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

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a state to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waivers 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:

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

1. Request Information (1 of 3)

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

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

North Carolina Innovations

C. Type of Request: renewal

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

○ **3 years** ◉ **5 years**

Original Base Waiver Number: NC.0423
Waiver Number:NC.0423.R04.00
Draft ID: NC.025.04.00

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

Regular Waiver

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

07/01/24

Approved Effective Date: 07/01/24

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: December 31, 2023). The time required to complete this information collection is estimated to average 160 hours per response for a new waiver application and 75 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:

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

☐ **Nursing Facility**

Select applicable level of care

○ **Nursing Facility as defined in 42 CFR ??440.40 and 42 CFR ??440.155**

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

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

☒ **Intermediate Care Facility for 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:

The NC Innovations waiver targets individuals who meet the ICF-IID eligibility criteria as defined in the State Medicaid Agency's Clinical Coverage Policy which is located on the NCDHHS Division of Health Benefits website at https://medicaid.ncdhhs.gov/.

1. Request Information (3 of 3)

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

Select one:

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

Check the applicable authority or authorities:

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

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

This waiver operates concurrently with the NC Mental Health, Intellectual and Developmental Disabilities and Substance Misuse Services Health Plan waiver, #NC-02.

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

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

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

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

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

Specify the program:

This waiver operates concurrently with the North Carolina Section 1115 Demonstration Project (11-Q00313/4) for beneficiaries who are not members of the Eastern band of Cherokee Indians (EBCI). EBCI members are only included under Section 1115, when they choose to enroll in Tailored Plan.

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.

NC Innovations operates concurrently with the 1915(b) NC MH/DD/SUS Health Plan and NC Section 1115 Demonstration Waiver. MH/DD/SUS local management entities - Managed Care Organizations (Tailored Plans-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. Tailored Plans function as fully capitated prepaid inpatient health plans (PIHPs) through which all State Plan MH, SA and IDD services and Innovations waiver services are delivered. The concurrent waivers began operating on April 1, 2005 in a five-county area. Statewide implementation was effective April 1, 2013.

Goals of the NC Innovations waiver:
(1) To value and support waiver beneficiaries to be fully functioning members of their community
(2) To promote promising practices that result in real life outcomes for beneficiaries
(3) To offer 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) To provide the opportunity for all beneficiary to direct their services to the extent that they choose
(5) To provide educational opportunities and support to foster the development of stronger natural support networks that enable beneficiary to be less reliant on formal support systems
(6) To ensure the wellbeing and safety of the people served
(7) To maximize beneficiaries' self-determination, self-advocacy and self-sufficiency
(8) To increase opportunities for community integration through work, life-long learning, recreation and socialization
(9) To deliver person centered services that leverage natural and community supports
(10) To provide quality services and improve outcomes

Objectives in the NC Innovations waiver include:
(1) Enhancing the focus on person centered planning and aligning services and supports with person centered plans
(2) Reforming residential service to facilitate 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 Tailored Plans (TP's) operating as prepaid inpatient health plans. The Tailored Plans/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 Tailored Plans/PIHP serving one's county of residence is mandatory for all Innovations waiver beneficiaries and other Medicaid eligibility groups specified in the concurrent 1915(b) and 1115 Waiver. NC Innovations 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. NC Innovations offers participant direction to beneficiaries who elect to direct their own services. Orientation to participant direction is offered to all waiver beneficiaries upon entrance to the waiver and annually thereafter during ISP development. Beneficiaries in the waiver have a Tailored Care Manager or a 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 for Community-based service providers of 1915 (c) Innovations 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 §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid state plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

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

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

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

- (●) **No**
- ( ) **Yes**

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

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

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

5. Assurances

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Additional Requirements

Note: Item 6-I must be completed.

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

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/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 §1915(b) or another provision of the Act.

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

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

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

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

The 1915 (c) Innovations Waiver and 1915 (C) TBI Waiver was posted for public comment on February 5, 2024 - March 8, 2024. Access to the document was provided on the NC Medicaid Website designated for public posting, with the opportunity to provide feedback through Medicaid.publicfeedback.gov and postal mail. The department provided a mailing address for submission of public comment through mail to North Carolina Department of Health and Human Services NC Medicaid HCBS 1915(c) Innovations Waiver Team
1950 Mail Service Center Raleigh, NC 27699-1950. The Department did not receive any feedback through postal mail.

Tribal officials of the Eastern Band of the Cherokee and the IHS were notified of the 1915 (c) Waiver changes and the opportunity for input on February 9, 2024, by a formal written notice. On February 29, 2024, NC Medicaid met with the Tribe to review the 191(C) Waiver Renewal. Feedback from the Eastern Band of Cherokee Indians was received on March 25, 2025. Feedback was incorporated the extent possible and approved by the Tribe.

The following public venues have been used to provide information/obtain stakeholder input on the statewide waiver program and transition to the 1115, specifically to the changes being requested in this TA:
- Beneficiary, advocate and provider stakeholder input on the 1915 (C) Waiver renewal changes through webinars which were held virtually on February 29, 2024 and March 6, 2024.The Webinar was recorded and posted on the website to support access to beneficiaries and Providers who were not able to attend the live sessions.
-The Waiver renewal changes were also discussed during regular scheduled meetings with the LME-MCO's, external provider meetings (i.e. DD Consortium) with the opportunity for feedback.
-All feedback was submitted through the Medicaid.publicfeedback.gov, no responses were received from U.S. Postal.
-Feedback was received from 22 Individuals/Family Members, 9 Provider agencies, 4 Tailored Plans.
_ The majority of public comments were on Appendix C (Services) accepted feedback included:
providing clarifications to service definitions (i.e., provider type, rewording definitions language, or adding clarification language)
Editing of language
Clarification of Relatives as Providers for minors (language changed from LRP to relative)
need for additional Waiver slots
Direct Care working shortage
Supported Living 3 definition, removing the requirement for an awake staff. The department will consider this request in the next amendment. DHB will need to engage
additional stake holders to determine this decision.

-The following public comments topics were received but not adopted by the department because they were not directly related to Waiver changes.
Comments regarding length of the Innovations Waiver Waitlist
Comments about Tailored Care Management
Comments about Provider Concerns
Comments other Medicaid services

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) 733-6608

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 Manager

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) 855-4173 **Ext:** ☐ **TTY**

Fax:

(919) 733-6608

E-mail:

Betty.j.Staton@dhhs.nc.gov

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the state's request for a waiver under §1915(c) of the Social Security Act. The state assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.
Upon approval by CMS, the waiver application serves as the state's authority to provide home and community-based waiver services to the specified target groups. The state attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Ashley Blango

State Medicaid Director or Designee

Submission Date: Jun 19, 2024

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

Last Name: Ludlam

First Name: Jay

Title: Deputy Secretary, NC Medicaid

Agency: Division of Health Benefits, North Carolina Department of Health and Human Services (NCDHHS)

Address: 2501 Mail Service Center

Address 2:

City: Raleigh

State: **North Carolina**

Zip: 27699-2501

Phone:

(919) 855-4105 **Ext:** ☐ **TTY**

Fax:

(919) 733-6608

E-mail:

Jay.Ludlam@dhhs.nc.gov

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:

NC HCBS 1915(C) Innovations Waiver effective July 1, 2024, will operate concurrently with NC Section 1115 Demonstration Waiver. Innovations Waiver services will be provided through Tailored Plans which function as fully capitated prepaid inpatient health plans (PIHPs) through which all State Plan MH, SA and IDD services are delivered. Eastern Band of Cherokee (ECBI) NC federally recognized tribe will not be auto enrolled in Tailored plan but can choose to received services through the Tailored plan. Waiver services will be available to EBCI members through the concurrent waiver 1915(b)/(C).

NC Medicaid began notifying individuals of their eligibility for a Tailored Plan beginning April 17, 2024, additional beneficiaries will be identified and receive notices based on regular review of newly available data. The criteria used to identify beneficiaries eligible for the Tailored Plan relied on data available to NC Medicaid, including but not limited to Medicaid and state-funded services claims and encounters, reports from LME/MCOs, and Medicaid enrollment and eligibility data. Beneficiaries meeting eligibility requirements will be auto enrolled in Tailored Plans. Beneficiaries identified for Tailored plans received letters mid-April 2024, informing them of the auto enrollment. Letters sent to beneficiaries provided the following information: assigned Tailored Plan, option to choose primary care provider, option to review if doctors or specialist are in network, option to update address, and guidance to identify Tailored Care Manager (if not already identified). Tailored Care Managers TCM's are available to Innovations Waiver beneficiaries. Waiver members may also choose to continue access to services through Care coordination. Through TCM, Behavioral Health I/DD Tailored Plan beneficiaries have a single designated care manager supported by a care team to provide care management that addresses all of their needs including physical health, behavioral health, I/DD, pharmacy, long-term services and supports (LTSS) and unmet health-related resource needs. TCM/Care Coordinators are available to support Waiver members in accessing and maintaining Waiver services.

Attachment #2: Home and Community-Based Settings Waiver Transition Plan

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.

To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may

reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.
Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.
Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.

North Carolina conducted an internal review of its state statutes and regulations governing Medicaid HCBS waiver services and assessed that the HCBS Final Rule applies to three 1915(c) waivers and select services offered under the 1915(b)(3) benefit operated by North Carolina. Services under the North Carolina waivers are provided in a variety of settings. NC identified sites impacted and not impacted by HCBS final rule, impacted sites including Residential and Day Support sites. These sites were identified as provider led and operated sites, HCBS services provided in integrated settings (i.e., private homes) were not considered as impacted sites.

Additional Needed Information (Optional)

Provide additional needed information for the waiver (optional):

The State is adding access to Remote monitoring for the following services Community Living and Supported Living:

Remote support equipment can be requested through Assistive technology and 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.

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.Informed consent shall be documented in the ISP to address potential issues of privacy, informed consent for using this service versus traditional service options.

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.

Remote Support is a 24-hour a day service. 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

Vendor 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 30 minutes.

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 30 minutes) when a request for beneficiary assistance is made.

