plan implementation.** *(Explain how the HCBS waiver service provider is the only willing and qualified entity in a geographic area who can monitor service plan implementation).*

The State allows the Cherokee Indian Hospital Authority (CIHA) to conduct assessment, care planning and monitoring though they may also provide services to the members. CHIA is the only entity that has willing and qualified providers with experience and knowledge to provide services to individuals who share a common language or cultural background. Individuals providing care management and services will not work in the same unit. Individuals providing care management/care coordination will not be:

related by blood or marriage to the individual, or any paid caregiver of the individual

financially responsible for the individual

empowered to make financial or health-related decisions on behalf of the individual

Tribal members will be provided information that it is their choice to use CIHA and that independent care managers and service providers are available.

For beneficiaries that are not members of Federally Recognized Tribes, the Care Manager/Care Coordinator may not provide direct waiver services to the beneficiary and may not be affiliated with a service provider that providers services to the beneficiary.

(Complete only if the second option is selected) The state has established the following safeguards to mitigate the potential for conflict of interest in monitoring of service plan implementation, participant health and welfare, and adherence to the HCBS settings requirements. *By checking each box, the state attests to having a process in place to ensure:*

☐ **Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of waiver services, not just the services furnished by the entity that is responsible for the person-centered service plan development;**

☐ **An opportunity for the participant to dispute the state's assertion that there is not another entity or individual that is not that individual's provider to develop the person-centered service plan through a clear and accessible alternative dispute resolution process;**

☐ **Direct oversight of the process or periodic evaluation by a state agency;**

☐ **Restriction of the entity that develops the person-centered service plan from providing services without the direct approval of the state; and**

☐ **Requirement for the agency that develops the person-centered service plan to administratively separate the plan development function from the direct service provider functions.**

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

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

a. Methods for Discovery: Service Plan Assurance/Sub-assurances

The state demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

i. Sub-Assurances:

a. ***Sub-assurance: Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of Individual Support Plans in which the services and supports reflect beneficiary assessed needs and personal goals Numerator: Number of Individual Support Plans in which services and supports reflect beneficiary assessed needs and personal goals Denominator: Total number of Individual Support Plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Signed individual support plan

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of C Waiver Beneficiaries reporting that their Individual Support Plan has the services and supports that they need Numerator: Number of C Waiver beneficiaries who indicate that the ISP contains the services and supports they need Denominator: total number of C Waiver beneficiaries

Data Source (Select one):
Other
If 'Other' is selected, specify:
Signed individual support plan

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

		Sample Confidence Interval =
☑ **Other** Specify: PIHPs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of Individual Support Plans that address identified health and safety risk factors Numerator: Number of Individual Support Plans for C waiver beneficiaries that address strategies to address health and safety risks factors Denominator: total number of Individual Support Plans.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Signed individual support plan

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

Data Aggregation and Analysis:

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

b. ***Sub-assurance: Service plans are updated/revised at least annually, when the individual's circumstances or needs change significantly, or at the request of the individual.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of person centered plans that are completed in accordance with the State Medicaid Agency's requirements Numerator: Total number of reviewed person centered plans that are in accordance with the SMA's requirements Denominator: Total number of person centered plans reviewed

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

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

		Review
☐ **Sub-State Entity**	☐ **Quarterly**	☑ **Representative Sample** Confidence Interval = Confidence Interval = 95% with +/-5% margin of error
☑ **Other** Specify: PIHPs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

c. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and Percentage of waiver participants whose Individual Support Plans were revised, as applicable, by the CC / TCM to address their changing needs. Percentage = Number of participants' Individual Support Plans that were revised, as applicable/ total number of waiver participants in the sample who required a revised ISP due to changing needs

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Record Reveiw

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

		95% with a +/- 5% margin of error
☑ **Other** Specify: PIHP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:

Proportion of individuals for whom an annual Individual Support Plan and/or needed update took place Numerator: Number of waiver beneficiaries for whom all annual Individual Support Plans and needed updates took place Denominator: Total number of waiver beneficiaries requiring an annual ISP or update.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review Spreadsheets

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

Data Aggregation and Analysis:

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

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

d. ***Sub-assurance: Participants are afforded choice between/among waiver services and providers.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Proportion of new waiver beneficiaries receiving the amount and duration services included in their ISP within 45 days of ISP approval Numerator: # of new waiver beneficiaries who receive the amount and duration services within 45 days of approval of the ISP Denominator: Total # of initial ISP's for new waiver beneficiaries

Data Source (Select one):
Other
If 'Other' is selected, specify:
Date of plan approval and service date on first claim

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

☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: PIHPs	☑ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Proportion of waiver beneficiaries who are receiving services in the type, scope, and frequency as specified in the Individual Support Plan Numerator: Number waiver beneficiaries reviewed who received services in the type, scope and frequency listed in the ISP Denominator: Total number of waiver beneficiaries reviewed

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review Spreadsheets

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☑ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☑ **Representative Sample** Confidence Interval = 95% confidence level with +/-5% margin of error
☑ **Other** Specify: PIHPs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other**	

	Specify:	

Data Aggregation and Analysis:

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

e. ***Sub-assurance: The state monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
proportion of Individual Support Plans for C waiver beneficiaries that indicate their CC / TCM helps them to know what wavier services are available. Numerator: Number of Individual Support Plans for C waiver beneficiaries that indicate the CC / TCM helps the beneficiary know what services are available. Denominator: Total number of ISPs for C waiver beneficiaries

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual service plans/Client Records- Initial Freedom of Choice in the Client record

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Proportion of beneficiaries reporting they have a choice between providers
Numerator: Proportion of Individual Support Plans for C waiver beneficiaries that report the beneficiary had a choice between providers. Denominator: Total number of Individual Support Plans for C waiver beneficiaries

Data Source (Select one):
Other
If 'Other' is selected, specify:
Signature on individual support plans

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Proportion of records that contain a signed freedom of choice statement Numerator: Total number of Individual Support Plans for C waiver beneficiaries where freedom of choice statement is signed Denominator: Total number of Individual Support Plans for C waiver beneficiaries.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual service plans/Client Records- Initial Freedom of Choice in the Client record

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

Data Aggregation and Analysis:

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

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The PIHP reviews service plan development via Tailored Care Management/Care Coordination and in Utilization Management (UM). Utilization Management ensures that all service plan elements are present. During the annual Mercer review, which consists of Mercer as well as DHB and DMH staff, state Subject Matter Experts in TBI services utilize a standard review tool to review the PIHP's monitoring process to ensure that the PIHP is indeed monitoring service plan development. A sample of plans is reviewed at this time.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The PIHPs will address and correct problems identified on a case-by-case basis and include the information in reports to DHB. DHB may require a corrective action plan if the problems identified appear to require a change in the PIHP's processes for developing, implementing and monitoring service plans. DHB monitors the corrective action plan.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Service Plans that are currently non-operational.

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- ( ) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- (●) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both.

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

Answers provided in Appendix E-0 indicate that you do not need to submit Appendix E.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The state provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The state provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The NC TBI waiver operates concurrently with an 1115 and 1915(b) waivers through prepaid Inpatient health plans (PIHP)/Tailored Plan. All waiver applicants/beneficiaries are notified of their right to request a fair hearing by the PIHP/Tailored Plan in accordance with 42 CFR 431 Subpart E and 42 CFR 438 Subpart F. Beneficiaries are required to access the PIHP's/Tailored Plan internal appeal process before requesting a hearing with the State.

Upon enrollment in the PIHP/Tailored Plan, the PIHP/Tailored Plan sends each enrollee a brochure explaining Medicaid appeal rights. For beneficiaries with limited literacy, the Tailored Care Manager verbally explains their appeal rights. When applicants/beneficiaries are denied participation in the waiver or specific waiver services are denied, terminated, suspended or reduced, the PIHP/Tailored Plan sends a written notice to the individual explaining the reason for the adverse action, instructions on how to access a fair hearing, the time frame for making the request, information on continuation of services during the appeal process (if applicable) and contact information for questions and concerns. The notice also contains information on the state level hearing processes and toll free numbers for the Medicaid agency and for requesting free legal assistance. Notices of termination, suspension or reduction are mailed to the beneficiary a minimum of 10 days before the service is actually reduced, terminated or suspended.

As stated above, applicants/beneficiaries must avail themselves of the appeal process offered by the PIHP/Tailored Plan before accessing the state fair hearing process. This requirement can be found in the concurrent 1115 waver and the 1915 (b) waiver. If the applicant/beneficiary requests a hearing, the PIHP/Tailored Plan gathers information on the case and schedules the appeal with an independent reviewer who had no prior involvement in making the adverse decision. The PIHP/Tailored Plan sends a written notice of the reconsideration decision to the individual, along with detailed instructions on requesting a hearing with the State which are conducted by the NC Office of Administrative Hearings.

When the suspension, reduction or termination of service is appealed, beneficiaries may continue to receive services up through the final decision by the Office of Administrative Hearings (OAH) as long as they meet the appeal deadlines, the original period covered by the authorization has not expired and the beneficiary requests continuation of the service. When the LME-MCO makes a denial based on Level of Care, appeal rights are preserved.

Copies of all notices and documentation of decisions are maintained by the agency from which they originate. The PIHP/Tailored Plan maintains records on the local appeal and the OAH maintains records on the formal hearing. Appeal decisions are loaded into the PCG system and monitored monthly by DHB.

Appendix F: Participant-Rights

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the state operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

- ○ **No. This Appendix does not apply**
- ● **Yes. The state operates an additional dispute resolution process**

• **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The PIHP/Tailored Plan has an internal dispute resolution system as required by 42 CFR 438 Subpart F. The individual is informed that the dispute resolution mechanism is not a pre-requisite for a Fair Hearing. The internal system encompasses both an appeal process, as described in Appendix F-1, for addressing an "action" and a grievance process for addressing grievances (complaints). "Actions" include the denial or limited authorization of a requested service, reduction, suspension or termination of a previously authorized service, denial of payment for a service, failure to provide services in a timely manner as specified in the risk contract and failure to take action within the timeframes specified in the contract for resolving grievances and appeals.

A grievance (complaint) is an enrollee's expression of dissatisfaction with any aspect of their care other than the appeal of an action. 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 enrollee's rights.

The requirements for the PIHP's/Tailored Plan internal appeal and grievance processes are outlined in the contract between the State and PIHP/Tailored Plan. The requirements cover the types of information that the PIHP/Tailored plan must provide to enrollees about grievances and appeals, provision of assistance to enrollees in completing necessary forms, reporting and record keeping, content of notices, expedited authorization decisions, continuation of benefits during appeals and time frames for addressing grievances and appeals.

The PIHP/Tailored Plan provides quarterly reports to the State Medicaid Agency on the types, number and resolution status of grievances and appeals. Tracking and analysis of grievances and appeals are to be used for internal quality improvement.

Appendix F: Participant-Rights

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

- ○ **No. This Appendix does not apply**
- ● **Yes. The state operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver**

• **Operational Responsibility.** Specify the state agency that is responsible for the operation of the grievance/complaint system:

DMH/DD/SAS

• **Description of System.** Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The North Carolina Administrative Code (NCAC) at 10A NCAC 27G.0609 requires local management entities (operating as PIHPs for waiver purposes) to report to the DHHS Division of MH/DD/SAS all complaints (grievances under 42 CFR 438 Subpart F) made to the PIHP not less than quarterly. The submission of the PIHP complaint report is included in the contract between the PIHP and the Division of MH/DD/SAS. Four documents provide procedures and instructions relative to the complaint process:
1. Guidelines for the complaint reporting system
2. Customer service collection forms
3. Quarterly complaint report
4. Complaint reporting instructions

A copy of the quarterly complaint report is shared with the PIHP/Tailored Plan Client Rights Committee and the PIHP/Tailored Plan Consumer and Family Advisory Committee in order to develop strategies for system improvement.

Guidelines require the documentation of any concern, complaint, compliment, investigation and request for information involving any person requesting or receiving publicly-funded mental health, developmental disabilities and/or substance abuse services, local management entity or MH/DD/SAS service provider.

Complaint Reporting Categories include:
(1) Abuse, neglect and exploitation
(2) Access to services
(3) Administrative issues
(4) Authorization/payment/billing
(5) Basic needs
(6) Client rights
(7) Confidentiality/HIPAA
(8) PIHP services
(9) Medication
(10) Provider choice
(11) Quality of care
(12) Service coordination between providers
(13) Other to include any complaint that does not fit the previous areas.

Information is recorded on the customer service form and recorded in the PIHP/Tailored plan complaint database for analysis. Action taken by the PIHP/Tailored plan is recorded to include a summary of all issues, investigations and actions taken and the final disposition resolution. Guidelines define the resolution for types of complaints that may be made. The total number of calendar and working days from receipt to completion are also recorded.

If the complainant is not satisfied with the initial resolution, the individual may request to appeal the decision.

The quarterly complaint reporting form includes the aggregate information on complaints to include:
(1) The total number of complaints received by the customer service office
(2) The total number of persons (by category) who are reporting complaints
(3) The total number of consumers by age group
(4) The total number of consumers by disability group (if applicable) involved in the complaint
(5) The primary nature of the complaints/concerns (by category)
(6) A summary of data analyses to identify patterns, strategies developed to address problems and actions taken
(7) An evaluation of results of actions taken and recommendations for next steps.

As stated in Appendix F-2 above, grievances (complaints) are also reported to the state Medicaid agency on a quarterly basis as required by the risk contract between the DHHS Division of Health Benefits and the PIHP/Tailored Plan. The Division of Health Benefits and the DMH/DD/SAS have developed a joint reporting form to increase consistency of processes to the extent possible.

The grievance process is conducted by the PIHP/Tailored Plan and is an expression of dissatisfaction by the enrollee about things that are not "actions." Actions refers to denial of a service request; limited authorization of a service request; reduction, suspension, or termination of a previously authorized service; denial of payment for a service; failure to authorize or deny a service request in a timely manner; or failure to resolve a grievance (i.e., within 90 calendar days).

The grievance process is separate from the reconsideration/state fair hearing process. Enrollees do not have to file a grievance before requesting reconsideration of an action.