The state is received authorization from CMS on March 1, 2024 to deliver services via telehealth for the following services; Community Living and Supports, Supported Employment, Supported Living, and Day Supports. Services provided through telehealth must:

o Facilitate community integration.
o Be delivered in a way that respects and protects the privacy of the waiver participant.
o Ensure the health and safety of the waiver participant.
o Ensure the service or service component being delivered via telehealth does not require in-person, physical assistance.
o Support the waiver participant if they need assistance with using the technology required for service delivery through telehealth.
o Be rendered in a non-residential location as described within the service definition.
o Ensure no duplication of services or billing, i.e., day Supports rendered via telehealth when waiver participant is with another service provider, e.g., Community Living and Support.

Telehealth is not intended to supplant full meaningful day, but rather to complement it. Services that support community integration are not eligible for 100% telehealth delivery. It provides individuals the ability to connect with providers via HIPAA compliant remote platforms. Services delivered via telehealth must follow the requirements and guidance in Clinical Coverage Policy 1-H, Telehealth, Virtual Patient Communications, and Remote Patient Monitoring. The provider agrees to comply with all

federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements
Prior authorization is required to receive services via telehealth. Services may be delivered via telehealth when identified through the person-centered service plan. The beneficiary's plan must outline what the provider will do to support each outcome, frequency and duration as well as beneficiary input to their activities. Providers must document in the plan, any services that the individual has agreed to be delivered through telehealth. This includes documentation that the individual has the ability to receive and benefit from this method of service delivery.
The provider shall also document that any platform used to conduct telehealth activities are in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Before a telehealth option is requested and/or authorized for an individual, the individual's support team (consisting of the Individual, their identified supports, Tailored Care Manager/Care Coordinator) will assess and document the individual's ability to be supported effectively via telehealth, and note the individual does not require in-person and/or physical assistance with the identifies activities. This information will be documented clearly in the individual's plan for support.
The provider will be required to provide service/support in person if the members health/safety cannot be maintained, and if the members goals require hand/hand or physical assistance. In addition, the ISP must note which goals/services will be provided via Telehealth.

Services identified to be delivered through telehealth are not eligible for 100% telehealth delivery. The utilization of telehealth platforms for services shall not exceed 25% of the authorized service hours (i.e., if someone is receiving 40 h/w of CLS services, no more than 10 hours/week of telehealth will be provided)

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;
+ An MMIS contractor which assists with recipient enrollment and payment;
+ An actuarial contractor which assists with setting the capitated payments to the Tailored Plan/PIHPs.

○ **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 local management entities (LME) operating as prepaid inpatient health plans (PIHP)for the delivery of all Medicaid MH/IDD/SUS services, including NC Innovations waiver services. LME/PIHPs conduct the following operational and administrative activities: utilization management and prior approval activities, provider network credentialing and enrollment and provider reimbursement.
LMEs, as defined in NC General Statute 122C, are area authorities, county programs, or consolidated human services agencies that are designated as “the locus of coordination” for publicly funded mental health, intellectual/developmental disabilities and substance abuse services in their respective catchment areas. Session laws 2011-264 and 2012-151 recently amended the statute to require the delivery of publicly funded services for individuals with mental illness, intellectual/developmental disabilities, and substance misuse disorders through LMEs under the authority of 1915(b)/(c) waivers.
The waiver responsibilities and performance requirements are set are set forth in a contract between the Division of Health Benefits and each LME 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 in conducting operational and administrative functions. The DHHS Office of the MMIS, including DHB (the State Medicaid agency), oversees 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 LME/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 contract managers assess 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.*

Function	Medicaid Agency	Contracted Entity	Local Non-State Entity
Participant waiver enrollment	☒	☒	☒
Waiver enrollment managed against approved limits	☒	☐	☒
Waiver expenditures managed against approved levels	☒	☐	☒
Level of care evaluation	☒	☐	☒
Review of Participant service plans	☒	☒	☒
Prior authorization of waiver services	☒	☐	☒
Utilization management	☒	☐	☒
Qualified provider enrollment	☒	☐	☐
Execution of Medicaid provider agreements	☒	☐	☒
Establishment of a statewide rate methodology	☒	☒	☐
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 States quality improvement strategy, provide information in the following fields to detail the States 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:
DHB reviews the PIHP Innovations provider network for adequate capacity and choice. Numerator: Number of PIHPs whose Network capacity studies and geo mapping show two available providers within a 30 minute/30 mile (Urban) or 45 minute/45 mile (rural) radius though out their catchment area. Denominator: Total Number 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:
DHB ensures that PIHPs submit information in a complete and timely manner. Numerator: Number of PIHPs that submit performance measure information in a complete and timely manner Denominator: Total Number of 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:	☒ **Annually**	☐ **Stratified** Describe Group:

Contracted external quality review organization (EQRO)		
	☐ **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:
DHB ensures that PIHPs follow the Level of Care Approval Process. Numerator: Number of PIHPs following the Level of Care Approval Process Denominator: Total Number of PIHPs

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

Responsible Party for data	**Frequency of data**	**Sampling Approach***(check*

collection/generation*(check each that applies):*	**collection/generation***(check each that applies):*	*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**

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

Performance Measure:
DHB ensures that PHIPs follow the ongoing monitoring process. Numerator: Number of PIHPs following the monitoring process Denominator: Total Number of 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:
DHB ensures that PIHPs follow the Plan of Care Approval and Implementation Processes. Numerator: Number of PIHPs following the Plan of Care Approval and Implementation Processes Denominator: Total Number of PIHPs

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:

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

The Tailored Plan/PIHPs will address and correct problems identified on a case-by-case basis in accordance with their contracts with the DHB. The Tailored Plan/PIHP 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 SubGroup	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			☐
	☐	HIV/AIDS			☐
	☐	Medically Fragile			☐
	☐	Technology Dependent			☐
☒ Intellectual Disability or Developmental Disability, or Both					
	☐	Autism			☐
	☒	Developmental Disability	0		☒
	☒	Intellectual Disability	0		☒
☐ Mental Illness					
	☐	Mental Illness			☐
	☐	Serious Emotional Disturbance			

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

The Innovations waiver targets individuals who meet the ICF-IDD eligibility criteria defined in the Division of Health Benefits Clinical Coverage Policy 8E on the DMA website at https://medicaid.ncdhhs.gov/.

New participants to this waiver will live in their own private residence, with their families, with other private families or in living arrangements with 6-beds or less for existing facilities, 4 beds or less for newly developed facilities.

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:

    $184,000.

- ○ **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 Innovations waiver by contacting the Tailored Plan/PIHP Access Center in his or her county. 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 NC Innovations Risk/Support Needs Assessment (or designated tool) to determine whether the waiver can meet the individual's needs. If health and/or safety risks are identified the Tailored Plan/PIHP clinical director (MD or PhD) will review the assessments and make a determination as to whether the individual's needs can be met by the waiver up to the $184,000 cost limit. Written notice of the outcome of this assessment will be provided to the individual.
If an individual is terminated from the waiver, the Tailored Plan/PIHP 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.

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 $184,000 waiver limit, per plan year 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.

This individual may live with family members if the family member is receiving Supported Living, other disability specific services, a spouse, or a minor child.

An individual requesting services and supports in excess of the $184,000 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.

☒ **Other safeguard(s)**

Specify:

If an individual chooses not to participate in the Innovations Waiver or has needs that exceed the $184,000 dollar waiver limit and is still eligible for Medicaid, other Medicaid funded services, including ICF-IDD would be made available. The individual's Care Coordinator or Tailored Care Manager will inform him/her of the other state and/or local services and supports available in lieu of waiver services.

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	14752
Year 2	14736
Year 3	14736
Year 4	14736
Year 5	14736

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	
MFP / DI	
Military	
CAP/C Age Out	
Children with Complex Needs (CWCN)	
Emergencies	

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):*

MFP / DI

Purpose *(describe):*

Capacity is being reserved to transition individuals out of Institutional Setting using the Money Follows the Person (MFP) federal grant as the grant still exisits. When the MFP grant ends, reserved capacity will be built in for participants institutional settings, who meet the criteria for NC Innovations, and choose to receive home and community-based services.

Describe how the amount of reserved capacity was determined:

Reserved capacity for MFP /DI is a percentage of the total number of participants approved for MFP participation in the State; the percentage is based on past utilization of the NC IDD waivers for MFP transitions.

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

Waiver Year	Capacity Reserved
Year 1	76
Year 2	76
Year 3	76
Year 4	76
Year 5	76

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):*

Military

Purpose *(describe):*

Military Transfers reserved capacity is for participants who were on a comparable 1915 (c) waiver in another state whose family was transferred to North Carolina for military service or were receiving Innovations waiver services prior to family transferring to another state and have now returned to North Carolina. Military slots utilization will be reviewed quarterly; if not assigned, one no more than two slots maybe reassigned as an emergency slot at the end of each quarter.

Describe how the amount of reserved capacity was determined:

Reserved capacity is an estimate based on the number of requests of continued services from military families transferring to NC with children on similar waivers in other states.

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

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

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):*

CAP/C Age Out

Purpose *(describe):*

Transition of individuals from the Community Alternatives Program for Children (CAP/C) when the participant ages out of the waiver.

Describe how the amount of reserved capacity was determined:

The reserve figure is based on historical numbers of participants that have aged out of the CAP/C waiver and transitioned to the State's IDD waivers.

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

Waiver Year	Capacity Reserved
Year 1	15
Year 2	15

Waiver Year	Capacity Reserved
Year 3	15
Year 4	15
Year 5	15

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):*

Children with Complex Needs (CWCN)

Purpose *(describe):*

The purpose of this reserved capacity is to address the needs of Children with Complex Needs between the ages of 5 and 21, with a developmental and/or intellectual disability and a mental health disorder diagnosis who are at risk of not being able to return to or maintain placement in a community setting.

Describe how the amount of reserved capacity was determined:

The reserve figure is based on historical numbers of participants statewide who were determined to be in an emergency situation requiring immediate admission to the IDD waiver.

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

Waiver Year	Capacity Reserved
Year 1	8
Year 2	8
Year 3	8
Year 4	8
Year 5	8

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:

The reserve figure is based on historical numbers of participants statewide who were determined to be in an emergency situation requiring immediate admission to the IDD waiver.

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

Waiver Year	Capacity Reserved
Year 1	57
Year 2	57
Year 3	57
Year 4	57
Year 5	57

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:

LME-MCOs; capacity is allocated based on population and this allocation is reevaluated each waiver cycle and when additional slots are allocated by the General Assembly. When DI/MFP slots are not utilized they may be reallocated on a quarterly basis. NC Innovations member's maintain their NC Innovations slot when transitioning to a new LME-MCO catchment area.

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 Innovations waiver will be served on a first come -first serve basis.

Screening for Potential Waiver Eligibility:
Individuals make application for the NC Innovations waiver by contacting the PIHP. 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 Innovations Risk /Support Needs Assessment (or designated tool), to determine whether the waiver can meet the individual's needs. If health and/or safety risks are identified, the PIHP 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 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 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 clinical director and a minimum of one developmental disability 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 issue(s) related to the child's disability has/have been determined by the County Department of Social Services to result in imminent risk of coming into custody of the agency
(3) The individual requires protection from confirmed abuse, neglect or exploitation as documented by the Department of Social Services, EBCI Childe Welfare Program, and Family Safety.

Reserved capacity for transition of individuals from CAP-C :
when the participant ages out of the waiver and meets, but does not exceed, the eligibility criteria for this waiver:
The reserve figure is based on historical numbers of participants that have transitioned and projected population growth. If reserved capacity is not available, individuals who are transitioning will be prioritized for entrance to the waiver based on non-reserved criteria.

Reserved capacity for Money Follows the Person (MFP):
When reserved capacity is available, individuals who meet the criteria for Money Follows the Person / NC Innovations 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.

Reserved capacity for military transfers:
Capacity is reserved for individuals who were on a comparable 1915 (c) waiver in another state whose family was transferred to North Carolina for military service or were receiving Innovations waiver services prior to family transferring to another state and have now returned to North Carolina.

Reserved capacity for Children with Complex Needs:
The purpose of this reserved capacity is to address the needs of Children with Complex Needs between the ages of 5 and 21,
with a developmental and/or intellectual disability and a mental health disorder diagnosis who are at risk of not being able to return to or maintain placement in a community setting.

Non Reserved Capacity:
Potentially eligible participants will be allocated waiver funding based on their date of application and their placement in priority ranking resulting from the equitable distribution of waiver funding among the sub divisions (counties) of the waiver region.

Appendix B: Participant Access and Eligibility

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

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

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

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

- (●) **§1634 State**
- ( ) **SSI Criteria State**
- ( ) **209(b) State**

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

- (●) **No**
- ( ) **Yes**

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

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

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

  Select one:

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

    Specify percentage: [ ]

- [ ] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [ ] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**

☐ **Medically needy in 209(b) States (42 CFR §435.330)**

☒ **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:

42 CFR 435.145
Individuals under 42 CFR 435.145(b)(1) Title IV-E adoptive children
Individuals under 42 CFR 435.145(b)(2) Title IV-E foster children

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 periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

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

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

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

Appendix B: Participant Access and Eligibility

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

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

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 five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. 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 a government agency under contract with the Medicaid agency.**

Specify the entity:

Each PIHP 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 or physicians as appropriate based on the disability of the participant. All professionals must hold current licensure in the state of North Carolina.

Item a.i above specifies that the individual must require at least one service to participate in the waiver. The following services are excluded: Assistive Technology, Vehicle Modifications, Home Modifications, Community Navigator, Community Transition, and Respite. Individuals diagnosed with Autism Spectrum Disorder and actively utilizing the Research Based - Behavioral Heath Treatment (RB-BHT) State Plan Service are exempt from the NC Innovations one waiver service per month requirement. RB-BHT services are not intended to be long term. RB-BHT services are Researched-Based behavioral Intervention services that prevent or minimize the disabilities and behavioral challenges associated with Autism Spectrum Disorder (ASD) and promote, to the extent practicable, the adaptive functioning of a beneficiary. RB-BHT demonstrate clinical efficacy in
treating ASD: prevent or minimizes the adverse effects of ASD; and promote, to the maximum extent possible, the functioning of a beneficiary. Monthly monitoring must be completed when the member is actively participating in RB-BHT services and not receiving at least 1 monthly Innovations Waiver service, per B-6-a-i.

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 Innovations waiver targets individuals who meet the ICF-IID eligibility criteria defined in The Division of Health Benefits Clinical Coverage Policy on the DHB website at https://medicaid.ncdhhs.gov/. The NC Innovations waiver utilizes the following ICF-IID criteria to evaluate and reevaluate waiver eligibility:

The waiver beneficiaries requires active treatment necessitating the ICF-IID level of care. (Active treatment refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. Active treatment does not include service to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.)

AND

Has a diagnosis of intellectual disability or a condition that is closely related to ID. Intellectual disability is a disability characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, practical and social skills. The condition originates before the age of 18.

- Persons with closely related conditions refers to individuals who have a severe chronic disability that meets ALL of the following conditions and;
- is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, that is closely related to intellectual disability because this condition results in impairment of general intellectual functioning or adaptive behavior similar to intellectually disabled persons:

1. It is manifested before the person reaches age 22
2. It is likely to continue indefinitely
3. It results in substantial functional limitations in three or more of the following areas of major life activity:

a. Self care (ability to take care of basic life needs for food, hygiene and appearance)
b. Understanding and use of language (ability to both understand others and to express ideas or information to others) and to express language (ability to both understand others and to express ideas or information to others either verbally or nonverbally)
c. Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)
d. Mobility (ambulatory, semi-ambulatory, non-ambulatory)
e. Self-direction (managing one's social and personal life and ability to make decisions necessary to protect oneself)
f. Capacity for independent living (age appropriate ability to live without extraordinary assistance)
g. Economic self-sufficiency

The NC Innovations Level of Care Assessment tool is used to determine the initial LOC for each waiver participant. Annual re-assessment of LOC is confirmed by the care coordinator or Tailored Care Manager

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.

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 Innovations Level of Care Assessment. This is the same tool used to document ICF-IID admission.

If the presenting issue is an intellectual disability, or a condition closely related to an intellectual disability, a psychologist or licensed psychological associate completes the evaluation. The evaluation includes intellectual testing and adaptive behavior assessment. The LOC Assessment tool is used to document the outcome of this evaluation. To assure the accuracy and timeliness of LOC determination, the signature of the psychologist or psychological associate must be no more than 30 days old.

If the condition is cerebral palsy, epilepsy or a condition closely related to one of these two disabilities, a physician completes the LOC determination. The evaluation will be a medical assessment. The LOC Assessment tool is used to document the outcome of this evaluation. To ensure the accuracy and timeliness of LOC determination, the signature of the physician must be no more than 30 days old. The PIHP reviews and makes the final determination of the authorization of LOC.

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 Care Coordinators or Tailored Care Managers employed or contracted with the PIHP, using the annual recommendation for LOC, a component of the ISP.

Annual assessments include the completion of an assessment of risks and support needs. 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, 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 or Care Coordinator within the PIHP or in the community. A qualified professional (QP) is equivalent to the federally defined qualified Developmental Disability professional.

The QP conducting the annual re-determination of LOC is performed by a QP as defined in NC General Statutes 122C-3 Definitions:

"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 data is reviewed monthly by the PIHP. The Tailored Care Manager or 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 for a minimum period of five years for those beneficiaries over the age of 18. For beneficiaries under the age of 18, documents must be maintained until their 23rd birthday.

Level of care documents are maintained in the beneficiary's record by the Tailored Care Manager or Care Coordinator.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 Waiver applicant who receive a preliminary screening for potential eligbility. Numerator: Number of (c) waiver applicants who received a preliminary screening for potential eligibility Denominator: Total number of new (c) waiver applicants.

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

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**	☒ **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:

Performance Measure:
Number and percent of waiver applicants for whom an LOC evaluation is provided and where there is reasonable indication that services may be needed in the future. Numerator: total number of Waiver applicants who have an LOC evaluation that indicate future needs. Denominator: Total number of waiver applicants.

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/TP	☐ **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):*
	☐ **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:
Number and percent of Wavier enrollees who received an annual LOC evaluation. Numerator: Number of New Level of Care evaluations completed using approved processes and instrument. Denominator: Total number of New Level of Care evaluations.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Signature on the Innovations Waiver / Level of Care Re-Determination section of the ISP.

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: 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:
Number and percent of annual Level of Care evaluations appropriately completed using waiver approved processes and instrument. Numerator: Number of annual LOC evaluations completed using LOC instrument/process for waiver participants Denominator: Total number of annual LOC evaluations reviewed.

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 = 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: Annually

Performance Measure:
Number and percent of New Level of Care evaluations appropriately completed using waiver 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: 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):*

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

The PIHPs 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, 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, assesses strengths and weaknesses and identifies opportunities for improvement. See Managed Care Organization Monitoring Activities - Attachment 4.

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: The PIHPs	☒ **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 funding is available, prospective participants are informed of their feasible alternatives under the waiver and their option to choose waiver services as an alternative to institutional ICF-IID services by the PIHP. This decision is documented on the Individual Support Plan (ISP) signature page. Annually, thereafter, the freedom of choice option is reviewed with the participant or the legally responsible person and the decision documented in the ISP

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 record of the Tailored Care Manager or Care Coordinator if the beneficiary opts out of CM.

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 TPs/PIHP 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 makes interpreter services available to individuals with limited English proficiency.