The appeal process (called "reconsideration" in North Carolina) is conducted by the PIHP/Tailored Plan. Appeal refers to a request for review of an action (please refer to the definition in the previous section of what constitutes "actions"). Appeals can be filed in writing or orally by the enrollee or provider (with written consent). The enrollee has 30 days to request an appeal of the PIHP/Tailored Plan action. If the request is made orally, the enrollee must submit a written request within 30 days of the date of the adverse notice. Individuals making decisions on appeals cannot have been involved in any previous level of review or decision-making. The enrollee must be allowed a reasonable opportunity to present evidence and allegations of fact or law and must be allowed to examine his/her medical records and the documents considered during the appeal. For standard resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 45 days from the day the PIHP/Tailored Plan receives the appeal. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 3 working days after the PIHP/Tailored Plan receives the appeal. Timeframes to decide both grievances and appeals (both standard and expedited) may be extended up to fourteen (14) calendar days if additional information is required.

In North Carolina, enrollees must exhaust the PIHP/Tailored Plan Appeal Process ("Reconsideration") before accessing the State Fair Hearing (referred to as an "Appeal"). Medicaid State Fair Hearings are governed by 42 Code of Federal Regulation (CFR) Part 431 and utilize the Administrative Hearings procedure. These hearings apply to an appeal ("reconsideration") not decided wholly in favor of the enrollee. The PIHP/Tailored Plan is a party to the State Fair Hearing and the process is controlled by state law and rules. The enrollee has 30 days to request a State Fair Hearing from the date of the appeal ("reconsideration") decision. After 30 days, the PIHP/Tailored Plan appeal ("reconsideration") decision becomes final.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. Critical Event or Incident Reporting and Management Process. Indicate whether the state operates Critical Event or Incident Reporting and Management Process that enables the state to collect information on sentinel events occurring in the waiver program.*Select one:*

- (●) **Yes. The state operates a Critical Event or Incident Reporting and Management Process** *(complete Items b through e)*
- ( ) **No. This Appendix does not apply** *(do not complete Items b through e)*

If the state does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the state uses to elicit information on the health and welfare of individuals served through the program.

b. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the state requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHHS Incident and Death Response System Guidelines describes who must report the documentation required, what/when/where reports must be filed and the levels of incidents, including responses to each level of incidents. Critical incident reporting requirements are outlined in North Carolina Administrative Code at 10A NCAC 27 G.0600. With the exception of Hospitals, Providers of publicly funded services licensed under North Carolina General Statute 122C and providers of publicly funded non-licensed periodic or community based mental health, developmental disability, Traumatic Brain Injury, or substance abuse services are required to report critical events or incidents involving consumers receiving mental health, developmental disability or substance abuse services. Hospitals report incidents to the Division of Health Service Regulation. Critical incidents are defined as any happenings which are not consistent with routine operation of a facility, or service, in the routine care of consumers and that is likely to lead to adverse effects upon the consumer. Any incidents containing allegations or substantiations of abuse, neglect or exploitation must be immediately reported to the local Department of Social Services responsible for investigation of abuse, neglect or exploitation allegations. Other reports may be required by law, such as reports to law enforcement. Facts regarding the incident should be reported objectively, in writing, without unsubstantiated conclusions, opinions or accusations. Incident reports are maintained in administrative files; however, incidents that have an effect on the beneficiary must be recorded in the progress note of the beneficiary record, as would any other consumer care information. Incident reports, including follow-up action requirements, are defined as one of three levels.

Level I incidents are defined as any incident that does not meet the requirements to be classified as a Level II or Level III incident. Examples of Level I incidents include, but are not limited to: beneficiary injury that does not require treatment by a licensed health care professional, and HIPAA/confidentiality violations. Level I incident reports are reviewed by the employee's supervisor, and are submitted to a designated person, per agency policy, and maintained in the administrative files of the employer of record. Level 1 reports are maintained by the provider agency and reviewed by the PIHP/Tailored Plan during routine monitoring.

Level II Incidents include any incident that involves a threat to a beneficiary's health or safety or a threat to the health and safety of others due to beneficiary behavior. Level II incidents are reported immediately to the employee's supervisor. A written report is prepared that is submitted to and reviewed by the employee's supervisor.
The written report is forwarded to the PIHP/Tailored Plan within 72 hours of the incident's occurrence.

Level III Incidents include any incident that results in a death or permanent physical or psychological impairment to a beneficiary, a death or permanent physical or psychological impairment caused by a consumer or a threat to public safety caused by a consumer. Level III incidents are reported immediately to the employee's supervisor.

The supervisor immediately notifies the PIHP/Tailored Plan, who notifies DMH/DD/SAS. The PIHPs/Tailored Plan coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared that is submitted to and reviewed by the employee's supervisor. The written report is forwarded to the PIHP/Tailored Plan within 72 hours of the incident's occurrence. All providers and Employers of Record are required to conduct a peer review of Level III incidents, beginning within 24 hours of the incident.

c. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of enrollment in the PIHP/Tailored Plan, beneficiaries are provided a beneficiary and family member handbook that outlines their rights, protections and the advocacy agencies who can educate and assist in the event of a concern. The Tailored Care Manager discusses the rights and protections, inclusive of agencies, to contact with the beneficiary/legally responsible person as a component of the admissions process to the NC TBI waiver. Opportunities for information training occur during routine monitoring. Providers within the PIHP/Tailored Plan network are required to inform the beneficiary of rights and protections through individual agency procedure.

The PIHP/Tailored plan and the NC DHHS operate toll-free care lines where beneficiaries can receive additional information or assistance, if needed. These lines have the capacity to assist beneficiaries that are primarily Spanish speaking and/or hearing impaired.

d. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incident reporting requirements and responses are based on state laws and regulations for each of the three levels of incidents.
Level 1 Incidents are maintained by the provider agency. Each provider agency is required to maintain copies of these reports for review by the PIHP/Tailored plan during routine monitoring. Written reports of Level II incidents are forwarded to the PIHP/Tailored plan within 72 hours of the incident's occurrence. The provider agency is responsible for attending to the health and safety of involved parties as well as analyzing causes, correcting problems and review in quality improvement process to prevent similar incidents. Level II incidents may signal a need for the PIHP/Tailored plan to review the provider's clinical care and practices and the PIHP's / PIHP's management processes, including Tailored Care Management, service oversight and technical assistance providers. These incidents require communication between the provider and the PIHP/Tailored plan, documentation of the incident and report to the PIHP and other authorities as required by law. The PIHP is responsible for reviewing provider handling of the incident and ensuring consumer safety.

Level III Incidents are immediately reported to the PIHP/Tailored plan who notifies DMH/DD/SAS. The PIHP/Tailored plan coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared and reviewed by the agency or employer submitting the incident. The written report is forwarded to the PIP within 72 hours of the incident's occurrence. Providers attend to the health and safety needs of involved parties, and conduct a peer review of Level III incidents beginning within 24 hours of the incident. The internal review:
(1) Ensures the safety of all concerned
(2) Takes action to prevent a re-occurrence of the incident
(3) Creates and secures a certified copy of the consumer record
(4) Ensures that necessary authorities and persons are notified within allowed time frames
(5) Conducts a root cause analysis once all needed information is received.

Level III incidents signal a need for DHHS, including DMH/DD/SAS and the PIHP/Tailored plan, to review the local and state service provision and management system, including coordination, technical assistance and oversight. These incidents require communication among the provider, the PIHP/Tailored plan and DHHS, documentation of the incident, and report to the PIHP/Tailored plan, DHHS and other authorities as required by law.

The PIHP/Tailored plan reviews provider handling of the Level III incident:
(1) To ensure that beneficiaries are safe
(2) A certified copy of the beneficiary record is secured
(3) A review committee meeting is convened
(4) Appropriate agencies are informed

DMH/DD/SAS reviews the PIHP/Tailored plan oversight of providers and follows up, as warranted, to ensure problems are corrected. The PIHP/Tailored plan also analyzes and responds to patterns of incidents as part of quality improvement and monitoring processes. DMH/DD/SAS analyzes and responds to statewide patterns of incidents as part of quality improvement and monitoring. DMH/DD/SAS includes information about deaths in their annual Legislative Report.

Other agency responsibilities for follow-up of incidents are:
(1) Local law enforcement agencies investigate legal infractions and take appropriate actions
(2) Local Department of Social Services investigates abuse, neglect or exploitation allegations and takes appropriate actions
(3) The Health Service Regulation Division of DHHS investigates licensure infractions and take appropriate actions
(4) The Health Care Personnel Registry section of the Health Services Regulation Division investigates personnel infractions and takes appropriate actions
(5) Disability Rights of NC, formerly the Governor's Advocacy Council for Persons with Disabilities analyzes trends and advocates as warranted

A summary of incident reporting and follow-up actions is included in the PIHP's/Tailored plan reporting to DHB. Providers are required to develop and implement written policies governing their response to incidents, including conducting investigations. The policies must also include attending to the health and safety needs of individuals involved in the incident, determining the cause of the incident, and developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days. Polices must also include notification of the beneficiary of the results of any investigation. The timeframe for informing the beneficiary, including all relevant parties, of the investigation results is within three (3) months of the date of the incident. The PIHP/Tailored plan submits a summary of

incident reports as well as related performance measures to DHB on a quarterly basis.

A provider internal review team must meet within 24 hours of any incident that results in, or creates a significant risk of resulting in death, sexual assault or permanent physical or psychological impairment to a consumer or by a consumer. In North Carolina, these are referred to as Level III Incidents. The internal review team consists of individuals who were not involved in the incident and who were not responsible for the consumer's direct care or with the direct professional oversight of the consumer's services at the time of the incident. Preliminary findings of fact are sent to the host PIHP/Tailored plan and the PIHP/Tailored plan where the consumer resides (if different) within five (5) working days of the incident. A final written report signed by the owner of the provider organization is submitted to the PIHP/Tailored plan within three (3) months of the incident. The final written report must address the issues identified by the internal review team; include all public documents related to the incident, and make recommendations for minimizing the occurrence of future incidents. The provider must also immediately report incidents of this level to the host PIHP/Tailored plan, the PIHP/Tailored plan where the consumer resides (if different), the North Carolina Department of Health and Human Services through the online Incident Response Improvement System (IRIS), the provider agency with responsibility for maintaining and updating the consumer's treatment plan if different from the reporting provider, the consumer's legal guardian if applicable, and any other authorities required by law.

The PIHP/Tailored plan must report Level III Incidents to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Licensed providers must also send a copy of all Level III Incidents involving a consumer death to the NC Division of Health Service Regulation within 72 hours of becoming aware of the incident when the death was an accident, suicide or homicide.

All cases of client death must be reported immediately to the PIHP/Tailored plan.

Each PIHP develops and implements written policies governing local monitoring based on provider incident reporting. Minimally, these policies include review of how providers respond to incidents and ensure consumer safety, monitor and provide technical assistance as warranted to ensure that problems are corrected, analyze and respond to patterns of incidents as part of QI monitoring and processes, determine if public scrutiny is an issue, and ensure that Level III Incidents are reported to the DMH/DD/SAS.

The DMH/DD/SAS is responsible for analyzing and responding to statewide patterns of incidents as part of QI and monitoring PIHP/Tailored plan oversight of response processes, produce statewide quarterly incident trend reports, review PIHP/Tailored plan oversight of providers and follow up as warranted to ensure problems are corrected, and analyze and respond to statewide patterns of incidents as part of QI and monitoring processes.

e. Responsibility for Oversight of Critical Incidents and Events. Identify the state agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

The Department of Health and Human Services is the State Department that oversees the Division of Health Benefits (DHB) and the DMH/DD/SAS. DHB tracks performance measures and receives all incident reports quarterly. The DMH/DD/SAS also assists in the oversight of critical incidents and events.

Aggregate data for all incidents is collected by the provider and submitted to the PIHP/Tailored plan quarterly. Additionally, all Level II and Level III incidents are recorded in the North Carolina online Incident Response Information System. DHB and the DMH/DD/SAS reviews all data and monitors the PIHPs/Tailored plan oversight of providers and follows up as warranted to ensure that problems are corrected. The DMH/DD/SAS also analyzes and responds to statewide patterns of incidents as part of Quality Improvement and monitoring processes.

Level I incidents are maintained on site by the provider agency and are reviewed by the PIHP/Tailored plan during routine monitoring. Level II and Level III incidents are reported by the provider within 72 hours of the incident occurring. The PIHP/Tailored plan and the DMH/DD/SAS reviews all Level III incidents within 72 hours of receiving the report. In cases of beneficiary death within 7 days of restrictive intervention, the PIHP/Tailored plan and the DHHS is notified immediately.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (1 of 3)

a. Use of Restraints. *(Select one)*: *(For waiver actions submitted before March 2014, responses in Appendix G-2-a will display information for both restraints and seclusion. For most waiver actions submitted after March 2014, responses regarding seclusion appear in Appendix G-2-c.)*

○ **The state does not permit or prohibits the use of restraints**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restraints and how this oversight is conducted and its frequency:

● **The use of restraints is permitted during the course of the delivery of waiver services**. Complete Items G-2-a-i and G-2-a-ii.

i. Safeguards Concerning the Use of Restraints. Specify the safeguards that the state has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

NC Administrative Code at 10A NCAC 27E.0107 addresses Training on Alternatives to Restrictive Interventions.

Restrictive interventions are reported via the incident reporting rules at 10A NCAC 27 G.0600. The DHHS Restrictive Intervention Details Report is completed along with the incident report.

Restrictive interventions governed by 10a NCAC 27e .0104 include seclusion, physical restraint, isolation time-out and protective devices used for behavioral control. Use of these interventions is limited to emergency situations in order to terminate a behavior or action in which the individual is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or as a planned measure of therapeutic treatment. Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.

All of the following elements must be addressed, for beneficiaries with approved restrictive interventions, in the beneficiary's ISP:

(1) Identify a specific and individualized assessed need.
(2) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
(3) Document less intrusive methods of meeting the need that have been tried but did not work.
(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
(5) Include regular collection and review of data to measure the ongoing effectiveness of the modification.
(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
(7) Include the informed consent of the individual.
(8) Include an assurance that interventions and supports will cause no harm to the individual.

Positive and less restrictive alternatives must be considered and attempted whenever possible prior to the use of more restrictive interventions. Providers shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. They shall establish training based on state competencies and the contents of the training must be approved by DMH/DD/SAS. Formal refresher training must be completed by each service provider at least annually. Competencies include:
• knowledge and understanding of the people being served;
• recognizing and interpreting human behavior;
• recognizing the effect of internal and external stressors that may affect people with disabilities;
• strategies for building positive relationships with persons with disabilities / TBI;
• recognizing cultural, environmental and organizational factors that may affect people with disabilities / TBI;
• recognizing the importance of and assisting in the person's involvement in making decisions about their life;
• skills in assessing individual risk for escalating behavior;
• communication strategies for defusing and de-escalating potentially dangerous behavior; and
• positive behavioral supports (providing means for people with TBI to choose activities which directly oppose or replace behaviors which are unsafe).

Emergency interventions may only be employed for up to 15 minutes without further authorization by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training. Whenever an individual is in seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior, the individual must be observed at least every 15 minutes, or more often as necessary, to assure safety. Whenever an individual is in isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the individual. There shall be continuous observation and verbal interaction when appropriate. This observation must be documented. If an

individual is in a physical restraint and may be subject to injury, a facility employee shall remain present with the individual continuously.

When protective devices are used for an individual, there must be documentation that the staff are trained and competent to use the device, that there has been a review of less restrictive alternatives that have not been successful, and that review has been made by a Client Right's Committee. The intervention and monitoring of the individual for health and safety must be documented.

When restraints are used, there must be continuous assessment of the individual to ensure their physical and psychological well being throughout the intervention. Staff who are trained in emergency safety interventions and CPR must be present during the restrictive procedure.

Seclusion, physical restraint and isolation time-out may be employed only by staff that have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Prior to providing direct care to people with traumatic brain injury whose treatment/rehabilitation plan includes restrictive interventions, staff shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. The training shall be competency-based and must be approved by DMH/DD/SAS. A formal refresher training must be completed by each staff at least annually. Training programs shall include, but are not limited to, presentation of:
• refresher information on alternatives to the use of restrictive interventions;
• guidelines on when to intervene (understanding imminent danger to self and others);
• emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
• strategies for the safe implementation of restrictive interventions;
• the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
• prohibited procedures;
• debriefing strategies, including their importance and purpose; and
• documentation methods/procedures.

At a minimum documentation of the use of restraints or seclusion must include:
• the individual's physical and psychological well-being;
• frequency, intensity and duration of the behavior which led to the intervention
• any precipitating event;
• the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
• a description of the intervention and the date, time and duration of its use;
• a description of accompanying positive methods of intervention;
• a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future
use of restrictive interventions;
• a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
• signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

When any restrictive intervention is utilized the legally responsible person shall be notified immediately unless she/he has requested not to be notified. When restrictive interventions are utilized as part of a behavioral plan, the behavior plan must include steps and less restrictive measures that must be utilized prior to the restrictive procedure. Planned use of restrictive interventions must be reviewed by a Human Rights Committee prior to implementation. Utilization of unplanned restrictive procedure will be documented on the DHHS online Incident Response Information System

(IRIS). This report is submitted within 72 hours of the use of a restrictive intervention to the PIHP/Tailored plan. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP/Tailored plan. The Tailored Care Manager/Care Coordinator monitors at least quarterly to ensure any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support plan and that the Positive Behavioral Support plan is signed/approved by a licensed psychologist and approved by the Client Right's Committee. The person-centered service plan will document assessed need for the intervention, less restrictive strategies attempted and frequency of assessing continuing need for the restrictive intervention

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of restraints and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

State agencies and the PIHP/Tailored plan are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. The PIHPs/Tailored plan report quarterly on the use of restraints to DHB. In addition, NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, requires provider agencies to participate in the DHHS online Incident Response Information System (IRIS) for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and beneficiary behavior issues. The PIHP/Tailored plans provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the PIHP/Tailored plan. State agencies review the use of restraints, restrictive interventions and rights restrictions if complaints are made to the state advocacy and consumer affairs office. Any significant injuries which result from employment of a restraint, restrictive intervention or rights restriction must be carefully analyzed and immediately reported to state agencies and the PIHP/Tailored plan.

If the agency is licensed through the Division of Health Service Regulation, the PIHP/Tailored plan, DHB, or the DMH/DD/SAS may contact the Division of Health Service Regulation regarding any concerns. Providers report aggregate data to the PIHP/Tailored plan quarterly. The PIHP/Tailored plan collects this data for DHB.

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (2 of 3)

b. Use of Restrictive Interventions. *(Select one)*:

○ **The state does not permit or prohibits the use of restrictive interventions**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:

● **The use of restrictive interventions is permitted during the course of the delivery of waiver services** Complete Items G-2-b-i and G-2-b-ii.

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the state has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

NC Administrative Code at 10A NCAC 27E.0107 addresses Training on Alternatives to Restrictive Interventions.

Restrictive interventions are reported via the incident reporting rules at 10A NCAC 27 G.0600 . The DHHS Restrictive Intervention Details Report is completed along with the incident report.

Restrictive interventions governed by 10a NCAC 27e .0104 include seclusion, physical restraint, isolation time-out and protective devices used for behavioral control. Use of these interventions is limited to emergency situations in order to terminate a behavior or action in which the individual is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or as a planned measure of therapeutic treatment. Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.

Positive and less restrictive alternatives must be considered and attempted whenever possible prior to the use of more restrictive interventions. Providers shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. They shall establish training based on state competencies and the contents of the training must be approved by DMH/DD/SAS. Formal refresher training must be completed by each service provider at least annually. Competencies include:
• knowledge and understanding of the people being served;
• recognizing and interpreting human behavior;
• recognizing the effect of internal and external stressors that may affect people with disabilities / TBI;
• strategies for building positive relationships with persons with traumatic brain injuries;
• recognizing cultural, environmental and organizational factors that may affect people with disabilities;
• recognizing the importance of and assisting in the person's involvement in making decisions about their life;
• skills in assessing individual risk for escalating behavior;
• communication strategies for defusing and de-escalating potentially dangerous behavior; and
• positive behavioral supports (providing means for people with TBI to choose activities which directly oppose or replace behaviors which are unsafe).

Emergency interventions may only be employed for up to 15 minutes without further authorization by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training. Whenever an individual is in seclusion or physical restraint, including a protective device when used for the purpose or with the intent of controlling unacceptable behavior, the individual must be observed at least every 15 minutes, or more often as necessary, to assure safety. Whenever an individual is in isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the individual. There shall be continuous observation and verbal interaction when appropriate. This observation must be documented. If an individual is in a physical restraint and may be subject to injury,
a facility employee shall remain present with the individual continuously.

When protective devices are used for an individual, there must be documentation that the staff are trained and competent to use the device, that there has been a review of less restrictive alternatives that have not been successful, and that review has been made by a Client Right's Committee. The intervention and monitoring of the individual for health and safety must be documented.

When restraints are used, there must be continuous assessment of the individual to ensure their physical and psychological well being throughout the intervention. Staff who are trained in emergency safety interventions and CPR must be present during the restrictive procedure.

Seclusion, physical restraint and isolation time-out may be employed only by staff that have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Prior to providing direct care to people with traumatic brain injuries whose treatment/ rehabilitation plan includes restrictive interventions, staff shall complete training in the use of seclusion, physical restraint
and isolation time-out and shall not use these interventions until the training is completed and competence is

demonstrated. A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. The training shall be competency-based and must be approved by DMH/DD/SAS. A formal refresher
training must be completed by each staff at least annually. Training programs shall include, but are not limited to, presentation of:
• refresher information on alternatives to the use of restrictive interventions;
• guidelines on when to intervene (understanding imminent danger to self and others);
• emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
• strategies for the safe implementation of restrictive interventions;
• the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
• prohibited procedures;
• debriefing strategies, including their importance and purpose; and
• documentation methods/procedures.
At a minimum documentation of the use of restraints or seclusion must include:
• the individual's physical and psychological well-being;
• frequency, intensity and duration of the behavior which led to the intervention
• any precipitating event;
• the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
• a description of the intervention and the date, time and duration of its use;
• a description of accompanying positive methods of intervention;
• a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
• a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
• signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

When any restrictive intervention is utilized the legally responsible person shall be notified immediately unless she/he has requested not to be notified. When restrictive interventions are utilized as part of a behavioral plan, the behavior plan must include steps and less restrictive measures that must be utilized prior to the restrictive procedure. Planned use of restrictive interventions must be reviewed by a
Human Rights Committee prior to implementation. Utilization of any restrictive procedure, planned or unplanned (unauthorized) will be documented on the DHHS online Incident Response Information System (IRIS). This report is submitted within 72 hours of the use of a restrictive intervention to the PIHP/Tailored plan. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP/Tailored plan. The Tailored Care Manager/Care Coordinator monitors at least quarterly to ensure any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support plan and that the Positive Behavioral Support plan is signed/approved by a licensed psychologist and approved by the Client Right's Committee.

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

State agencies and the PIHP/Tailored plan are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. The PIHPs/Tailored plan report quarterly on the use of restraints to DHB. In addition, NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, requires provider agencies to participate in the DHHS online Incident Response Information
System (IRIS) for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and beneficiary behavior issues. The PIHPs/Tailored plan provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the PIHP/Tailored plan. State agencies review the use of restraints, restrictive interventions and rights restrictions if complaints are made to the state advocacy and consumer affairs office. Any significant injuries which result from employment of a restraint, restrictive intervention or rights restriction must be carefully analyzed and immediately reported to state agencies and the PIHP/Tailored plan.

If the agency is licensed through the Division of Health Service Regulation, the PIHP/Tailored plan, DHB, or the DMH/DD/SAS may contact the Division of Health Service Regulation regarding any concerns. Providers report aggregate data to the PIHP/Tailored plan quarterly. The PIHP collects this data for DHB.

Unauthorized use of restrictive interventions is detected and addressed through Tailored Care Management/Care Coordination monitoring of both services and health and safety on a monthly or quarterly basis. One aspect of the Tailored Care Management/Care Coordination monitoring tool is to determine whether any incidents have occurred and to determine any patterns or unauthorized use of restraints. Furthermore, Utilization of unplanned restrictive procedure will be documented on the DHHS online Incident Response Information System (IRIS). This report is submitted within 72 hours of the use of a restrictive intervention to the PIHP/Tailored plan. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP/Tailored plan. The Tailored Care Manager/Care Coordinator monitors at least quarterly to ensure any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support plan and that the Positive Behavioral Support plan is signed/approved by a licensed psychologist and approved by the Client Right's Committee."

Appendix G: Participant Safeguards

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions (3 of 3)

c. Use of Seclusion. *(Select one)*: *(This section will be blank for waivers submitted before Appendix G-2-c was added to WMS in March 2014, and responses for seclusion will display in Appendix G-2-a combined with information on restraints.)*

○ **The state does not permit or prohibits the use of seclusion**

Specify the state agency (or agencies) responsible for detecting the unauthorized use of seclusion and how this oversight is conducted and its frequency:

● **The use of seclusion is permitted during the course of the delivery of waiver services**. Complete Items G-2-c-i and G-2-c-ii.

i. Safeguards Concerning the Use of Seclusion. Specify the safeguards that the state has established concerning the use of each type of seclusion. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

NC Administrative Code at 10A NCAC 27E.0107 addresses Training on Alternatives to Restrictive Interventions.

Restrictive interventions governed by 10a NCAC 27e .0104 include seclusion, physical time-out and protective devices used for behavioral control. Use of these interventions is limited to emergency situations in order to terminate a behavior or action in which the individual is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others; or as a planned measure of therapeutic treatment. Restrictive interventions shall not be employed as a means of coercion, punishment or retaliation by staff or for the convenience of staff or due to inadequacy of staffing. Restrictive interventions shall not be used in a manner that causes harm or abuse.

Positive and less restrictive alternatives must be considered and attempted whenever possible prior to the use of more restrictive interventions. Providers shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. They shall establish training based on state competencies and the contents of the training must be approved by DMH/DD/SAS. Formal refresher
training must be completed by each service provider at least annually. Competencies include:
• knowledge and understanding of the people being served;
• recognizing and interpreting human behavior;
• recognizing the effect of internal and external stressors that may affect people with disabilities/TBI;
• strategies for building positive relationships with persons with disabilities / TBI;
• recognizing cultural, environmental and organizational factors that may affect people with disabilities / TBI;
• recognizing the importance of and assisting in the person's involvement in making decisions about their life;
• skills in assessing individual risk for escalating behavior;
• communication strategies for defusing and de-escalating potentially dangerous behavior; and
• positive behavioral supports (providing means for people with disabilities / TBI to choose activities which directly oppose or replace behaviors which are unsafe).
Emergency interventions may only be employed for up to 15 minutes without further authorization by the responsible professional or another qualified professional who is approved to use and to authorize the use of the restrictive intervention based on experience and training. Whenever an individual is in seclusion or physical restraint, including a protective device when used for the purpose or with the intent
of controlling unacceptable behavior, the individual must be observed at least every 15 minutes, or more often as necessary, to assure safety. Whenever an individual is in isolation time-out: there shall be a facility employee in attendance with no other immediate responsibility than to monitor the individual. There shall be continuous observation and verbal interaction when appropriate. This observation must be documented. If an individual is in a physical restraint and may be subject to injury, a facility employee shall remain present with the individual continuously.

When protective devices are used for an individual, there must be documentation that the staff are trained and competent to use the device, that there has been a review of less restrictive alternatives that have not been successful, and that review has been made by a Client Right's Committee. The intervention and monitoring of the individual for health and safety must be documented.

When restraints are used, there must be continuous assessment of the individual to ensure their physical and psychological well-being throughout the intervention. Staff who are trained in emergency safety interventions and CPR must be present during the restrictive procedure.