The PIHP 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, 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	**Community Navigator**		
Statutory Service	**Community Networking**		
Statutory Service	**Day Supports**		
Statutory Service	**Residential Supports**		
Statutory Service	**Respite**		
Statutory Service	**Supported Employment**		
Supports for Participant Direction	**Financial Support Services**		
Other Service	**Assistive Technology**		
Other Service	**Benefits Counseling**		
Other Service	**Community Living and Support**		
Other Service	**Community Transition**		
Other Service	**Crisis Services**		
Other Service	**Home Delivered Meal**		
Other Service	**Home Modifications**		
Other Service	**Individual Goods and Services**		
Other Service	**Natural Supports Education**		
Other Service	**Specialized Consultation**		
Other Service	**Supported Living - Periodic**		
Other Service	**Supported Living - Transition**		
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:

Case Management

Alternate Service Title (if any):

Community Navigator

HCBS Taxonomy:

Category 1:

12 Services Supporting Self-Direction

Sub-Category 1:

12020 information and assistance in support of self-direction

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 Navigator Services is to promote self-direction. support the individual in making life choices, provide advocacy and identify opportunities to become a part of their community. Community Navigator provides support to individuals and planning teams in developing social networks and connections within the community. Community Navigator Services also emphasizes, promotes and coordinates the use of generic resources to address the individual's needs in addition to paid services. Community Navigator will have an annual informational session on Self Determination and Self-Direction. Individuals and legal responsible persons may choose to opt out of this requirement.

This service also supports individuals, representatives, and Managing Employers by providing assistance to those that direct their own waiver services. Community Navigator is mandatory for all Employers of Record until competence in directing service is demonstrated. Community Navigator Services may be intermittent and will fade as community connections develop and skills increase in self direction. Community Navigators assist and support (rather than direct and manage) the individual throughout the service delivery process. Community Navigator Services are intended to enhance, not replace, existing natural and community resources.

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

Self-Direction

1. Provide initial training on the Individual and Family Directed Supports Options, if the individual is considering directing services and supports (Agency With Choice and Employer of Record Models)
2. Provide intermediate to long term training as needed on the Individual and Family Directed Supports duties to ensure Employer is competent in the skills to carry out responsibilities of Employer (Agency with Choice and Employer of Record Models.)
3. Coordinate services with the Financial Support Services provider such as guidance on use of the Individual and Family Directed Budget (Employer of Record Model)
4. Provide information/coaching/technical assistance on recruiting, hiring, managing, training, evaluating, and changing support staff (Agency With Choice and Employer of Record Models)
5. Provide information/coaching/technical assistance with the development of schedules and outlining staff duties (Agency With Choice and Employer of Record Models)
6. Provide information/coaching/technical assistance to understand staff financial forms, staff qualifications and employee record keeping requirements (Agency With Choice and Employer of Record Models)
7. Provide information/coaching/technical assistance support to EOR to write short-range goals and task analysis strategies per established guidelines.
8. Provide information/coaching/technical assistance for the Employer of Record to perform review of service documentation to ensure data is collected per established guidelines. Assist as needed to update/modify Short Range Goals.
9. Provide information/coaching/technical assistance on maintenance of records in accordance with the Employer of Record Model (Employer of Record Models)
10. Coordinate services with the Agency with Choice if the individual is directing services under the Agency with Choice Model
11. Provide information/technical assistance to the individual on setting staff pay rates (Employer of Record).

Tenancy Support

1. Develop an independent housing plan based on the participant's preferences and possible barriers
2. Assist with housing search process
3. Assist with housing application process, including assistance with applying for housing vouchers/applications
4. Identifying resources to cover expenses.
5. Assisting the individual to create a budget to cover expenses
6. Ensure that living environment is safe and move-in ready
7. Developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized
8. Assistance with finding and establishing a relationship with a housemate
9. Assistance with obtaining and identifying resources to assist the participant with financial education and planning for housing.
10. Assistance with budgeting for housing and living expenses
11. Assistance with coordinating resources to complete the move

12. Training on how to be a good tenant

Exclusions:
• This service does not duplicate Tailored Care Management/Care Coordination. Tailored Care Management/Care Coordination under managed care includes the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the beneficiary consistent with 42 CFR 438.208(c).
•
• A provider agency that is an Agency with Choice may provide all Agency with Choice services, Community Navigator, Community Transition, Financial Support Services, Individual Goods and Services, and Primary Crisis Response Services to the same individual
• The Community Navigator Self-Directed activities listed above, can only to be used to provide support to the individual under Individual and Family Directed Supports: Employer of Record and Agency with Choice Models, as approved in this Waiver.

The creation and the facilitation of the Individual Support Plan is the responsibility of the Tailored Care Manager or Care Coordinator if the beneficiary opts of Tailored Care Management.

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

Exclusions: Beneficiaries receiving Tailored Care Management may not receive Community Navigator unless they are self directing one or more of their services through the Agency With Choice or Employer of Record Model.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider agencies
Individual	Employee in Self-Directed

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Navigator

Provider Category:
Agency
Provider Type:

Provider agencies

Provider Qualifications
License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

n/a

Other Standard *(specify):*

Must meet requirements of NC General Statute 122C, as applicable
Approved as a provider in the PIHP provider network:
• 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.
• Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Meets community guide competencies specified by the PIHP

Tribal providers are not subject to licensure but substantial equivalency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agency
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: Community Navigator

Provider Category:

Individual

Provider Type:

Employee in Self-Directed

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

n/a

Other Standard *(specify):*

Staff that work with participants are approved by employer of record OR recommended by managing employer and approved by Agency with Choice that work with participants:
• GED or High school diploma
• 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
• Supervised by the employer of record or managing employer
• For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
• State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director
• Agencies with Choice follow the NC State Nursing Board regulations
• Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.
Tribal providers are not subject to licensure but substantial equivalency

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record or Agency with Choice
PIHP

Frequency of Verification:

Prior to hiring
Employer of Record annually
Agency with Choice as specified for provider agencies

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:

Habilitation

Alternate Service Title (if any):

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 individual's definition of a meaningful day in an integrated community setting, with persons who are not disabled. If the person requires paid supports to participate / engage in the activity once connected, Community Networking can be used to refer and link the individual. This service is provided separate and apart from the individual'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 individual 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 individual to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community. As individuals gain skills and increase community connections, service hours may fade.
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. For children, this service includes staffing supports to assist children to participate in day care/after school summer programs/camps that serve typically developing children and are not funded by Day Supports.
10. Payment for attendance at classes and conferences is also included.
11. Payment for memberships can be covered when the individual will be participating in an integrated class.
12. Transportation when the activity does not include staffing support and the destination of the transportation is an integrated community setting or a self-advocacy activity. Payments for transportation are an established per trip charge or mileage.

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

1. Career Exploration
2. Discovery and Career Planning
3. Participation in Workshops and Classes on Topics Related to integrated employment
4. Skill and Education-Focused Activities
5. Volunteering Opportunities (Career Focus)
6. Social Networking and Skills for Social Capital to Obtain/Maintain community based integrated employment

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

Exclusions:
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.
This service does not pay day care fees or fees for other childcare related activities.
The waiver beneficiary may not volunteer for the Community Networking service provider.
Volunteering may not be done at locations that would not typically have volunteers (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 Day Supports, Community Living and Support, Residential Supports, Respite, Supported Employment or one of the state plan Medicaid services that works directly with the beneficiary.
For beneficiaries who are eligible for educational services under the Individuals with Disability Educational Act, Community Networking does not include transportation to/from school settings. This service includes transportation to/from beneficiary's home or any community location where the beneficiary may be receiving services before/after school.
This service does not pay for overnight programs of any kind.
Classes that offer one-to-one instruction are not covered. Classes that and are in a nonintegrated community setting are not covered.

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 beneficiary plan year. The amount of Community Networking is subject to the Limits on Sets of Services.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies
Individual	Employee in a self-directed arrangement

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Community Networking

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

n/a

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

- 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.
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Providers that only provide transportation may be accredited by The Joint Commission.

Tribal providers are not subject to licensure but substantial equivalency.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies

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: Community Networking

Provider Category:

Individual

Provider Type:

Employee in a self-directed arrangement

Provider Qualifications

License *(specify):*

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

Certificate *(specify):*

n/a

Other Standard *(specify):*

Staff that work with participants are approved by employer of record OR recommended by managing employer and approved by Agency with Choice 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 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
- Supervised by the employer of record or managing employer
- For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director
- Agencies with Choice follow the NC State Nursing Board regulations
- Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Tribal providers are not subject to licensure but substantial equivalency

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record or Agency with Choice.

PIHP

Frequency of Verification:

Prior to hiring

Employer of Record annually
Agency with Choice as specified for provider agencies

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:
04 Day Services	04010 prevocational 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):*

Day Supports is a service that may originate from a facility and provides assistance to the individual with acquisition, retention, or improvement in socialization and daily living skills and is one option for a meaningful day. Individuals therefore are often in the community with individuals without intellectual and developmental disabilities.

Day Supports emphasizes inclusion and independence with a focus on enabling the individual to attain or maintain his/her maximum self-sufficiency, increase self-determination and enhance the person's opportunity to have a meaningful day. To ensure informed choice among a variety of options for a meaningful day, individuals new to the service and 16 years of age and older, will receive education on available options during the planning meeting and on an ongoing basis through service delivery. Education must include exposure to the same day activities as others in the community and the structure of Day Supports must provide the opportunity to discover his or her skills, interests, and talents in his or her community. Grouping of individuals must be appropriate to the age and preferences of the person.
Day Supports can be provided in Adult Day Care Programs, 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 are 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.
For school-aged or younger children, Day Supports can be provided in a Developmental Day Program. Developmental Day is a service which provides individual habilitative programming in a licensed childcare center. Developmental Day services are provided in certified centers. Developmental day services are not Day care services as they are designed to meet the ongoing developmental needs of the child in an inclusive setting. Developmental day is designed to provide specialized services that promote skill acquisition in areas such as self-help, fine and gross motor skills, language and communication, cognitive and social skills in order to facilitate their functioning in a less restrictive environment through a plan of care, written by a treatment team consisting of health and education professionals. Developmental Day is provided in day care settings for children who do not function with an intellectual or developmental disability. For individuals who are eligible for educational services under the Individuals with Disability Educational Act, Day Supports will be the payer of last resort for Developmental Day.
For working-age individuals (ages 16 or older) not also working in competitive integrated employment, Day Supports may include career and employment exploration through educational and experiential opportunities designed to identify a person's specific interests and aptitudes for paid work, including experience and skills transferable to competitive integrated employment, and also typically includes business tours, informational interviews and job shadows, related to the person's identified interests, experiences and/or skills, in order to explore potential opportunities for competitive integrated employment in the person's local area. Individuals participating in prevocational services may be compensated in accordance with applicable federal laws and regulations and the provision of prevocational services is always delivered with the intention of leading to permanent integrated employment at or above the minimum wage in the community.