Seclusion, physical restraint and isolation time-out may be employed only by staff that have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Prior to providing direct care to people with disabilities whose treatment/rehabilitation plan includes restrictive interventions, staff shall complete training in the use of seclusion, physical restraint
and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. A prerequisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. The training shall be competency-based and must be approved by DMH/DD/SAS. A formal refresher

training must be completed by each staff at least annually. Training programs shall include, but are not limited to, presentation of:
• refresher information on alternatives to the use of restrictive interventions;
• guidelines on when to intervene (understanding imminent danger to self and others);
• emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
• strategies for the safe implementation of restrictive interventions;
• the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
• prohibited procedures;
• debriefing strategies, including their importance and purpose; and
• documentation methods/procedures.
At a minimum documentation of the use of restraints or seclusion must include:
• the individual's physical and psychological well-being;

ii. State Oversight Responsibility. Specify the state agency (or agencies) responsible for overseeing the use of seclusion and ensuring that state safeguards concerning their use are followed and how such oversight is conducted and its frequency:

State agencies and the PIHP/Tailored plan are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. The PIHPs/Tailored plan report quarterly on the use of restraints to DHB. In addition, NC Administrative Code 10A NCAC 27E .0104 and 10A NCAC 27G .0600, requires provider agencies to participate in the DHHS online Incident Response Information System (IRIS) for responding to and reporting critical incidents and other life endangering situations. This system addresses deaths, injuries, behavioral interventions, including physical restraints, management of medications, allegations of abuse or neglect, and beneficiary behavior issues. The PIHPs/Tailored plan provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the PIHP/Tailored plan. State agencies review the use of restraints, restrictive interventions and rights restrictions if complaints are made to the state advocacy and consumer affairs office. Any significant injuries which result from employment of a restraint, restrictive intervention or rights restriction must be carefully analyzed and immediately reported to state agencies and the PIHP/Tailored plan.

Unauthorized use of seclusion is detected and addressed through Tailored Care Management monitoring of both services and health and safety on a monthly or quarterly basis. One aspect of the Tailored Care Management/ Care Coordination monitoring tool is to determine whether any incidents have occurred and to determine any patterns or unauthorized use of restraints. Furthermore, Utilization of unplanned restrictive procedure will be documented on the DHHS online Incident Response Information System (IRIS). This report is submitted within 72 hours of the use of a restrictive intervention to the PIHP/Tailored plan. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP/Tailored plan. The Tailored Care Manager/Care Coordinator monitors at least quarterly to ensure any restrictive interventions (including protective devices used for behavioral support) are written into the ISP and the Positive Behavior Support plan and that the Positive Behavioral Support plan is signed/approved by a licensed psychologist and approved by the Client Right's Committee."
If the agency is licensed through the Division of Health Service Regulation, PIHP/Tailored plan, DHB, or the DMH/DD/SAS may contact the Division of Health Service Regulation regarding any concerns. Providers report aggregate data to the PIHP/Tailored plan quarterly. The PIHP/Tailored plan collects this data for DHB.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (1 of 2)

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of

a family member.

a. Applicability. Select one:

- ○ **No. This Appendix is not applicable** *(do not complete the remaining items)*
- ◉ **Yes. This Appendix applies** *(complete the remaining items)*

- **Medication Management and Follow-Up**

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

North Carolina Administrative Code at 10A NCAC 27G.0209 outlines medication requirements for individuals in 24-hour facilities. Provider agencies are required to have a pharmacist or physician complete quarterly medication/drug reviews for consumers taking medications with potentially serious side effects. The results of the review are reviewed by the PIHP/Tailored plan with the provider agency. An independent peer review by a pharmacist or physician is conducted at least once every six months for service beneficiaries receiving antipsychotic medications and at least once every three months for individuals receiving opioids. PIHP/Tailored plans conduct monitoring of providers on an annual basis in addition to the quarterly review completed by the pharmacist and physician.

PIHP/Tailored plans complete incident reports with aggregate information and submit to the state agency quarterly. More serious incidents that threaten an individual's health and safety as determined by a pharmacist or physician are reported through the state's incident reporting system.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the state uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the state agency (or agencies) that is responsible for follow-up and oversight.

State rules and regulations outline requirements for policies and procedural precautions which must be implemented for medication management, which includes prohibited practices. Provider agencies are required to have a pharmacist or physician complete quarterly medication/drug reviews for consumers taking medications with potentially serious side effects. The results of the review are reviewed by the state regulatory entities during annual or complaint reviews.

Harmful practices are identified through the incident reporting and PIHP/Tailored plans monitoring process. These practices are addressed through plans of corrections, increased monitoring, and additional training. Criteria for additional training include Level 1 and Level 2 incidents that could be remediated via training. The DDHB contract monitors are responsible for oversight. In addition to quarterly reporting, critical incidents are reported to the contract managers immediately for follow up by DMH/DD/SAS Customer Services. Depending on the nature of the strategy, the PIHP/Tailored plan quality strategy may be amended or the strategy may be used by the PIHP/Tailored plan as a Performance Improvement Plan.

Appendix G: Participant Safeguards

Appendix G-3: Medication Management and Administration (2 of 2)

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one:*

- ○ **Not applicable.** *(do not complete the remaining items)*
- ◉ **Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications.** *(complete the remaining items)*

- **State Policy.** Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Beneficiaries who self-medicate are required to have an assessment on their ability to self medicate and a physician must sign an order for self-medication. Documentation must be maintained as outlined in state rules/regulations.

The rule specific to medication administration is 10A NCAC 27G. 0209. It notes the following:
• Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.
• Medications shall be self-administered by beneficiaries only when authorized in writing by the beneficiary's physician.
• Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.
• A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration

As State administrative rules require that unlicensed personnel who administer medication be trained by registered nurses, pharmacists or physicians, The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) endorses the instructor training offered at Area Health Education Centers (AHECs).

Please note that licensed home care and licensed hospice agencies must comply with applicable licensure rules and requirements as outlined by the Division of Health Service Regulation (DHSR). As such, if a waiver provider is also a licensed home care or hospice provider then the administrative rules that govern mental health/developmental disabilities, Traumatic Brain Injury, and substance abuse providers do not supersede those that govern licensed home care or hospice providers.

- **Medication Error Reporting.** *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

a) Provider agencies report medication errors to the PIHP/Tailored plan who, in turn, reports the errors to the Division of MH/DD/SAS through incident reporting described in Appendix G-1.

(b) Specify the types of medication errors that providers are required to *record:*

b) Errors reported include: wrong or missed dosage, wrong medication, wrong time (over 1 hour from prescribed time) or medication refusals by the beneficiary.

c) Errors reported include: medication refusals by the beneficiary.

(c) Specify the types of medication errors that providers must *report* to the state:

d) Any error that results in permanent physical or psychological impairment is reported to the Division of MH/DD/SAS via Level III incident reporting.

Any error that does not threaten the individual's health and safety, as determined by a physician or pharmacist notified of the error is reported via Level I incident reporting.

Providers responsible for medication administration are required to record medication errors but make information about medication errors available only when requested by the state.

Specify the types of medication errors that providers are required to record:

- **State Oversight Responsibility.** Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The PIHP reports medication errors via incident reporting described in Appendix G-1. This includes Quarterly Reporting to the Division of DMH/DD/SAS.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

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

a. Methods for Discovery: Health and Welfare

The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Number and Percent of Actions Taken to Protect the Beneficiary, where indicated.
Numerator: Number of incidents where protective action was taken to protect the beneficiary. Denominator: Number of incidents where protective action was indicated.

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

NC Incident and Reporting System

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of beneficiaries who received appropriate medication Numerator: Total number of beneficiaries who did not have a medication error reported Denominator: Total number of beneficiaries prescribed medication

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of beneficiaries who received medication as prescribed Numerator: Total number of beneficiaries who did not have a medication refusal reported
Denominator: Total number of beneficiaries prescribed medication

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: PIHP	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Number and percentage of deaths reviewed and determined not to be of unexplained or suspicious cause. Numerator: Number of deaths not of unexplained or suspicious cause. Denominator: total number of deaths.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of substantiated incidents required to be reported to the Division of Social Services (DSS) or the Division of Health Service Regulation (DHSR). Numerator: Number of substantiated incidents that were reported to DHSR or DSS. Denominator: Total number of substantiated incidents required to be reported to DHSR or DSS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

		Sample Confidence Interval =
☑ **Other** Specify: PIHPs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number and Percentage of deaths where required PIHP follow-up interventions were completed as required. Numerator: Number of deaths where follow up intervention was completed by the PIHP. Denominator: All deaths where follow up intervention was required by the PIHP.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of medication errors not resulting in emergency medical treatment or hospitalization. Numerator: Number of medication errors not requiring emergency medical treatment or hospitalization. Denominator: All medication errors that were reported for beneficiaries.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

Specify: PIHPs		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
% of beneficiaries(families/legal guardians) who received information on how to report abuse,neglect,exploitation and unexplained death during their annual plan meeting. Numerator: # of beneficiaries (families/legal guardians) who received information on how to report abuse, neglect, exploitation and unexplained death during their Annual Plan Meeting. Denominator: Number of beneficiaries.

Data Source (Select one):

Other
If 'Other' is selected, specify:
Annual Plan Meeting

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

Data Aggregation and Analysis:

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

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

b. ***Sub-assurance: The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Percentage of level 2 or 3 incidents where required LME-MCO follow-up interventions were completed as required. Numerator: Number of Level 2 or 3 incident reports where LME-MCO required follow-up interventions were completed. Denominator: All level 2 or 3 incidents where LME-MCO follow-up intervention was required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

☐ **Sub-State Entity**	☑ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: PIHPs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

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

Performance Measure:
Percentage of level 2 and 3 incidents reported within required time frames as specified in State Policy. Numerator: Number of level 2 and 3 incidents reported within required time frames as specified in State Policy. Denominator: Total number of level 2 and 3 incidents reported

Data Source (Select one):
Record reviews, on-site
If 'Other' is selected, specify:
Critical events and incident reports

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of critical incidents required to be reported to the Division of Social Services or the Division of Health Service Regulation are reported. Numerator: Number of required critical incidents reported to DHSR or DSS Denominator: Total number of critical incidents required to be reported to DHSR or DSS.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

		Confidence Interval =
☑ **Other** Specify: PIHPs	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Number of incidents of abuse, neglect, exploitation, and death in which root cause identified. Numerator: Number of incidents of abuse, neglect, exploitation, and death in which root cause identified. Denominator: Number of incidents of abuse, neglect, exploitation, and death reviewed for root cause

Data Source (Select one):
Other
If 'Other' is selected, specify:
IRIS

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of level 2 or 3 incidents where the supervisor completed the "cause of the incident" and "what can be done to prevent future occurrences" fields. Numerator: Number of Level 2 or 3 incident reports with both "cause of the incident" and "what can be done to prevent future occurrences" fields completed. Denominator: All level 2 or 3 incidents.

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

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

Specify: PIHP		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

c. ***Sub-assurance: The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
Percent of restrictive interventions used by a trained staff member. Numerator: Number of restrictive interventions used by a trained staff member. Denominator: Number of restrictive interventions."

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

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

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of restrictive interventions that do not result in medical treatment. Numerator: Number of restrictive interventions that do not result in medical treatment due to injury related to the use of a restrictive intervention Denominator: All restrictive interventions

Data Source (Select one):
Other
If 'Other' is selected, specify:
Critical events and incident reports

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

Specify: PIHPs		Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

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

Performance Measure:
Percentage of restrictive interventions (both restraint and seclusion) that comply with State policies and procedures regarding the use of restrictive interventions. Numerator: Number of restrictive interventions that comply with the State policies and procedures regarding the use of restrictive intervention. Denominator: All incidents of restrictive interventions.

Data Source (Select one):

Record reviews, on-site
If 'Other' is selected, specify:
Critical events and incident reports

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

Data Aggregation and Analysis:

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

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

Performance Measure:
Percent of restrictive interventions used in an emergency after exhausting all other possibilities. Numerator: Number of restrictive interventions used in an emergency after exhausting all other possibilities. Denominator: Number of restrictive interventions used.

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

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

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

Data Aggregation and Analysis:

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

d. ***Sub-assurance: The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.***

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
The percentage of waiver beneficiaries who had a primary care or preventative care visit during the waiver year. Numerator: Number of waiver beneficiaries who had a primary care or preventative care visit during the waiver year. Denominator: Number of waiver beneficiaries

Data Source (Select one):
Other
If 'Other' is selected, specify:
Review of claims data on primary care or preventative care visits.

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

Data Aggregation and Analysis:

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

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.

The PIHP/Tailored plans will analyze and address problems identified and include the analysis in the report to DHB. In situations where providers are involved, the PIHP/Tailored plans may require provider corrective action plans or take other measures to ensure consumer protection. DHB will require corrective action plans of the PIHP if it is determined that appropriate action was not taken by the PIHP/Tailored plan. Such corrective action plans are subject to DHB approval and monitored by DHB. DHB requires the PIHPs to contact DHB immediately about any issue that has or may have a significant negative impact on beneficiary health and welfare. DHB and the PIHPs work together to resolve such issues as they occur.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of health and welfare that are currently non-operational.

◉ **No**

○ **Yes**

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

Appendix H: Quality Improvement Strategy (1 of 3)

Under Section 1915(c) of the Social Security Act and 42 CFR § 441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver quality improvement strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a quality improvement strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the quality improvement strategy.

Quality Improvement Strategy: Minimum Components

The quality improvement strategy (QIS) that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I) , a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the state's QIS is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its QIS, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the QIS spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the QIS. In instances when the QIS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. Unless the state has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the state must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 3)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The North Carolina quality management strategy for the 1915(c) Innovations waiver and the accompanying 1115 waiver and 1915(b) waiver is a comprehensive plan incorporating quality assurance monitoring and ongoing quality improvement processes. The strategy focuses on methods for coordinating, assessing and continually improving the delivery of behavioral healthcare, intellectual and developmental disabilities (I/DD) and Traumatic Brain Injury services (TBI) provided through prepaid Inpatient health plans (PIHPs)/Tailored plan. The strategy encompasses an interdisciplinary collaborative approach through partnerships with enrollees and their families, stakeholders, governmental departments and divisions, contractors, the PIHP/Tailored plans, and community groups. System improvements are made based on findings from a number of discovery activities, including: performance measures outlined in both waivers and the PIHP/Tailored plan contracts; external quality reviews; grievances and appeals tracking and trending; network adequacy studies; and, and consumer and provider surveys. (A brief description of each key activity and how they are used for system improvement is provided at the end of this narrative.)

Findings from these activities are reviewed and addressed by DHB.

Oversight of the PIHP /Tailored plan is led by DHB, the Division of MH/DD/SUS, other divisions within the NC DHHS as needed and the PIHP/Tailored plan. Collectively, the individuals reviewing the PIHP/Tailored plan have expertise in all areas of waiver operations, including clinical, finance, health information systems, program integrity, quality management and state and federal rules and regulations relevant to the waiver program. This oversight provide technical assistance, review findings from discovery activities, identify challenges and successes, make recommendations for system improvements and monitor progress of any corrective action plans.

Through this multi-level process which provides for evaluation and feedback from consumers, providers, state staff and program experts, both challenges and successes in operating the waivers are identified. Potential solutions to concerns are thoroughly vetted by all stakeholders through SCFAC, and recommendations are made to DHB for system improvements.

Discovery Activities:

Performance Measures and Performance Improvement Projects:
DHB, in conjunction with the PIHP/Tailored plans and system stakeholders, identified the performance measures outlined in the Innovations waiver document and in the DHB-PIHP/Tailored plan contract. The performance measure results are reviewed annually and benchmarked with established performance standards/goals. DHB has also identified performance improvement projects that address a range of priority issues for the Medicaid population. Each PIHP/Tailored plan is required to implement performance improvement projects in both clinical and non-clinical areas and report findings to DHB.

On-Site Reviews:
DHB and DMH conduct onsite monitoring reviews of each PIHP annually to evaluate compliance with the terms of the contract between DHB and the PIHP and State and federal Medicaid requirements, including Innovations waiver requirements. The review of administrative operations (financial management, information technology, claims) and clinical operations (Tailored Care Management, utilization management, network management, quality management) consists of a documentation review and onsite interviews. A review of MH/DD/SUS Tailored Care Management records may be included in the review. Any compliance issues found during the review will require the submission of a corrective action plan to the IMT for approval and ongoing monitoring.

External Quality Review:
The federal and State regulatory requirements and performance standards as they apply to PIHP/Tailored plans are evaluated annually for the State in accordance with 42 CFR 438.310 by an independent External Quality Review Organization (EQRO), including a review of the services covered under each PIHP/Tailored plan contract for a) timeliness, b) outcomes and c) accessibility. The EQRO produces, at least, the following information:

- A detailed technical report describing data aggregation and analysis and the conclusions (including an assessment of strengths and weaknesses) that were drawn as to the quality, timeliness and access to care furnished by the PIHP/Tailored plan.
- Validation of performance measures and performance improvement projects
- Recommendations for improving the quality of healthcare services furnished by the PIHP/Tailored plan

• An assessment of the degree to which the PIHP/Tailored plan effectively addressed previous EQRO review recommendations

EQR results and technical reports are reviewed by the IMT for feedback. Ongoing EQR status reports, and final technical and project reports, are communicated through the IMT. Report results, including data and recommendations, are analyzed and used to identify opportunities for process and system improvements, performance measures or performance improvement projects. Report results are also used to determine levels of compliance with requirements and assist in identifying next steps.

Grievance and Appeal Reports:
DHB review of grievance and appeal information is used to assess quality and utilization of care and services. The PIHP/Tailored plan reports address type of grievance, source of grievance, type of provider (MH, I/DD, SU) and grievance resolution. The number, types and disposition of appeals are also reported. Results from ongoing analysis are applied to evaluation of grievances with quality expectations. Reports are submitted to DHB quarterly.

Network Adequacy:
The PIHP/Tailored plans are required to establish and maintain provider networks that meet the service needs of the waiver participants and to establish policies and procedures to monitor the adequacy, accessibility and availability of their provider networks. The PIHP/Tailored plans are required to conduct an analysis of their networks to demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access of its members to practitioners and facilities. The analysis and findings are submitted to DHB annually.

Provider and Consumer Surveys:
Each PIHP/Tailored plan administers a consumer survey annually designed to measure adult and child consumer experience and satisfaction with the PIHP/Tailored plan. The survey contains questions designed to measure at least the following dimensions of client satisfaction with PIHP/Tailored plan providers, services, delivery and quality:

- Overall satisfaction with PIHP/Tailored plan services, delivery, access to care and quality
- Consumer knowledge of managed care from a patient's perspective
- Consumer knowledge of rights and responsibilities, including knowledge of grievance procedures and transfer process
- Cultural sensitivity
- Consumer perception of accessibility to services, including access to providers
- Additional factors that may be requested by the State

Each PIHP/Tailored plan also administers a provider survey annually. The purpose of the provider satisfaction survey is to solicit input from providers regarding levels of satisfaction with program areas, such as claims submission and payment, assistance from the PIHP/Tailored plan and communication.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☐ **Annually**
☐ **Other** Specify:	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

DHB prioritizes and implements the needed changes. DHB uses the discovery activities described above on an ongoing basis to determine whether the desired improvements have been achieved. Additional discovery activities or changes to those already in place may be made to more effectively track the result of system changes.

ii. Describe the process to periodically evaluate, as appropriate, the quality improvement strategy.

The quality strategy is reviewed by the quality staff of DHB through an ongoing process that incorporates input from a multitude of sources. The effectiveness of the quality strategy is reviewed on an annual basis and revised based upon analysis of results by the quality management staff in DHB. The quality strategy may be reviewed more frequently if significant changes occur that impact quality activities or threaten the potential effectiveness of the strategy. As a result of the annual analysis process, a quality plan for the upcoming year is developed that is congruent with the overall quality strategy. If changes need to be made to the quality strategy, DHB seeks public input

The revised quality management strategy is placed on the DHB website for public input over a 30-day period. In addition, each PIHP/Tailored plan will present the quality strategy update for comments at CQI and CFAC meetings. Once public input has been received, the final strategy document is prepared and approved by the quality management staff in DHB. Following approval by DHB, any amendments to the quality strategy are shared with CMS. The final quality strategy is also published on the DHB website.

Appendix H: Quality Improvement Strategy (3 of 3)

H-2: Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months *(Select one):*

- **No**
- **Yes** *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- **HCBS CAHPS Survey :**
- **NCI Survey :**
- **NCI AD Survey :**
- **Other** *(Please provide a description of the survey tool used):*

Experience of Care Survey was developed by DHB and DMH/DD/SAS.

Appendix I: Financial Accountability

I-1: Financial Integrity and Accountability

Financial Integrity. *Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).*

The NC TBI waiver operates in conjunction with the 1115 and 1915(b) waivers and all services are provided through prepaid inpatient health plans (PIHP)/Tailored plan for Tribal Members. The Division of Health Benefits (DHB) makes a capitated payment monthly to the PIHP/Tailored plans for each enrollee and the PIHPs provide all needed MH/DD/SA and Physical Health services to Medicaid beneficiaries through their provider networks. The PIHP/Tailored plans are required through their contracts with DHB to implement a compliance plan to guard against fraud and abuse, to conduct provider audits to verify that services authorized and paid for by the PIHP are actually provided and to take disciplinary action when needed. The PIHP/Tailored plans must report any incidents of fraud and abuse to DHB. Provider agencies are monitored at a frequency set by the PIHP/Tailored plans but no less than every three years.

The PIHP/Tailored plans are also contractually required to have their annual financial reports audited in accordance with Generally Accepted Auditing Standards by an independent certified public accountant and submit the audits to DHB. The annual financial audit is subject to independent verification and audit by a firm of DHB's choosing.

DHB assures that services are provided to waiver beneficiaries appropriately and as needed through several required activities described in the contract, such as routine financial and clinical reports by the PIHP/Tailored plan, administration of consumer and provider surveys by the PIHP/Tailored plan or an external entity, on site reviews of operational processes and procedures, record reviews and external quality review activities through an independent entity.

The entity responsible for conducting the independent audit of the waiver required by the Single Audit Act is the North Carolina Office of the State Auditor.

Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

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

a. Methods for Discovery: Financial Accountability Assurance:

The state must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

i. Sub-Assurances:

a. Sub-assurance: The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

Performance Measure:
The proportion of C Waiver claims paid by the PIHP for NC TBI waiver services that have been authorized by Utilization Management. Numerator: Number of C waiver claims paid for services that have been authorized by Utilization Management (UM). Denominator: Total number of C waiver claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Report from UM to DHB on claims paid.

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

Data Aggregation and Analysis:

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

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

Performance Measure:
The proportion of C Waiver claims that are coded and paid in accordance with the rate methodology specified in the approved waiver and only for services rendered.
Numerator: C Waiver claims that are coded and paid in accordance with the rate methodology specified in the approved waiver and only for services rendered.
Denominator: Total number of C waiver claims paid.

Data Source *(Select one):*
Other
If 'Other' is selected, specify:
Reports from LME-MCO paid claim system.

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

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

Data Aggregation and Analysis:

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

b. Sub-assurance: The state provides evidence that rates remain consistent with the approved rate methodology throughout the five year waiver cycle.

Performance Measures

For each performance measure the state will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

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

identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Number/percent of capitation payments made in accordance with the approved reimbursement methodology. Numerator: number of capitation payments paid in accordance with the approved reimbursement methodology throughout the five-year waiver cycle. Denominator: number of capitation payments. Capitation payments are reviewed and adjusted on an annual basis.

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

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

Data Aggregation and Analysis:

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

ii. *If applicable, in the textbox below provide any necessary additional information on the strategies employed by the state to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Medicaid capitated payments to the PIHP/Tailored plan are developed and certified by actuarial staff in accordance with managed care requirements for contracts and rate development in 42 CFR Part 438. The actuaries use the PIHP encounter data to set the rates and take into consideration any program or policy changes that might impact the waiver program. Capitation payments are reviewed and adjusted on an annual basis.

b. Methods for Remediation/Fixing Individual Problems

i. *Describe the state's method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction and the state's method for analyzing information from individual problems, identifying systemic deficiencies, and implementing remediation actions. In addition, provide information on the methods used by the state to document these items.*

The PIHP/Tailored plan has the authority to require corrective action plans of each of their providers and recoup payments if they find that services are provided inappropriately - i.e. services are not provided in accordance with program requirements. The PIHP/Tailored plan may require the providers to implement corrective action plans depending on the severity and nature of the problem. When significant problems are detected that may impact the health and safety of consumers, the PIHP/Tailored plan reports to the State immediately. The State assists with remediation as appropriate and may require corrective actions by the PIHP/Tailored plan.

ii. Remediation Data Aggregation

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

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

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

c. Timelines

When the state does not have all elements of the quality improvement strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Financial Accountability that are currently non-operational.

- ◉ ***No***
- ○ ***Yes***

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

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (1 of 3)

a. Rate Determination Methods. *In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).*

The State employs an actuary to calculate actuarially sound payment rates per 42 CFR 438.6(c).
The PIHP/Tailored plans are responsible for setting all provider rates for waiver services. The PIHP/Tailored plans set rates based on demand for services, availability of qualified providers, clinical priority or best clinical practices and estimated provider service cost. The PIHP/Tailored plans use the State's Medicaid rates for the same or similar services as a guide in setting rates.

All proposed changes to existing rates or for implementing new rates are reviewed internally by the PIHP/Tailored plans and externally by their respective PIHP/Tailored plan provider advisory committee. The provider council is comprised of a cross section of the PIHP/Tailored plan's provider networks. Rate reviews focus on internal and external equity and consistency. Providers are notified of rate changes by announcement at the provider meetings and online posting on the PIHP/Tailored plan's website.

The PIHPs reimburse waiver service providers on a fee-for-service basis for most services and for most providers. To the extent that providers are capitated, then service level encounter data is provided so that the State can track services and set PIHP capitated rates.

b. Flow of Billings. *Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the state's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:*

DHB makes capitated payments to the PIHP/Tailored plans monthly for each waiver beneficiary through the State's Medicaid Management Information System (MMIS), in accordance with Section A.I.B of the concurrent 1115 and 1915(b) waivers, "Delivery Systems" and the risk contract between the state Medicaid agency and the PIHP/Tailored plan. The capitated payments are considered payment in full for all services covered under the waiver program.

Individual providers bill the PIHP/Tailored plans according to the terms of their respective contracts with the PIHP/Tailored plan. The contract between DHB and the PIHP/Tailored plans outline requirements for subcontracting and timeliness of payment to providers by the PIHP/Tailored plan. The PIHP/Tailored plan may not contract with a subcontractor who is not eligible for participation in the Medicaid program.

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (2 of 3)

c. Certifying Public Expenditures *(select one):*

- ◉ ***No. state or local government agencies do not certify expenditures for waiver services.***
- ○ ***Yes. state or local government agencies directly expend funds for part or all of the cost of waiver services and certify their state government expenditures (CPE) in lieu of billing that amount to Medicaid.***

Select at least one:

☐ ***Certified Public Expenditures (CPE) of State Public Agencies.***

Specify: (a) the state government agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b).(Indicate source of revenue for CPEs in Item I-4-a.)

☐ ***Certified Public Expenditures (CPE) of Local Government Agencies.***

Specify: (a) the local government agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the state verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR § 433.51(b). (Indicate source of revenue for CPEs in Item I-4-b.)

Appendix I: Financial Accountability

I-2: Rates, Billing and Claims (3 of 3)

d. Billing Validation Process. *Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:*

At the State Level:
The State determines eligibility for capitated payments by identifying individuals through the Medicaid Management Information System (MMIS) who, as of a set date at the end of each month have a special indicator that signifies participation in the TBI waiver. (The special indicator is entered in the State's Eligibility Information System (EIS) by the local departments of social services upon notification by the PIHP/Tailored plans that the individual has been approved for waiver participation. Eligibility changes are transmitted to the MMIS on a nightly basis.) The MMIS generates a capitated payment to the PIHP/Tailored plans at the beginning of the following month for each waiver beneficiary identified through this process. DHB requires the PIHP/Tailored plans to review a representative sample of records and encounter data periodically to determine whether assurances as to service plans and service delivery are met and report findings to DHB.

When NC TRACKS recoups a capitation (or another other type) payment, it uses the same accounting codes as a payment, but the opposite direction. The accounting codes have a field that indicates the FFP, plus the accounting codes have a field that maps to specific programs, like TBI. Federal shares are refunded on NC-TRACKS recoups, and if for TBI, get refunded to that specific program.