Individuals participating in prevocational services: Prevocational services provide learning and work experiences, including volunteer work, where the individuals can develop general, non-job-task specific strengths and skills that contribute to employability in paid employment in integrated community settings. Prevocational services should create a path to integrated community-based employment. Services are expected to occur over a defined period and with specific outcomes to be achieved, as determined by the individual and his/her service and supports planning team through an ongoing person-centered planning process. Individuals receiving prevocational services must have employment-related goals in their person-centered service plan; the general habilitation activities must be designed to support such employment goals. Prevocational services are delivered for the purpose of furthering habilitations goals that will lead to greater opportunities for competitive integrated employment and career advancement.

Prevocational services should enable each individual to attain the highest level of work in the most integrated setting and with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines. Services are intended to develop and teach general skills; Examples include but are not limited to: ability to communicate effectively with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; general workplace safety and mobility training.

Participation in prevocational services is not a required pre-requisite for individual or small group supported employment services provided under the waiver. As individuals can choose to transition from school directly into supported employment.

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 (as of 3/19/22) and must not isolate participants from community members not receiving HCBS services. Facility-based Day Supports must be provided by a licensed Day Supports provider that serves individuals with Intellectual and Developmental Disabilities. Individuals who receive facility-based Day Supports only have to attend the Day Supports Facility once per week and therefore are able to maximize their time in the community with individuals without intellectual and developmental disabilities. Developmental Day is provided in day care settings for children who do not function with an intellectual or developmental disability.
Day Supports provided in a facility-based setting, including licensed community day programs, may include prevocational activities.
Individuals receiving prevocational services must have employment-related goals in their ISP; Competitive integrated employment in the community at or above the minimum wage is considered to be the optimal outcome of prevocational services.
Individual Day Supports are available to meet specific and well documented needs of the person. 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 shall 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 individual'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. This minimum requirement does not apply to individuals who attend Adult Basic Education classes.
Transportation to/from school settings is not included for individuals who are eligible for educational services under the Individuals With Disability Educational Act. This includes transportation to/from the individual's home or any community location where the individual may be receiving services before or after school.
NC Innovations Day Supports Group can be provided in a group setting that includes State-funded Day Supports / Activity as long as the NC Innovations definition is met and the staff meet the qualifications of NC Innovations Day Supports Group.
Day Supports is billed in 1 hour unit increments. An individual must receive Day supports 15 minutes before the 1 hour unit may be billed. 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.).

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

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

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

Waiver funding is not available for vocational services delivered in facility based or sheltered work settings. The following criteria differentiate between prevocational and vocational services:
a. Prevocational services are provided to individuals who are not expected to join the general work force within one year of service initiation, except if expected to join the general workforce through the use of Supported Employment services .
b. Prevocational services include activities that are not directed at teaching job-specific tasks but at underlying skills that may support the individual to increase his/her ability to pursue competitive integrated employment with the assistance of Supported Employment services as needed.

Meals provided as part of these services shall not constitute a "full nutritional regimen" (i.e., up to 2 meals per day and which do not constitute a full nutritional regimen is permitted).

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Before and After School Day Care Programs Operated by NC Public School System
Agency	Licensed Developmental Day Care Programs
Agency	Provider Agencies
Agency	Adult Day Health and Adult Day Care Programs

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:

Before and After School Day Care Programs Operated by NC Public School System

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Before and After Day Care School Programs
PIHP

Frequency of Verification:

Verifies employee qualifications at the time employee is hired.

Credentialing by State.

Upon initial review; PIHP 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:

Licensed Developmental Day Care Programs

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 providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

• 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.
• 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:

Developmental Day Care Programs
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialling at 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 providers are not subject to licensure but substantial equivalency.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

• 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.
• Upon enrollment with the PHP / 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.
Credentialling 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:

Adult Day Health and Adult Day Care Programs

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):*

Certified by NC Division of Aging and Adult Services in accordance with NC General Statute 131 D 6. Tribal providers are not subject to licensure but substantial equivalency.

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

- 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 Health and Adult Day Care Programs
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired

Credentialling 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:

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. The intended outcome of the service is to:

1. increase or maintain the life skills,
2. provide supervision to support Individuals in maximizing self-sufficiency,
3. increase self- determination, and
4. to support individuals in accessing opportunities to have full inclusion in their community.

Residential Supports includes the implementation of goals that support the individual to learn new skills, maintain and/or improvement of existing skills, and sustain skills to assist the person to complete an activity to their level of independence. Residential Supports includes supervision and assistance in activities of daily living when the individual is dependent on others to ensure health and safety.

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-5: Home and Community Based Settings of the Waiver application.

Residential Supports may be provided in an Assisted Family Living setting (AFL). AFL Residential Support sites must be the primary residence of the AFL provider (includes couples and single persons); who receive reimbursement for the cost of care. These sites are licensed or unlicensed in accordance with state rule. All unlicensed AFL sites will be reviewed annually by the PIHP/Tailored Plan using the AFL checklist for health and safety related issues.

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

Residential Support Levels

Residential Supports are provided as tiered support service; levels are determined by the Individual Budget Tool (IBT) and other evidence (i.e. medical documentation, etc.) that support members level of Residential Support needs.

Level 1: SIS Level A
Level 2: SIS Level B
Level 3: SIS Level C and D
Level 4: SIS Level E, F, and G

The Support Intensity Scale (SIS) score is only one piece of evidence that may be considered when determining the level of Residential Support services. The results of a SIS and the IBT Base Budget are guidelines that do not constitute a binding limit that may not be exceeded on the amount of services (including the level of this service) that may be requested or authorized in a Plan of Care.

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”.

•Transportation to/from a child’s school is the responsibility of the school system rather than the Residential Supports Provider.

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

• NC Innovations respite may be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports
And
• Respite may be used by individuals residing in Residential Living settings when the individual is accessing a summer camp or support group. The Residential Living service will not be billed on days when an individual is utilizing respite to access an overnight summer camp.
•Vehicle Modifications may be accessed when the vehicle belongs to the individual and can transition to other settings with the individual.

This service is not available at the same time of day as Community Networking, Day Supports, Supported Living, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.
• • Transportation to/from a child’s school is the responsibility of the school system rather than the Residential Supports Provider.

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

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

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

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

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

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

Provider Specifications:

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

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 providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

• 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.
• Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.
• The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for cost of care.
• Back up staff must be employees of the agency

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.
Credentialing by the State.
PIHP credentialing is conducted no less than every 3 years.

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: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Residential Supports

Provider Category:

Agency

Provider Type:

Supervised Living Facility, Type C

Provider Qualifications

License *(specify):*

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

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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 4 beds or less for newly developed facilities; 6 beds or less for existing facilities except that any facility licensed on June 15, 2001 for more than six beneficiaries at that time may be grandfathered at no more than the facility's licensed capacity. The grandfathered facilities are listed in this service definition. Currently approved facilities, under six beds, are allowed to have new admissions.
Supervised Living Facilities, type C, must be approved as a provider in the PIHP provider network and meet the following qualifications:

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

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
Credentialing by State: No Less than every 3 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 Facility, Type B

Provider Qualifications

License *(specify):*

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

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Supervised Living facilities, type B, serve minors whose primary diagnosis is a developmental disability and may be licensed for 4 beds or less for newly developed facilities; 6 beds or less for existing facilities except that any facility licensed on June 15, 2001 for more than six clients at that time may be grandfathered at no more than the facility's licensed capacity.
Supervised Living Facilities, type B, must be approved as a provider in the PIHP provider network and meet the following qualifications:

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

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
State credentialing: no less than every 3 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:

Unlicensed Supervised Living Facilities

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency.

Certificate *(specify):*

Other Standard *(specify):*

Unlicensed Supervised Living Facilities (AFL) 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 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 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.
• Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies.
• The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Site must be the primary residence of the provider (includes couples and single persons) who receive reimbursement for cost of care.
• Back up staff must be employees of the agency.

Verification of Provider Qualifications

Entity Responsible for Verification:

LME-MCO / PIHP

Frequency of Verification:

The facility is monitored by the PIHP according to the requirements of the DHHS Provider Monitoring Process.
Facility employee verification of employee qualifications: upon hiring
State credentialing: 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 individual. NC Innovations respite may also be used to provide temporary relief to individuals who reside in Licensed and Unlicensed AFLs, but it may not be billed on the same day as Residential Supports unless it is for a individual to access a summer camp or support group. This service enables the primary caregiver to meet or participate in planned or emergency events, and to have planned time for him/her and/or family members. This service also enables the individual to receive periodic support and relief from the primary caregiver(s) at his/her choice. Respite may be utilized during school hours for sickness, injury, or when a student is suspended or expelled. Respite may include in and out-of-home services, inclusive of overnight, weekend care, or emergency care (family emergency based, not to include out of home crisis). The primary caregiver(s) is the person principally responsible for the care and supervision of the beneficiary and must maintain his/her primary residence at the same address as the beneficiary.

- The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-IID Facility.
- This service is not to be used as a regularly scheduled daily service in the individual support plan.

- This service is not available to beneficiaries who reside in licensed facilities that are licensed as 5600B or 5600C unless it is used to support an individual with accessing a summer Camp or support group. Staff sleep time is not reimbursable.
- Respite services are only provided for the individual; other family members, such as siblings of the individual, may not receive care from the provider while Respite Care is being provided/billed for the individual.
- Respite Care is not provided by any person who resides in the individual's primary place of residence.
- Respite may be allowed in the private home of the provider or staff of an employer of record at the discretion and agreement of the support team and when consistent with the ISP goals. The Innovations Health and Safety Checklist must be completed annually if the service is provided in the home of the provider or staff of an employer of record.
- FFP (Federal Financial Participation)will not be claimed for the cost of room and board except when provided, as part of respite

- 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.
- For individuals who are eligible for educational services under Individual's With Disability Educational Act, Respite does not include transportation to/from school settings. This includes transportation to/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.
- Respite may not be used for beneficiaries who are living alone or with a roommate; staff sleep time is not reimbursable.
- Respite may be provided by relatives or legal guardians if they do not live in the same home as the individual.

Exclusions:

- This service is not available at the same time of day as Community Networking, Day Supports, Community Living and Supports, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.
- Residential Support AFL cannot be billed on the same day as Per Diem Respite for the same individuals.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies, Nursing Respite
Individual	Employee in a self-directed arrangement
Agency	Home Care Agencies
Agency	Adult Day Health
Agency	Provider Agencies, facility based and in home services
Agency	Provider Agencies who operate private respite homes

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 providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:
- GED or High School
- Provided by an RN or LPN licensed in the State of North Carolina
- 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.
- State Nursing Board Regulations must be followed for tasks that present health and safety risks to the beneficiary as directed by the PIHP Medical Director or Assistant Medical Director
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the Agency with Choice qualified professional or the Employer of Record.

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 and reverifies 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:

Individual

Provider Type:

Employee in a self-directed arrangement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Staff that work with participants are approved by Employer of Record OR recommended by managing employer and approved by Agency with Choice that work with participants:

- 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
- Supervised by the employer of record or managing employer
- For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director
- Agencies with Choice follow the NC State Nursing Board regulations.
- Upon enrollment with the PIHP, enrollment as a provider, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the Agency with Choice qualified professional or the Employer of Record.

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record or Agency with Choice
PIHP

Frequency of Verification:

Prior to hire
Employer of Record Annually
Agency with Choice as specified for provider agencies

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 providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

NC G.S. 122C, as applicable
Approved as a provider in the PIHP provider network:
- GED or High School Diploma
- Provided by an RN or LPN licensed in the State of North Carolina
- 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.
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the Agency with Choice qualified professional or the Employer of Record.

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 and reverifies 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:

Adult Day Health

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Certified by NC Division of Aging and Adult Services in accordance with NC General Statute 131 D 6.

Other Standard *(specify):*

Approved as a provider in the PIHP provider network.

Verification of Provider Qualifications

Entity Responsible for Verification:

Adult Day Health
PIHP

Frequency of Verification:

Provider verifies employee qualification at the time employee hired

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 providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

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

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

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 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 providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

- 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.
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.
- Services provided in the private home of the direct service employee are subject to the checklist and monthly monitoring by the Agency with Choice qualified professional or the Employer of Record.

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: 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):

Supported Employment

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 is designed to be a supportive, therapeutic employment relationship between the provider and the individual which addresses and/or implements interventions outlined in the Career Development Plan that is integrated in the person centered/individual support plan.

Supported Employment providers:
a. Help develop community involvement and relationships that promote full citizenship, b. Coordinate education and assistance related to finances, healthcare, and other needs,
c. Assist with day-to-day planning and problem solving,
d. Train and support people who assist the individual incidental to the PCP,
e. Train and support individuals on accessing public transportation,
f. Train and support individuals with new skill acquisition related to interpersonal skill
Supported Employment-Individual services provide assistance, based on individual circumstances and need, to explore, seek, choose, acquire, maintain, increase and/or advance in competitive integrated employment. Competitive integrated employment is an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage.
This service is available to any beneficiary ages 16 and older for whom individualized, competitive integrated employment has not been achieved, and/or has been interrupted or intermittent. Assistance with increasing or advancing in competitive integrated employment is available to beneficiaries, ages 16 and older, for whom their current competitive integrated employment is insufficient in terms of meeting the beneficiary's goals for hours worked and income earned, or is considered underemployment in that the beneficiary desires, and could reasonably be expected to achieve, a promotion to a position with increased responsibilities and pay.

Documentation is maintained in the file of each provider agency specifying that the particular service(s) being provided under this Supported Employment-Individual service category is not otherwise available, without undue delay, to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973, or under the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
This service is available to any beneficiary ages 16 and older for whom individualized, competitive integrated employment has not been achieved, and/or has been interrupted or intermittent. Assistance with increasing or advancing in competitive integrated employment is available to beneficiaries, ages 16 and older, for whom their current competitive integrated employment is insufficient in terms of meeting the beneficiary's goals for hours worked and income earned, or is considered underemployment in that the beneficiary desires, and could reasonably be expected to achieve, a promotion to a position with increased responsibilities and pay.

Supported Employment services include:
a. Job Placement and Coaching Services;
b. Customized Employment;
c. Transportation Services between; and
1. service delivery location(s) and the beneficiary's primary private residence,
2. different service delivery locations,
3. locations that support the respective employment phase; and
4. the beneficiary's job site.
d. Best practices that are supported by the Office of Disability Employment Policy (ODEP) which promote competitive integrated
employment specific to supporting a members with an I/DD.

Supported Employment services will occur in three phases, members are required to complete each phase in order to access the next phase. Except in instances where a member is actively working and desires to find other employment or has an option for job advancement. In these instances, a member may access any Supported Employment phase to support access to competitive integrated employment.
a. Pre-employment Phase,
b. Employment Stabilization Phase
c. Long-term Supported Employment Phase.

Note: Supported Employment Career Planning is expected to be provided during the preemployment Phase and reassessment must occur during the Employment Stabilization or Long-Term Support Phase. Supported Employment Career Planning can be conducted during any phase to ensure the beneficiary meets their employment goals.

1. Pre-employment Phase: The pre-employment phase consists of the following activities which must occur before obtaining Competitive Integrated Employment (CIE):
a. benefits counseling referral;
b. career exploration and discovery;
c. job readiness skills; and,
d. job development activities.

2.Employment Stabilization Phase: The goal of the Employment Stabilization Phase of this service is to:
a. enable a beneficiary to complete initial job training,
b. develop skills necessary to maintain competitive integrated employment, and
c . successfully assimilate into the workplace.

Typical activities include a variety of approaches to teach the beneficiary how to complete assigned job tasks. It is critical that job fading occurs early during this phase to allow the beneficiary to develop on-the-job and natural supports. The Employment Stabilization Phase can also be used to stabilize a beneficiary's unique needs related to self-employment. This phase consists of the following activities that must occur when the beneficiary has obtained competitive integrated employment.

3. Long-Term Supported Employment Phase: This employment maintenance phase has various activities designed to continue to support the beneficiary in maintaining competitive integrated employment. The goal of this phase is to enable a beneficiary to work as independently as possible and prepare for a reduced level of staff support. In this phase the assessment of long-term support needs occurs. The outcome of the assessment of long-term support needs will address ongoing retention, prevention of job loss, or make recommendations for discharge. Detailed documentation of goals specific to long-term support needs must reflect how the services are received and preparing the beneficiary for working as independently as possible. Continuation in this employment phase is determined by an individualized assessment of employment goals and the need for ongoing employment

1. Pre-employment Phase: The pre-employment phase consists of the following activities which must occur before obtaining Competitive Integrated Employment (CIE):
a. benefits counseling referral;
b. career exploration and discovery;
c. job readiness skills; and,
d. job development activities.

2.Employment Stabilization Phase: The goal of the Employment Stabilization Phase of this service is to:
a. enable a beneficiary to complete initial job training,
b. develop skills necessary to maintain competitive integrated employment, and
c . successfully assimilate into the workplace.

Typical activities include a variety of approaches to teach the beneficiary how to complete assigned job tasks. It is critical that job fading occurs early during this phase to allow the beneficiary to develop on-the-job and natural supports. The Employment Stabilization Phase can also be used to stabilize a beneficiary's unique needs related to self-employment. This phase consists of the following activities that must occur when the beneficiary has obtained competitive integrated employment.

3. Long-Term Supported Employment Phase: This employment maintenance phase has various activities designed to continue to support the beneficiary in maintaining competitive integrated employment. The goal of this phase is to enable a beneficiary to work as independently as possible and prepare for a reduced level of staff support. In this phase the assessment of long-term support needs occurs. The outcome of the assessment of long-term support needs will address ongoing retention, prevention of job loss, or make recommendations for discharge. Detailed documentation of goals specific to long-term support needs must reflect how the services are received and preparing the beneficiary for working as independently as possible. Continuation in this employment phase is determined by an individualized assessment of employment goals and the need for ongoing employment

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

The service includes transportation to and from the service and/or the job site, only if there is no other viable and more cost-effective alternative available to the beneficiary. The provider agency's payment for transportation from the individual's residence and the place of service or job site is authorized service time. When the individual has a need for transportation, but not on-the-job support, to maintain competitive integrated employment, payments for transportation are established as a per trip charge or mileage.

The exact amount and duration of Initial Supported Employment-Individual services authorized should be individually determined and based on individual need.
A authorization of Initial Supported Employment-Individual services may be needed after transition to long-term follow-along, if the individual's job duties change or if a new job is acquired.

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.

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.

For individuals who are eligible for educational services under the Individuals with Disability Educational Act, Supported Employment does not include transportation to/from school settings. This includes transportation to/from the individual's home, provider home where the individual may be receiving services before or after school or any other community location where the individual may be receiving services before or after school.
Supported Employment services occur in integrated environments with non-disabled individuals or is a business owned by the beneficiary.
Supported Employment services do not occur in licensed community day programs.

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 amount of Supported Employment is subject to the Limits on Sets of Services.
This service is not available at the same time of day as Community Networking, Day Supports, Community Living and Support, Residential Supports, Respite or one of the State Plan Medicaid services that works directly with the person.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Employee in a self-directed arrangement

Provider Category	Provider Type Title
Agency	Supported Employment Providers

Appendix C: Participant Services

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

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Individual

Provider Type:

Employee in a self-directed arrangement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Meet applicable requirements of NC General Statute 122C
Staff that work with participants are approved by employer of record OR recommended by Managing Employer and approved by Agency with Choice that work with participants:

- 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
- Supervised by the employer of record or managing employer
- For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director
- Agencies with Choice follow the NC State Nursing Board regulations

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record or Agency with Choice
PIHP

Frequency of Verification:

Prior to hire and re-verify:
Employer of Record annually
Agency with Choice as specified for 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:

Supported Employment Providers

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

The provider shall ensure that staff (i.e., paraprofessionals, Direct Support Professionals) who are providing Supported Employment have completed competency-based training in an evidenced-based supported employment model endorsed and/or supported by the Office of Disability Employment Policy (ODEP) and/or NC DHHS.