At the PIHP/Local Levels:
Eligibility for waiver participation is determined by the PIHP/Tailored plans and eligibility for Medicaid is determined by the local departments of social services (DSS). Initial level of care determinations are made by the PIHP/Tailored plans. The PIHP/Tailored plans notify the DSS when eligibility for waiver participation is authorized, the DSS then enters the special waiver indicator into the State's Eligibility Information System and the indicator is transmitted to the MMIS. The MMIS generates an enrollment report at the end of each month, which identifies waiver beneficiaries for whom payment will be made at the beginning of the next month. The PIHP/Tailored plans use this report to verify that waiver eligibility has been entered into the system and to identify any waiver beneficiaries who have lost Medicaid eligibility. Regarding payment for waiver services according to the plan of care, authorization for the individual waiver services in the plan is entered into the PIHP'/Tailored plans claims payment system, which prevents payment for unauthorized services. The PIHP/Tailored plans monitor service delivery through Tailored Care Manager /Care coordinator contact with waiver beneficiaries and billing audits of providers.

e. Billing and Claims Record Maintenance Requirement. *Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR § 92.42.*

Appendix I: Financial Accountability

I-3: Payment (1 of 7)

a. Method of payments -- MMIS *(select one):*

- ***Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).***
- ***Payments for some, but not all, waiver services are made through an approved MMIS.***

  Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) and how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

- ***Payments for waiver services are not made through an approved MMIS.***

  Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:

◉ ***Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS.***

Describe how payments are made to the managed care entity or entities:

The PIHP/Tailored plans notify the local department of social services (DSS) that the individual has been approved to participate in the waiver. The DSS then enters eligibility for waiver participation into the State's Eligibility Information System (NCFAST). NCFAST transmits eligibility to the MMIS, which pays a capitated payment to the PIHP/Tailored plan monthly for each waiver beneficiary. Capitated payments continue until one of the following occurs: the individual loses Medicaid eligibility; or, the DSS, upon instruction from the PIHP/Tailored plans, removes the individual from the waiver. For waiver beneficiaries who have deductibles (spend-downs), the MMIS pays prorated capitated payments based on the date the deductible is met.

Appendix I: Financial Accountability

I-3: Payment (2 of 7)

b. Direct payment. *In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (select at least one):*

☐ ***The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.***

☐ ***The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.***

☐ ***The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent.***

Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

☑ ***Providers are paid by a managed care entity or entities for services that are included in the state's contract with the entity.***

Specify how providers are paid for the services (if any) not included in the state's contract with managed care entities.

Not applicable

Appendix I: Financial Accountability

I-3: Payment (3 of 7)

c. Supplemental or Enhanced Payments. *Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to states for expenditures for services under an approved state plan/waiver. Specify whether supplemental or enhanced payments are made. Select one:*

◉ ***No. The state does not make supplemental or enhanced payments for waiver services.***

○ ***Yes. The state makes supplemental or enhanced payments for waiver services.***

Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made; (b) the types of providers to which such payments are made; (c) the source of the non-Federal share of the supplemental or enhanced payment; and, (d) whether providers eligible to receive the supplemental or enhanced payment retain 100% of the total computable expenditure claimed by the state to CMS. Upon request, the state will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

Appendix I: Financial Accountability

I-3: Payment (4 of 7)

d. Payments to state or Local Government Providers. *Specify whether state or local government providers receive payment for the provision of waiver services.*

● ***No. State or local government providers do not receive payment for waiver services.*** *Do not complete Item I-3-e.*

○ ***Yes. State or local government providers receive payment for waiver services.*** *Complete Item I-3-e.*

Specify the types of state or local government providers that receive payment for waiver services and the services that the state or local government providers furnish:

Appendix I: Financial Accountability

I-3: Payment (5 of 7)

e. Amount of Payment to State or Local Government Providers.

Specify whether any state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing waiver services and, if so, whether and how the state recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. Select one:

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

○ ***The amount paid to state or local government providers is the same as the amount paid to private providers of the same service.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.***

○ ***The amount paid to state or local government providers differs from the amount paid to private providers of the same service. When a state or local government provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the state recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report.***

Describe the recoupment process:

Appendix I: Financial Accountability

I-3: Payment (6 of 7)

f. Provider Retention of Payments. *Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. Select one:*

- ***Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.***
- ***Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment.***

Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the state.

The PIHP/Tailored plans retain 100 percent of the monthly capitated payment.

Appendix I: Financial Accountability

I-3: Payment (7 of 7)

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

- ***No. The state does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.***
- ***Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR § 447.10(e).***

Specify the governmental agency (or agencies) to which reassignment may be made.

ii. Organized Health Care Delivery System. *Select one:*

- ***No. The state does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR § 447.10.***
- ***Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR § 447.10.***

Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:

iii. Contracts with MCOs, PIHPs or PAHPs.

- ***The state does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.***
- ***The state contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of section 1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.***

  Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

- ***This waiver is a part of a concurrent section 1915(b)/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***This waiver is a part of a concurrent section 1115/section 1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The section 1115 waiver specifies the types of health plans that are used and how payments to these plans are made.***
- ***If the state uses more than one of the above contract authorities for the delivery of waiver services, please select this option.***

  In the text box below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of section 1915(a)(1) of the Act to furnish waiver services: Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of section 1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (1 of 3)

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the state source or sources of the non-federal share of computable waiver costs. Select at least one:*

☑ ***Appropriation of State Tax Revenues to the State Medicaid Agency***

☐ ***Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.***

If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the state entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by state agencies as CPEs, as indicated in Item I-2-

c:

☐ ***Other State Level Source(s) of Funds.***

Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by state agencies as CPEs, as indicated in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (2 of 3)

b. Local Government or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. *Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. Select One:*

◉ ***Not Applicable***. *There are no local government level sources of funds utilized as the non-federal share.*

○ ***Applicable***

Check each that applies:

☐ ***Appropriation of Local Government Revenues.***

Specify: (a) the local government entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

☐ ***Other Local Government Level Source(s) of Funds.***

Specify: (a) the source of funds; (b) the local government entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the state Medicaid agency or fiscal agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by local government agencies as CPEs, as specified in Item I-2-c:

Appendix I: Financial Accountability

I-4: Non-Federal Matching Funds (3 of 3)

c. Information Concerning Certain Sources of Funds. *Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) health care-related taxes or fees; (b) provider-related donations; and/or, (c) federal funds. Select one:*

- (●) ***None of the specified sources of funds contribute to the non-federal share of computable waiver costs***
- ( ) ***The following source(s) are used***

Check each that applies:

- [ ] ***Health care-related taxes or fees***
- [ ] ***Provider-related donations***
- [ ] ***Federal funds***

For each source of funds indicated above, describe the source of the funds in detail:

Appendix I: Financial Accountability

I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

- ( ) ***No services under this waiver are furnished in residential settings other than the private residence of the individual.***
- (●) ***As specified in Appendix C, the state furnishes waiver services in residential settings other than the personal home of the individual.***

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. *The following describes the methodology that the state uses to exclude Medicaid payment for room and board in residential settings:*

The capitated payments to the PIHP/Tailored plans are based on cost and utilization data submitted by the PIHP/Tailored plans for waiver services. Any costs of room and board for beneficiaries living in residential facilities are excluded from the rate setting calculations.

Appendix I: Financial Accountability

I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver. *Select one:*

- (●) ***No. The state does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.***
- ( ) ***Yes. Per 42 CFR § 441.310(a)(2)(ii), the state will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The state describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services.***

The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (1 of 5)

a. Co-Payment Requirements. *Specify whether the state imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. Select one:*

- ◉ ***No. The state does not impose a co-payment or similar charge upon participants for waiver services.***
- ○ ***Yes. The state imposes a co-payment or similar charge upon participants for one or more waiver services.***

i. Co-Pay Arrangement.

Specify the types of co-pay arrangements that are imposed on waiver participants (check each that applies):

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*

- ☐ ***Nominal deductible***
- ☐ ***Coinsurance***
- ☐ ***Co-Payment***
- ☐ ***Other charge***

Specify:

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (2 of 5)

a. Co-Payment Requirements.

ii. Participants Subject to Co-pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (3 of 5)

a. Co-Payment Requirements.

iii. Amount of Co-Pay Charges for Waiver Services.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (4 of 5)

a. Co-Payment Requirements.

iv. Cumulative Maximum Charges.

Answers provided in Appendix I-7-a indicate that you do not need to complete this section.

Appendix I: Financial Accountability

I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing (5 of 5)

b. Other State Requirement for Cost Sharing. *Specify whether the state imposes a premium, enrollment fee or similar cost sharing on waiver participants. Select one:*

- ◉ ***No. The state does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.***
- ○ ***Yes. The state imposes a premium, enrollment fee or similar cost-sharing arrangement.***

Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income; (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. *Complete the fields in Cols. 3, 5 and 6 in the following table for each waiver year. The fields in Cols. 4, 7 and 8 are auto-calculated based on entries in Cols 3, 5, and 6. The fields in Col. 2 are auto-calculated using the Factor D data from the J-2-d Estimate of Factor D tables. Col. 2 fields will be populated ONLY when the Estimate of Factor D tables in J-2-d have been completed.*

Level(s) of Care: Hospital, Nursing Facility

Col. 1	*Col. 2*	*Col. 3*	*Col. 4*	*Col. 5*	*Col. 6*	*Col. 7*	*Col. 8*
Year	*Factor D*	*Factor D'*	*Total: D+D'*	*Factor G*	*Factor G'*	*Total: G+G'*	*Difference (Col 7 less Column4)*
1	*57040.38*	*14549.00*	*71589.38*	*70310.00*	*4641.00*	*74951.00*	*3361.62*
2	*57604.95*	*14930.00*	*72534.95*	*84125.00*	*4762.00*	*88887.00*	*16352.05*
3	*58210.45*	*15321.00*	*73531.45*	*86228.00*	*4887.00*	*91115.00*	*17583.55*
4	*58789.34*	*15723.00*	*74512.34*	*88384.00*	*5015.00*	*93399.00*	*18886.66*
5	*59394.43*	*16134.00*	*75528.43*	*90593.00*	*5146.00*	*95739.00*	*20210.57*

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (1 of 9)

a. Number Of Unduplicated Participants Served. *Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:*

Table: J-2-a: Unduplicated Participants

Waiver Year	*Total Unduplicated Number of Participants (from Item B-3-a)*	*Distribution of Unduplicated Participants by Level of Care (if applicable)*	
		Level of Care:	*Level of Care:*
		Hospital	*Nursing Facility*
Year 1	*107*	*5*	*102*
Year 2	*107*	*5*	*102*

Waiver Year	Total Unduplicated Number of Participants (from Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care: Hospital	Level of Care: Nursing Facility
Year 3	107	5	102
Year 4	107	5	102
Year 5	107	5	102

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (2 of 9)

b. Average Length of Stay. *Describe the basis of the estimate of the average length of stay on the waiver by participants in item J-2-a.*

The average length of stay for the waiver is 310.0 days. This figure is expected to be similar to the average length of stay for the State's current CAP/DA waiver, which was based on the actual State experience. While the observed average waiver length of stay for the Traumatic Brain Injury (TBI) waiver between May 2019 and April 2020 is 235.7 days, the current CAP/DA waiver average length of stay was utilized as it is expected that the TBI waiver will have a similar average length of stay once fully established. Even though the original Traumatic Brain Injury (TBI) waiver used the average length of stay observed for the Innovations waiver, the initial TBI experience has indicated a higher disenrollment rate than the Innovations waiver. The source for the SFY 2016 CAP/DA waiver was historical FFS for Medicaid services covered under the CAP/DA HCBS program.

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (3 of 9)

c. Derivation of Estimates for Each Factor. *Provide a narrative description for the derivation of the estimates of the following factors.*

i. Factor D Derivation. *The estimates of Factor D for each waiver year are located in Item J-2-d. The basis and methodology for these estimates is as follows:*

Alliance Behavioral Healthcare (Alliance) is the Local Management Entity / Managed Care Organization (LME/MCO) that operates the TBI waiver. The Alliance catchment area, includes Cumberland, Durham, Johnston, Wake, Mecklenburg and Orange counties.
The 372 Report is the emerging TBI experience reported by Alliance.
"State encounter data from the Innovations waiver" refers to the State encounter data for the Innovations 1915(c) waiver, limited to SFY 2016, which was used to develop the original TBI waiver utilization estimates as well as the utilization assumptions underlying the TBI capitation rates. While the Alliance 372 Report was available for year 2 (May 1, 2019 - April 30, 2020) of the TBI waiver, there is limited experience available due to the small number of individuals on the waiver. For services where TBI waiver experience was unavailable or limited, Factor D assumptions were informed by either the original TBI waiver utilization estimates, Innovations waiver experience or the CAP/DA waiver.

The historical data for the TBI waiver is not sufficient to perform trend analysis due to the small size of the population and ramp-up of the waiver enrollment. The 1% annual inflation adjustment was based on Innovations waiver data as Innovations waiver services are generally comparable to the array of services available under the TBI waiver. These trends are consistent with the actuarial trend developed for the managed-care rate-setting. Mercer reviews multiple data sources, including LME/MCO-specific managed care data and LME/MCO monthly financial reports through December 2019 to develop the prospective trend assumptions. LME/MCO-specific unit cost and utilization trend factors were developed for each major category of service.

Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:
The basis for Factor D was the emerging TBI experience as reported by Alliance for the 372 Report, and the historical managed care encounter data for Medicaid services for the Innovations waiver which was used to develop the original TBI waiver utilization estimates as well as the utilization assumptions underlying the TBI capitation rates.
While the 372 Report was available for year 2 (May 1, 2019 - April 30, 2020) of the TBI waiver, there is limited experience available due to the small number of individuals on the waiver. For services where TBI waiver experience was unavailable or limited, Factor D assumptions were informed by either the original TBI waiver utilization estimates, the historical managed care encounter data for Medicaid services for the SFY 2016 Innovations and SFY 2016 CAP/DA waiver. These services were Adult Day Health, Community Transition, Crisis Services, Extended Clinical (PT, OT, SLP), Home Modifications, Natural Supports Education, Resource Facilitation, Respite, Supported Employment, Vehicle Modifications, and Supported Living.

Cost/Unit: The State expects the providers of these services to be reimbursed at the TBI Provider Fee Schedule Effective February 1, 2020. In cases where a unit cost is not specified but a maximum billable amount is specified, the State expects the providers of these services (qualifications, etc.) to be similar, if not the same actual providers, as those serving the current Innovations waiver participants. The reasonability of these unit costs were verified with the TBI 372 data where available. It is assumed that services not included in the TBI 372 report will also be reimbursed at the TBI provider fee schedule. Unit costs were established with consideration of unit cost trend of 1.0% annually for waiver projection years. This level of trend is consistent with the unit cost component of trend assumed in recent CAP/DA Factor D development.
Number of Users and Units/User: The State worked with our actuaries to incorporate the TBI 372 data into the service cost projections as clinically appropriate in development of Factor D. Any utilization differences (both for proportion of users and units per user) of the TBI population compared to assumptions underlying the data were adjusted for as deemed appropriate.

- *Supported Living: The waiver cost projections were developed based on Innovations service utilization experience.*

Cost/Unit: The State expects the providers of these services (qualifications, etc.) to be similar, if not the same actual providers, as those serving the current Innovations waiver participants. Therefore, unit costs were established consistent with the Innovations waiver with consideration of unit cost trend of 1.0% annually for waiver projection years. This level of trend is consistent with the unit cost component of trend assumed in recent CAP/DA Factor D development.
Number of Users and Units/User: The State worked with our actuaries to adjust the service cost projections as clinically appropriate in development of Factor D. Any utilization differences (both for proportion of users and

units per user) of the TBI population compared to assumptions underlying the data were adjusted for as deemed appropriate.

- *Remote Supports: The waiver cost projections utilized the Remote Supports rate and utilization experience of the Ohio Individual Options (IO) Waiver population as North Carolina will be using a similar service definition. Cost/Unit: As noted in Appendix I, NC operates the TBI waiver under managed care where the managed care entity has authority to establish rates for each service. For purposes of Appendix J, the State developed an estimated unit cost for Remote Supports using data from the Ohio program with an adjustment for regional wage differences. To account for cost and regional wage differences, an adjustment was calculated by comparing the North Carolina State Plan Personal Care rate to the Ohio State Plan Home Health Aide rate. The resulting adjusted cost/unit was used for waiver year 1 projections with unit cost trend of 1.0% annually for waiver years 2-5.*

Number of Users and Units/User: The State worked with our actuaries to adjust the service cost projections as clinically appropriate in development of Factor D. The State assumed approximately one-third of the users that would access Assistive Technology would utilize Remote Supports. The State again utilized information from Ohio to estimate the utilization per user for Remote Supports at approximately 1950 hours in waiver year 1.

Since this waiver operates under managed care, the actual provider reimbursement rates are established by the managed care entity. The unit costs utilized in the waiver development are consistent with the State's expectations that will be considered in the development of the capitation rate.

Effective February 1, 2022, the State implemented a 10% provider rate increase for services subject to EVV requirements to support additional provider responsibilities. This increase was applied to the services listed below. The waiver Year 2 through Year 5 average cost per unit projections were updated to reflect these increases.

- *Life Skills Training*
- *Supported Living - Periodic*
- *Personal Care*
- *In-Home Intensive Services*

Effective March 1, 2022, the State implemented provider rate increases for select HCBS services to support wage increases for direct care workers. The waiver Year 2 through Year 5 average cost per unit projections were updated to reflect the following increases. Impacted services included:

- *Life Skills Training: $0.54 per 15-minute unit; $0.36 per Group 15-minute unit*
- *Residential Supports: $13.82 per diem*
- *Supported Living: $17.28 to $51.84 per diem; $0.54 per 15-minute unit*
- *Day Supports: $2.16 per hour; $0.72 per Group hour*
- *Supported Employment: $0.54 per 15-minute unit; $0.27 per Group 15-minute unit*
- *Adult Day Health: $3.46 per diem*
- *Personal Care: $0.54 per 15-minute unit*
- *Respite - Institutional and Community: $11.52 per diem; $0.54 per 15-minute unit; $0.27 per Group 15-minute unit*
- *Community Networking: $0.54 per 15-minute unit; $0.18 per Group 15-minute unit*

Effective October 1, 2023, The State implemented changes to the services offered under the TBI Waiver for Year 3 - Year 5. The following changes will have a financial impact on the TBI waiver which were incorporated in the development of Factor D.

- *Home Delivered Meals is being added as a new waiver service.*
- *Resource Facilitation is being removed as it is duplicative of Tailored Care Management.*

ii. Factor D' Derivation. *The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The basis for Factor D' costs were users enrolled in the TBI waiver, utilizing services not covered under the waiver. The State utilized detailed encounter claims and fee-for-service (FFS) data for users enrolled in the TBI waiver during May 1, 2019 - April 30, 2020.
Since utilization of Factor D' services in waiver years 1-5 are per user estimates, Mercer did not include future utilization growth in the estimates. Unit cost was trended at 2.6% annually for waiver projection years 1-5. Annual trend was calculated using statewide encounter data for SFY 2017 - SFY 2019 for the BH I/DD LME-MCO population. The TBI population is assumed to utilize a similar array of non-waiver services as this population.

The encounter data refers to the historical managed care encounter data for Medicaid services that are covered by the LME/MCO program. FFS data is for other services that are currently not covered by the LME/MCO program but are part of the State's fee-for-service claims data used Factor D' derivation. Both data sets reflect data through April 2020.

iii. Factor G Derivation. *The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The basis for Factor G was detailed statewide encounter claims and FFS data for the time period between October 1, 2017 and August 31, 2020, which was used to identify individuals meeting the institutional and additional criteria for the TBI waiver.
For the Nursing Facility level of care, the State worked with our actuaries to identify adult patients (defined as greater than or equal to age 22) with at least 12 continuous months of Nursing Facility claims with a TBI diagnosis code. The TBI diagnosis codes were defined as ICD-10 codes F07.81, S02.0-S02.19, S02.8-S02.9, S04.02-S04.049, S06, S07.1, and Z87.820. Nursing Facility service costs from May 1, 2019 - April 30, 2020 in the encounter claims and FFS data for the identified individuals were included in Factor G.
The State does not currently have a Chronic Hospital or Rehabilitation Hospital level of care at which this population is accessing services. As such, the Specialty Rehabilitation Hospital level of care was estimated based on individuals utilizing services at Black Mountain Intermediate Care Facility (ICF), as the State expects the cost and utilization levels are similar for individuals with TBI if this level of care was available in the State. All claims were summarized for adult patients (defined as greater than or equal to age 22) with at least 12 continuous months of Black Mountain Intermediate Care Facility (ICF) claims with a TBI diagnosis code. Specialty Rehabilitation Hospital service costs from May 1, 2019 - April 30, 2020 in the encounter claims and FFS data for the identified individuals were included in Factor G.
The cost per user figures for the Nursing Facility level of care and the Specialty Rehabilitation Hospital level of care were multiplied by the distribution of individuals in J-2-a to arrive at the weighted average Factor G for this waiver period.
Since utilization of Factor G Institutional level of care services that are expected to be replaced by the waiver services in waiver years 1-5 are per user estimates, the State does not expect growth in the length of stay and did not include future utilization growth in the Factor G development. Unit cost was trended at 2.6% annually for waiver projection years 1-5. This level of trend is consistent with the unit cost component of trend assumed in recent statewide capitation rate development for LTSS services.

The encounter data refers to the historical managed care encounter data for Medicaid services that are covered by the LME/MCO program. FFS data is for other services that are currently not covered by the LME/MCO program but are part of the Factor G derivation.

Annual trend was calculated using statewide encounter data for SFY 2017 - SFY 2019 for LTSS services for the BH I/DD LME-MCO population. Skilled nursing facilities are included in the array of LTSS services.

Effective February 1, 2022, the State implemented provider per diem increases for private ICF/IID providers to support wage increases for direct care workers. Approximately two-thirds of the claims underlying the Factor G development were at private ICF/IID providers. The average impact across all nursing level of care providers was approximately 19%. Waiver Year 2 through Year 5 Factor G projections were updated to reflect these increases.

iv. Factor G' Derivation. *The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:*

The basis for Factor G' were the other Medicaid claims for the individuals identified for the Factor G development, limited to the services other than a Nursing Facility level of care and the Specialty Rehabilitation Hospital level of care. The State utilized detailed encounter claims and fee-for-service (FFS) data for users identified for Factor G during the May 1, 2019 - April 30, 2020 data period.
The cost per user figures for the Nursing Facility level of care and the Specialty Rehabilitation Hospital level of care were multiplied by the distribution of individuals in J-2-a to arrive at the weighted average Factor G' for this waiver period.
Since utilization of Factor G' services in waiver years 1-5 are per user estimates, Mercer did not include future utilization growth in the estimates. Unit cost was trended at 2.6% annually for waiver projection years 1-5. Annual trend was calculated using statewide encounter data for SFY 2017 - SFY 2019 for the BH I/DD LME-MCO population. This trend captures the array of services outside of LTSS services

The encounter data refers to the historical managed care encounter data for Medicaid services that are covered by the LME/MCO program. FFS data is for other services that are currently not covered by the LME/MCO program but are part of the Factor G derivation.

The annual growth is projected to be 2.6% annually, please see revised waiver submission. Annual trend was calculated using statewide encounter data for SFY 2017 - SFY 2019 for the BH I/DD LME-MCO population. This trend captures the array of services outside of LTSS services

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (4 of 9)

Component management for waiver services. *If the service(s) below includes two or more discrete services that are reimbursed separately, or is a bundled service, each component of the service must be listed. Select "manage components" to add these components.*

Waiver Services	
Day Supports	
Personal Care	
Residential Supports	
Respite	
Supported Employment	
Occupational Therapy	
Physical Therapy	
Speech and Language Therapy	
Assistive Technology	
Cognitive Rehabilitation (CR)	
Community Networking	
Community Transition	
Crisis Supports Services	
Home Delivered Meals	
Home Modifications	
In Home Intensive Support	
Life Skills Training	
Natural Supports Education	
Remote Supports	
Specialized Consultation	
Supported Living	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other authorities utilizing capitated arrangements (i.e., 1915(a), 1932(a), Section 1937). *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 1

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							**623274.21**
Day Supports	☑	1 Hour	27	923.00	25.01	**623274.21**	
Personal Care Total:							**443910.87**
Personal Care	☑	15-minute	39	3153.00	3.61	**443910.87**	
Residential Supports Total:							**1068238.08**
Residential Supports	☑	Day	24	312.00	142.66	**1068238.08**	
Respite Total:							**126734.70**
Respite	☑	15-minute	30	1103.00	3.83	**126734.70**	
Supported Employment Total:							**143244.92**
Supported Employment	☑	15-minute	14	1357.00	7.54	**143244.92**	
Occupational Therapy Total:							**12359.14**
Occupational Therapy	☑	15-minute	5	96.33	25.66	**12359.14**	
Physical Therapy Total:							**12359.14**
Physical Therapy	☑	15-minute	5	96.33	25.66	**12359.14**	
Speech and Language Therapy Total:							**14830.97**
Speech and Language	☑	15-minute	6	96.33	25.66	**14830.97**	

GRAND TOTAL: **6103320.84**

Total: Services included in capitation: 6103320.84

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **107**

Factor D (Divide total by number of participants): **57040.38**

Services included in capitation: 57040.38

Services not included in capitation:

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy							
Assistive Technology Total:							**237806.58**
Assistive Technology	☑	Event	31	591.00	12.98	**237806.58**	
Cognitive Rehabilitation (CR) Total:							**248841.60**
Cognitive Rehabilitation (CR)	☑	15-minute	56	322.00	13.80	**248841.60**	
Community Networking Total:							**422331.00**
Community Networking	☑	15-minute	65	1190.00	5.46	**422331.00**	
Community Transition Total:							**50920.74**
Community Transition	☑	Event	13	1.00	3916.98	**50920.74**	
Crisis Supports Services Total:							**4681.29**
Crisis Supports Services	☑	15-minute	1	67.00	69.87	**4681.29**	
Home Delivered Meals Total:							**0.00**
Home Delivered Meals	☑	Event	0	453.00	7.53	**0.00**	
Home Modifications Total:							**212389.58**
Home Modifications	☑	Event	26	1.00	8168.83	**212389.58**	
In Home Intensive Support Total:							**114562.80**
In Home Intensive Support	☑	15-minute	10	2367.00	4.84	**114562.80**	
Life Skills Training Total:							**1332189.60**
Life Skills Training	☑	15-minute	70	3544.00	5.37	**1332189.60**	
Natural Supports Education Total:							**7121.40**
Natural Supports Education	☑	Event	4	165.00	10.79	**7121.40**	

GRAND TOTAL: 6103320.84

Total: Services included in capitation: 6103320.84

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 107

Factor D (Divide total by number of participants): 57040.38

Services included in capitation: 57040.38

Services not included in capitation:

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports Total:							**218595.00**
Remote Supports	☑	1-hour	10	1950.00	11.21	**218595.00**	
Specialized Consultation Total:							**574323.75**
Specialized Consultation	☑	15-minute	55	273.00	38.25	**574323.75**	
Supported Living Total:							**175303.44**
Supported Living	☑	Event	3	312.00	187.29	**175303.44**	
Vehicle Modifications Total:							**59302.04**
Vehicle Modifications	☑	Event	7	1.00	8471.72	**59302.04**	

GRAND TOTAL: 6103320.84
Total: Services included in capitation: 6103320.84
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: 107
Factor D (Divide total by number of participants): 57040.38
Services included in capitation: 57040.38
Services not included in capitation:
Average Length of Stay on the Waiver: 310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements.*Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 2

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							**629504.46**
Day Supports	☑	1-Hour	27	923.00	25.26	**629504.46**	