Minimally, staff (i.e., paraprofessionals, Direct Support Professionals) providing the services are required to have completed Job Coach training. Job Coach training requires pre-approval from NC DHHS in accordance with the published employment training list housed on the DHHS website.

Additionally, staff (i.e., paraprofessionals, Direct Support Professionals) providing Supported Employment services are recommended to have initiated training to meet certification requirements of either Association of Community Rehabilitation Educators (ACRE), including ACRE with a focus on Customized Employment OR Association of People Supporting Employment First (APSE) (i.e., Certified Employment Support Professional (CESP)) within one year of the onset of Supported Employment services.

In addition, staff should receive special population training based on staff experience and training needs (e.g., intellectual and developmental disabilities, geriatric, traumatic brain injury, deaf and hard of hearing, co- occurring intellectual and mental health and cooccurring intellectual and developmental disabilities and substance use disorder) as required. Such training should be completed prior to working with individuals and updated as individuals' needs change.

Other Standard *(specify):*

Meet applicable requirements in NC General Statute 122C Approved as a vendor in the PIHP provider network Approved as a provider in the PIHP provider network:

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

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

Service Type:

Supports for Participant Direction

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

Support for Participant Direction:

Financial Management Services

Alternate Service Title (if any):

Financial Support Services

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

12 Services Supporting Self-Direction	12010 financial management services in support of self-directio

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):*

Financial support services is the umbrella service for the continuum of supports offered to NC Innovations waiver participants who elect the individual and family directed services option, employer of record model. Financial support services are provided to assure that funds for self-directed services are managed and distributed as intended. The service also facilitates employment of support staff by the employer.
(1) Filing claims for self-directed services and supports
(2) Payment of payroll to employees hired to provide services and supports
(3) Deducting all required federal, state, and local taxes, including unemployment fees, prior to issuing paychecks to employees
(4) Ordering employment related supplies and paying invoices for other expenses such as training of employees
(5) Administering benefits for employees hired to provide services and supports
(6) Maintaining ledger accounts for each participant's funds
(7) Producing expenditure reports that are required, including reports to the participant/employer/family concerning expenditures of funds against their budgets
(8) Requesting criminal background checks, driver's license checks and health care registry checks of providers of self-directed services
(9) Tracking and monitoring individual budget expenditures
(10) Facilitating workers compensation application on behalf of the employer of record and/or (11) serving as the internal revenue approved fiscal employer agent.

Individuals who choose to self-direct via the Employer of Record model will require equipment necessary to carry out duties of Employer of Record may access this service. (This is not an all inclusive list). Employer Supplies may include following equipment:
a. Laptop/Computer /Printer used to by to carry out administrative duties of Employer of Record.
b. Electronic Health Records (EHR) Software used to perform Employer of Record duties.

Employer Supplies may also be utilized to pay for training and other work related requirements such as Hepatitis B Vaccines for employees. Other typical office supplies needed to perform duties may be purchased (this is not an inclusive list):
a. Training for new Employees – CPR, First Aid, Blood borne Pathogens, Medication Administration other Beneficiary Specific Training
b. Hepatitis B Vaccine for Employees per Bloodborne Pathogen Requirements
c. Protective Equipment for Employees such as Gloves, CPR mask, and First Aid Kit
d. Lock box/file cabinet to secure PHI and Employee Personal Information
e. Office supplies (file folders, notebook/binders, pens/ pencils, calculator, etc.)
f. Paper for Printer
g. Ink for Printer
One laptop/computer /EHR software may be purchased over the life of the waiver.
EHR software may be upgraded more than once over the life of waiver if necessary to maintain functionality of software. Documentation to show that if upgrade is not completed, software will not function, will be required from vendor to support request.

Exclusions

The provider of financial support services may only additionally provide Community Navigator services. The financial support service may bill for the following services: Community Transition services, and Individual Goods and Services under the NC Innovations waiver.
The financial supports agency may be an Agency with Choice and provide Community Navigator. Regarding Community Navigator, the provider choice is offered by the Tailored Care Manager/Care Coordinator.

An FSA may bill for Community Transition and Individual Goods and Services to the same participant. Community Transition Services and Individual Goods and Services are not directly provided to the member by the FSA. For example, if the individual needs a deposit to turn on their electricity to move into their own home and it is authorized by the PIHP, then the FMS would issue payment to the utility company on behalf of the beneficiary.

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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Applicable state/local business license

Tribal providers are not subject to licensure but substantial equivalency.

Certificate *(specify):*

Other Standard *(specify):*

NC G.S. 122C, as applicable
Approved as a provider in the PIHP provider network
Approved by the Internal Revenue Service (IRS) to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6,
Bonded
Meets all IRS requirements and be certified by the IRS as an employer agent
Understands the laws and rules that regulate the expenditure of public funds
Able to utilize accounting systems that operate effectively on a large scale, as well as track individual budgets
Able to develop, implement and maintain an effective payroll system that adheres to all related tax obligations, both payment and reporting
Able to conduct criminal and other required background checks
Able to generate service management and statistical information and reports during each payroll cycle
Have at least two years of basic accounting and payroll experience

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Upon initial approval 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

Assistive Technology, Equipment and Supplies (ATES) are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain, or improve functional capabilities of individuals. Assistive Technology and Supplies can be accessed when the item requested will belong to the individual. This service covers purchases, leasing, trial periods and shipping costs, and as necessary, repair/modification of equipment required to enable individuals to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. Service contracts and extended warranties may be covered for a one year time frame. All items must meet applicable standards of manufacture, design, and installation. The Individual Support Plan clearly indicates a plan for training the individual, the natural support system and paid caregivers on the use of the requested equipment and supplies. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the person. This service may cover an evaluation, when the Medicaid State Plan option has been exhausted.

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

Medical necessity must be documented by the physician, physician assistant, doctor of osteopathic medicine 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, nurse practitioner or doctor of osteopathic medicine 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, then a physician, physician assistant, nurse practitioner or doctor of osteopathic medicine must write a letter of medical necessity OR sign off on the letter of medical necessity prepared by professional AND write 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
- Communication Aids not covered by regular Medicaid State Plan
- Mobility Aids not covered by DME
- Nutritional supplements covered under the NC DME fee schedule for adults
  Medical Supplies not covered by regular state plan formulary

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.

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.

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

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

Individuals under the age of 21 will access Durable Medical Equipment though the State Plan Durable Medicaid Equipment through EPSDT

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

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

Alert Response Centers

Provider Qualifications

License *(specify):*

Applicable state/local business license

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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:

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. Tribal Providers 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:

Durable Medical Equipment Providers

Provider Qualifications

License *(specify):*

Applicable state/local business license

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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:

Individual

Provider Type:

Specialized Vendors

Provider Qualifications

License *(specify):*

Applicable state/local business license

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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:

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 providers are not subject to licensure but substantial equivalency.

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:

Benefits Counseling

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):*

Benefits Counseling is a direct service designed to inform, and answer questions from, a participant about competitive integrated employment and how and whether it will result in increased economic self-sufficiency and/or net financial benefit through the use of various work incentives. Through an accurate individualized assessment, this service provides information to the participant regarding the full array of available work incentives for essential benefit programs including Supplemental Security Income, SSDI, Medicaid, Medicare, housing subsidies, food stamps, etc.

The service also will provide information and education to the participant regarding income reporting requirements for public benefit programs, including the Social Security Administration. Benefits Counseling provides work incentives counseling and planning services. It is provided to participants considering or seeking employment or career advancement or to participants who need problem solving assistance to maintain competitive integrated employment.

Benefits Counseling must be provided in a manner that supports the participant's communication style and needs, and shall meet at a minimum what is required under the Americans with Disabilities Act. This service may be provided in person or virtually based on the participant's informed choice, after the pros and cons of each method are explained to the participant.

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

BBenefits Counseling may only be provided after Benefits Counseling services provided by a Community Work Incentives Coordinator through a federal Work Incentives Planning and Assistance (WIPA) program were sought and it was determined and documented by the Tailored Care Manager or Care Coordinator that such services were not available either because of ineligibility or because services are not available within 30 calendar days (this is only required once per year; i.e., it must be repeated if Benefits Counseling is needed in a subsequent year).

Benefits Counseling services are limited to a maximum of 60 (15-minute) units which is equal to 15 hours per participant per plan year for any combination of initial benefits counseling, supplementary benefits counseling when a participant is evaluating a job offer/promotion or a self-employment opportunity, or problem-solving assistance to maintain competitive integrated employment.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Benefits Counseling

Provider Category:
Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Staff (direct, contracted or in a consulting capacity) who will work directly with the participant to provide Benefits Counseling services shall hold one of the following:

•Certified Work Incentives Counselor certification that is accepted by the Social Security Administration for its Work Incentives Planning and Assistance program,
or
•Work Incentive Practitioner Credentials and the completion of a NC Benefits Counseling Training that ensures the Benefits Counselor has NC specifics Benefits knowledge, experience , and training needed to competently serve
NC beneficiaries.

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

• Provided by a qualified professional in the field of developmental disabilities, who meets competencies established by the PIHP
• 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, First Aid and NCI
• Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP
• Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable
of meeting all of the requirements of the PIHP. This includes national accreditation within the prescribed timeframe.

NC G.S. 122C, as applicable Credentialed as a provider in the PIHP provider network Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Tailored Plan/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:

Community Living and 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):*

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

Community Living and Support enables the person to learn new skills, practice and/or improve existing skills. Areas of skill acquisition may include: interpersonal, independent living, community living, self- care, and self-determination.

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

Community Living and Support provides technical assistance to unpaid supports who live in the home of the individual to assist the individual to maintain the skills they have learned. This assistance can be requested by the unpaid support or suggested by the Individual Support Planning team and should be a collaborative decision. The technical assistance should be incidental to the provision of Community Living and Support.