GRAND TOTAL: 6163730.06
Total: Services included in capitation: 6163730.06
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: 107
Factor D (Divide total by number of participants): 57604.95
Services included in capitation: 57604.95
Services not included in capitation:
Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:							**448829.55**
Personal Care	☑	15-minute	39	3153.00	3.65	**448829.55**	
Residential Supports Total:							**1078945.92**
Residential Supports	☑	Day	24	312.00	144.09	**1078945.92**	
Respite Total:							**128058.30**
Respite	☑	15-minute	30	1103.00	3.87	**128058.30**	
Supported Employment Total:							**144764.76**
Supported Employment	☑	15-minute	14	1357.00	7.62	**144764.76**	
Occupational Therapy Total:							**12484.37**
Occupational Therapy	☑	15-minute	5	96.33	25.92	**12484.37**	
Physical Therapy Total:							**12484.37**
Physical Therapy	☑	15-minute	5	96.33	25.92	**12484.37**	
Speech and Language Therapy Total:							**14981.24**
Speech and Language Therapy	☑	15-minute	6	96.33	25.92	**14981.24**	
Assistive Technology Total:							**240188.31**
Assistive Technology	☑	Event	31	591.00	13.11	**240188.31**	
Cognitive Rehabilitation (CR) Total:							**251366.08**
Cognitive Rehabilitation (CR)	☑	15-minute	56	322.00	13.94	**251366.08**	
Community Networking Total:							**426198.50**
Community Networking	☑	15-minute	65	1190.00	5.51	**426198.50**	
Community Transition Total:							**51429.95**

GRAND TOTAL: **6163730.06**

Total: Services included in capitation: 6163730.06

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **107**

Factor D (Divide total by number of participants): **57604.95**

Services included in capitation: 57604.95

Services not included in capitation:

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition	☑	Event	13	1.00	3956.15	51429.95	
Crisis Supports Services Total:							4728.19
Crisis Supports Services	☑	15-minute	1	67.00	70.57	4728.19	
Home Delivered Meals Total:							0.00
Home Delivered Meals	☑	Event	0	453.00	7.53	0.00	
Home Modifications Total:							214513.52
Home Modifications	☑	Event	26	1.00	8250.52	214513.52	
In Home Intensive Support Total:							115746.30
In Home Intensive Support	☑	15-minute	10	2367.00	4.89	115746.30	
Life Skills Training Total:							1344593.60
Life Skills Training	☑	15-minute	70	3544.00	5.42	1344593.60	
Natural Supports Education Total:							7194.00
Natural Supports Education	☑	Event	4	165.00	10.90	7194.00	
Remote Supports Total:							220740.00
Remote Supports	☑	1-hour	10	1950.00	11.32	220740.00	
Specialized Consultation Total:							580029.45
Specialized Consultation	☑	15-minute	55	273.00	38.63	580029.45	
Supported Living Total:							177053.76
Supported Living	☑	Event	3	312.00	189.16	177053.76	
Vehicle Modifications Total:							59895.43
Vehicle Modifications	☑	Event	7	1.00	8556.49	59895.43	

GRAND TOTAL: 6163730.06

Total: Services included in capitation: 6163730.06

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 107

Factor D (Divide total by number of participants): 57604.95

Services included in capitation: 57604.95

Services not included in capitation:

Average Length of Stay on the Waiver: 310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 3

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Day Supports Total:							***635734.71***
Day Supports	☑	*1-Hour*	*27*	*923.00*	*25.51*	***635734.71***	
Personal Care Total:							***453748.23***
Personal Care	☑	*15-minute*	*39*	*3153.00*	*3.69*	***453748.23***	
Residential Supports Total:							***1089728.64***
Residential Supports	☑	*Day*	*24*	*312.00*	*145.53*	***1089728.64***	
Respite Total:							***129381.90***
Respite	☑	*15-minute*	*30*	*1103.00*	*3.91*	***129381.90***	
Supported Employment Total:							***146284.60***
Supported Employment	☑	*15-minute*	*14*	*1357.00*	*7.70*	***146284.60***	
Occupational Therapy Total:							***12609.60***
Occupational Therapy	☑	*15-minute*	*5*	*96.33*	*26.18*	***12609.60***	
Physical Therapy Total:							***12609.60***
Physical Therapy	☑	*15-minute*	*5*	*96.33*	*26.18*	***12609.60***	
Speech and Language Therapy Total:							***15131.52***
Speech and Language	☑	*15-minute*	*6*	*96.33*	*26.18*	***15131.52***	

GRAND TOTAL: ***6228518.66***

Total: Services included in capitation: *6228518.66*

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: ***107***

Factor D (Divide total by number of participants): ***58210.45***

Services included in capitation: *58210.45*

Services not included in capitation:

Average Length of Stay on the Waiver: *310*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy							
Assistive Technology Total:							**242570.04**
Assistive Technology	☑	Event	31	591.00	13.24	**242570.04**	
Cognitive Rehabilitation (CR) Total:							**253890.56**
Cognitive Rehabilitation (CR)	☑	15-minute	56	322.00	14.08	**253890.56**	
Community Networking Total:							**430839.50**
Community Networking	☑	15-minute	65	1190.00	5.57	**430839.50**	
Community Transition Total:							**51944.23**
Community Transition	☑	Event	13	1.00	3995.71	**51944.23**	
Crisis Supports Services Total:							**4775.76**
Crisis Supports Services	☑	15-minute	1	67.00	71.28	**4775.76**	
Home Delivered Meals Total:							**3329.55**
Home Delivered Meals	☑	Event	1	453.00	7.35	**3329.55**	
Home Modifications Total:							**216658.78**
Home Modifications	☑	Event	26	1.00	8333.03	**216658.78**	
In Home Intensive Support Total:							**116929.80**
In Home Intensive Support	☑	15-minute	10	2367.00	4.94	**116929.80**	
Life Skills Training Total:							**1356997.60**
Life Skills Training	☑	15-minute	70	3544.00	5.47	**1356997.60**	
Natural Supports Education Total:							**7266.60**
Natural Supports Education	☑	Event	4	165.00	11.01	**7266.60**	

GRAND TOTAL: **6228518.66**

Total: Services included in capitation: 6228518.66

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **107**

Factor D (Divide total by number of participants): **58210.45**

Services included in capitation: 58210.45

Services not included in capitation:

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports Total:							**222885.00**
Remote Supports	☑	1-hour	10	1950.00	11.43	**222885.00**	
Specialized Consultation Total:							**585885.30**
Specialized Consultation	☑	15-minute	55	273.00	39.02	**585885.30**	
Supported Living Total:							**178822.80**
Supported Living	☑	Event	3	312.00	191.05	**178822.80**	
Vehicle Modifications Total:							**60494.35**
Vehicle Modifications	☑	Event	7	1.00	8642.05	**60494.35**	

GRAND TOTAL: 6228518.66
Total: Services included in capitation: 6228518.66
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: 107
Factor D (Divide total by number of participants): 58210.45
Services included in capitation: 58210.45
Services not included in capitation:
Average Length of Stay on the Waiver: 310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 4

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports Total:							**642214.17**
Day Supports	☑	1 Hour	27	923.00	25.77	**642214.17**	

GRAND TOTAL: 6290459.65
Total: Services included in capitation: 6290459.65
Total: Services not included in capitation:
Total Estimated Unduplicated Participants: 107
Factor D (Divide total by number of participants): 58789.34
Services included in capitation: 58789.34
Services not included in capitation:
Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Personal Care Total:							**458666.91**
Personal Care	☑	15-minute	39	3153.00	3.73	**458666.91**	
Residential Supports Total:							**1100661.12**
Residential Supports	☑	Day	24	312.00	146.99	**1100661.12**	
Respite Total:							**130705.50**
Respite	☑	15-minute	30	1103.00	3.95	**130705.50**	
Supported Employment Total:							**147804.44**
Supported Employment	☑	15-minute	14	1357.00	7.78	**147804.44**	
Occupational Therapy Total:							**12734.83**
Occupational Therapy	☑	15-minute	5	96.33	26.44	**12734.83**	
Physical Therapy Total:							**12734.83**
Physical Therapy	☑	15-minute	5	96.33	26.44	**12734.83**	
Speech and Language Therapy Total:							**15281.79**
Speech and Language Therapy	☑	15-minute	6	96.33	26.44	**15281.79**	
Assistive Technology Total:							**244951.77**
Assistive Technology	☑	Event	31	591.00	13.37	**244951.77**	
Cognitive Rehabilitation (CR) Total:							**256415.04**
Cognitive Rehabilitation (CR)	☑	15-minute	56	322.00	14.22	**256415.04**	
Community Networking Total:							**435480.50**
Community Networking	☑	15-minute	65	1190.00	5.63	**435480.50**	
Community Transition Total:							**52463.71**

GRAND TOTAL: **6290459.65**

Total: Services included in capitation: 6290459.65

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **107**

Factor D (Divide total by number of participants): **58789.34**

Services included in capitation: 58789.34

Services not included in capitation:

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Transition	☑	Event	13	1.00	4035.67	52463.71	
Crisis Supports Services Total:							4823.33
Crisis Supports Services	☑	15-minute	1	67.00	71.99	4823.33	
Home Delivered Meals Total:							3361.26
Home Delivered Meals	☑	Event	1	453.00	7.42	3361.26	
Home Modifications Total:							218825.36
Home Modifications	☑	Event	26	1.00	8416.36	218825.36	
In Home Intensive Support Total:							118113.30
In Home Intensive Support	☑	15-minute	10	2367.00	4.99	118113.30	
Life Skills Training Total:							1369401.60
Life Skills Training	☑	15-minute	70	3544.00	5.52	1369401.60	
Natural Supports Education Total:							7339.20
Natural Supports Education	☑	Event	4	165.00	11.12	7339.20	
Remote Supports Total:							225030.00
Remote Supports	☑	1-hour	10	1950.00	11.54	225030.00	
Specialized Consultation Total:							591741.15
Specialized Consultation	☑	15-minute	55	273.00	39.41	591741.15	
Supported Living Total:							180610.56
Supported Living	☑	Event	3	312.00	192.96	180610.56	
Vehicle Modifications Total:							61099.29
Vehicle Modifications	☑	Event	7	1.00	8728.47	61099.29	

GRAND TOTAL: 6290459.65

Total: Services included in capitation: 6290459.65

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: 107

Factor D (Divide total by number of participants): 58789.34

Services included in capitation: 58789.34

Services not included in capitation:

Average Length of Stay on the Waiver: 310

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent section 1915(b)/section 1915(c) waivers, or other concurrent managed care authorities utilizing capitated payment arrangements. *Complete the following table for each waiver year. Enter data into the Unit, # Users, Avg. Units Per User, and Avg. Cost/Unit fields for all the Waiver Service/Component items. If applicable, check the capitation box next to that service. Select Save and Calculate to automatically calculate and populate the Component Costs and Total Costs fields. All fields in this table must be completed in order to populate the Factor D fields in the J-1 Composite Overview table.*

Waiver Year: Year 5

Waiver Service/ Component	*Capi-tation*	*Unit*	*# Users*	*Avg. Units Per User*	*Avg. Cost/ Unit*	*Component Cost*	*Total Cost*
Day Supports Total:							***648693.63***
Day Supports	☑	*1 Hour*	*27*	*923.00*	*26.03*	***648693.63***	
Personal Care Total:							***463585.59***
Personal Care	☑	*15-minute*	*39*	*3153.00*	*3.77*	***463585.59***	
Residential Supports Total:							***1111668.48***
Residential Supports	☑	*Day*	*24*	*312.00*	*148.46*	***1111668.48***	
Respite Total:							***132029.10***
Respite	☑	*15-minute*	*30*	*1103.00*	*3.99*	***132029.10***	
Supported Employment Total:							***149324.28***
Supported Employment	☑	*15-minute*	*14*	*1357.00*	*7.86*	***149324.28***	
Occupational Therapy Total:							***12860.06***
Occupational Therapy	☑	*15-minute*	*5*	*96.33*	*26.70*	***12860.06***	
Physical Therapy Total:							***12860.06***
Physical Therapy	☑	*15-minute*	*5*	*96.33*	*26.70*	***12860.06***	
Speech and Language Therapy Total:							***15432.07***
Speech and Language	☑	*15-minute*	*6*	*96.33*	*26.70*	***15432.07***	

GRAND TOTAL: ***6355203.52***

Total: Services included in capitation: *6355203.52*

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: ***107***

Factor D (Divide total by number of participants): ***59394.43***

Services included in capitation: *59394.43*

Services not included in capitation:

Average Length of Stay on the Waiver: *310*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Therapy							
Assistive Technology Total:							**247333.50**
Assistive Technology	☑	Event	31	591.00	13.50	**247333.50**	
Cognitive Rehabilitation (CR) Total:							**258939.52**
Cognitive Rehabilitation (CR)	☑	15-minute	56	322.00	14.36	**258939.52**	
Community Networking Total:							**440121.50**
Community Networking	☑	15-minute	65	1190.00	5.69	**440121.50**	
Community Transition Total:							**52988.39**
Community Transition	☑	Event	13	1.00	4076.03	**52988.39**	
Crisis Supports Services Total:							**4871.57**
Crisis Supports Services	☑	15-minute	1	67.00	72.71	**4871.57**	
Home Delivered Meals Total:							**3392.97**
Home Delivered Meals	☑	Event	1	453.00	7.49	**3392.97**	
Home Modifications Total:							**221013.52**
Home Modifications	☑	Event	26	1.00	8500.52	**221013.52**	
In Home Intensive Support Total:							**119296.80**
In Home Intensive Support	☑	15-minute	10	2367.00	5.04	**119296.80**	
Life Skills Training Total:							**1384286.40**
Life Skills Training	☑	15-minute	70	3544.00	5.58	**1384286.40**	
Natural Supports Education Total:							**7411.80**
Natural Supports Education	☑	Event	4	165.00	11.23	**7411.80**	

GRAND TOTAL: **6355203.52**

Total: Services included in capitation: 6355203.52

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **107**

Factor D (Divide total by number of participants): **59394.43**

Services included in capitation: 59394.43

Services not included in capitation:

Average Length of Stay on the Waiver: 310

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Remote Supports Total:							**227370.00**
Remote Supports	☑	1-hour	10	1950.00	11.66	**227370.00**	
Specialized Consultation Total:							**597597.00**
Specialized Consultation	☑	15-minute	55	273.00	39.80	**597597.00**	
Supported Living Total:							**182417.04**
Supported Living	☑	Event	3	312.00	194.89	**182417.04**	
Vehicle Modifications Total:							**61710.25**
Vehicle Modifications	☑	Event	7	1.00	8815.75	**61710.25**	

GRAND TOTAL: **6355203.52**

Total: Services included in capitation: 6355203.52

Total: Services not included in capitation:

Total Estimated Unduplicated Participants: **107**

Factor D (Divide total by number of participants): **59394.43**

Services included in capitation: 59394.43

Services not included in capitation:

Average Length of Stay on the Waiver: 310