Extraordinary Needs:

Medicaid Waivers: Under 1915(c) waivers, States may provide respite care, training and family counseling. They may also pay legally responsible relatives to provide care that is "extraordinary" (example: a parent lifting a 1-year-old is ordinary; lifting a 16-year-old is extraordinary). The services provided by the caregiver need to be necessary in order to prevent the beneficiary from being institutionalized. Parents of minor children receiving Community Living and Support may continue to provide these services to their child who has been indicated as having extraordinary support needs. Extraordinary care means exceeding the range of activities that a legally responsible individual would ordinarily perform in the household on behalf of 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.

Relatives as Providers for Adult Waiver individuals may provided 56 hours/week, not exceeding the sets on limits of services of Community Living and Supports.

Exceptional Needs:

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

All Requests for Community Living and Support require prior approval by the PIHP.

-Requests for up to 12 hours daily may be authorized for the entire plan year.
-Requests for up to 16 hours daily may be authorized for a six-month timeframe, within the plan year.
-Requests for more than 16 hours daily are authorized for up to a 90 day period within the plan year.

In situations requiring an authorization beyond the initial 90 day period, the PIHP must approve such authorization based on review of the transition plan that details the transition of the participant from Community Living and Support to other appropriate services.

The service may be provided in the home or community. The involvement of unpaid supports in the generalization of the service is an important aspect to ensure that achieved goals are practiced and maintained. Services may be allowed in the private home of the provider or staff of an employer of record at the discretion and agreement of the support team and when consistent with the ISP goals. Community Living and Support services may be provided in the home of the provider, and staff of an employer of record as an alternative setting. Individuals can receive services in the alternative setting until the disaster or health situation resolves through their current authorization. However, the approval to receive services in an alternative setting during a natural disaster or health situation should be documented in the Person Centered Plan and be part of the emergency planning process for the beneficiary. A Health and Safety checklist must be completed before Community Living and Supports services can be provided in this setting, must be completed before service begins and annually thereafter.

EXCLUSIONS:
A. This service includes transportation to/from the person's home or any community location where the person is receiving services.
B. The school system is responsible for transportation to and from the school setting.
C. The paraprofessional is responsible for the individual and incidental housekeeping/meal preparation for and with the individual only, and not others within the household.
D. A beneficiary who receives Community Living and Supports may not receive Residential Supports or Supported Living at the same time and may only receive the community component of Community Living and Supports.
e. This service is not available at the same time of day as Community Networking, Day Supports, Supported Living, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.

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

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.Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required to ensure health and safety, virtual support may not be provided.
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.

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.

The service may be provided in the home or community. The involvement of unpaid supports in the generalization of the service is an important aspect to ensure that achieved goals are practiced and maintained. Services may be allowed in the private home of the provider or staff of an employer of record at the discretion and agreement of the support team and when consistent with the ISP goals. Community Living and Support services may be provided in the home of the provider, and staff of an employer of record as an alternative setting. Individuals can receive services in the alternative setting until the disaster or health situation resolves through their current authorization. However, the approval to receive services in an alternative setting during a natural disaster or health situation should be documented in the Person Centered Plan and be part of the emergency planning process for the beneficiary. A Health and Safety checklist must be completed before Community Living and Supports services can be provided in this setting, must be completed before service begins and annually thereafter.

EXCLUSIONS:
A. This service includes transportation to/from the person's home or any community location where the person is receiving services.
B. The school system is responsible for transportation to and from the school setting.
C. The paraprofessional is responsible for the individual and incidental housekeeping/meal preparation for and with the individual only, and not others within the household.
D. A beneficiary who receives Community Living and Supports may not receive Residential Supports or Supported Living at the same time and may only receive the community component of Community Living and Supports.
e. This service is not available at the same time of day as Community Networking, Day Supports, Supported Living, Supported Employment or one of the State Plan Medicaid Services that works directly with the person such as Private Duty Nursing.

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

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.Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required to ensure health and safety, virtual support may not be provided.
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.

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:

The amount of Community Living and Support is subject to the Limits on Sets of Services.

Remote Monitoring Vendor 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 30 minutes.
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 30 minutes) when a request for beneficiary assistance is made.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☒ **Relative**

☒ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency
Individual	Employee in a self-directed arrangement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Community Living and Support

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

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

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 at 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: Community Living and Support

Provider Category:

Individual

Provider Type:

Employee in a self-directed arrangement

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 that work with participants are approved by employer of record OR recommended by Managing Employer and approved by Agency with Choice that work with participants:

• 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
• Supervised by the employer of record or managing employer
• For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in
10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
• State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director
• Agencies with Choice follow the NC State Nursing Board regulations
• Beneficiaries who utilize EOR to self-direct services will receive education on the following:
a. An enrolled Provider of one of the IW Crisis Services (Crisis Intervention & Stabilization Supports, Crisis Consultation, or Out of Home Crisis). These services are provider directed and would be identified
on the ISP and Cost Summary
b. Mobile Crisis Management provider
c. NC START

When the member has an identified Crisis service need the ISP shall indicate such in the in the Crisis Plan section. The selection of the Crisis Provider is individualized and will be decided based on the member's
identified Crisis service support needs.
Additionally, EOR can contract with an enhanced professional to provide support during a crisis. This professional can be a QP with crisis response experience or a Medical professional to provide assistance and education
to prevent medical emergencies, such as an RN.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record
Agency with Choice
PIHP

Frequency of Verification:

Prior to hiring
Employer of record annually
Agency with Choice as specified for provider agencies

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 individuals 18 years old or older to facilitate their transition from a Developmental Center (institution), community ICF-IID Group Home, nursing facility or another licensed living arrangement (group home, foster home, Psychiatric Residential Treatment Facility, alternative family living arrangement), or a family home / one person AFL(Alternative Family Living) to a living arrangement where the individual is directly responsible for his or her own living expenses. This service may be provided only in a private home or apartment with a lease in the 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:
a. Security deposits that are required to obtain a lease on an apartment or home;
b. Essential furnishings, such as furniture, window coverings, food preparation items, bed/bath linens;
c. Moving expenses required to occupy and use a community domicile;
d. Set-up fees or deposits for utility or service access, such as telephone, electricity, heating and water; and/or
e. Service necessary for the beneficiary's health and safety such as pest eradication, one-time cleaning prior to occupancy and coordination of care pretransition.

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

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

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

The cost of Community Transition has a life of the Waiver limit of $5000.00 per individual. Community Transition includes the actual cost of services and does not include provider overhead charges.

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

Community Transition has a limit of $5000.00 per Waiver period.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Commercial/Retail Businesses
Individual	Specialized Vendor Suppliers
Individual	Employee in Self-Directed

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

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:

Individual

Provider Type:

Specialized Vendor Suppliers

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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:

Individual

Provider Type:

Employee in Self-Directed

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Staff that work with participants are approved by employer of record OR recommended by Managing Employer and approved by Agency with Choice 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 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
• Supervised by the employer of record or managing employer
• For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
• State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director
• Agencies with Choice follow the NC State Nursing Board regulation
• Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record or Agency with Choice PIHP.

Frequency of Verification:

Prior to hiring
Employer of Record Annually
Agency with Choice as specified for a provider agency

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 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 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 waiver participants who have heightened behavioral needs.
- 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 core competency requirements outlined in the Waiver and the activities performed by non-licensed staff must be overseen by licensed staff with experience serving individuals with IDD and behavioral health needs.
- 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 within 48 hours or no later than the next business day to 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

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Independent Practitioners
Agency	Provider Agencies who operate licensed facilities
Agency	Provider Agencies Primary Crisis Response

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Crisis Services

Provider Category:

Agency

Provider Type:

Independent Practitioners

Provider Qualifications

License *(specify):*

Licensure specific to discipline, if applicable

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

Staff that work with individuals:

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 IDD and mental health needs OR a physician assistant with a minimum of one year of experience serving individuals with IDD and mental health needs.
In addition, all Crisis Services staff must have access to a licensed practicing psychologist with a minimum of one year of experience in working with individuals with IDD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider agency verifies employee qualifications at the time employee is hired; if provider is an individual practitioner, the PIHP verifies employee qualifications prior to contracting with individual and at least every 3 years thereafter.

at least 18 years old
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 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 NC DHSS licensing agency (Department of Health Services Regulation). Facilities that are licensed which provide facility-based crisis services, as per 10A NCAC 27G .5001

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

At least 18 years of age.

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

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 IDD and mental health needs OR a physician assistant with a minimum of one year of experience serving individuals with IDD and mental health needs.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider agency 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 Services

Provider Category:

Agency

Provider Type:

Provider Agencies Primary Crisis Response

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Approved as a provider in the PIHP provider network:

- Provided by a qualified professional in the field of developmental disabilities, who meets competencies established by the PIHP
- 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, First Aid and NCI
- Staff that work with participants must be qualified in the customized needs of the participant as described in the ISP
- Upon enrollment with the PIHP, the organization must have achieved national accreditation with at least one of the designated accrediting agencies. The organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP. This includes national accreditation within the prescribed timeframe

Staff providing Crisis Services, including first response activities, shall demonstrate strong clinical skills, professional qualifications, experience, and competency. Staff 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 IDD and mental health needs OR a physician assistant with a minimum of one year of experience serving individuals with IDD and mental health needs.
In addition, all Crisis Services staff must have access to a licensed practicing psychologist with a minimum of one year of experience in working with individuals with IDD.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Provider agency 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 Meal

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, of daily living 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 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 to medical conditions (i.e., reduced sodium, diabetic diet), or specialized textures, therapeutic or kosher meals.

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 fourteen days that are compliant with food storage and safety requirements. Home delivered meal services provide up
to one meal a day and does not constitute a full nutritional regimen.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Specialized Vendors
Agency	Commercial/Retail Business

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Home Delivered Meal

Provider Category:

Individual

Provider Type:

Specialized Vendors

Provider Qualifications

License *(specify):*

Applicable state/local business license.

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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:

Tailored Plan/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 Meal

Provider Category:

Agency

Provider Type:

Commercial/Retail Business

Provider Qualifications

License *(specify):*

Applicable state/local business license
Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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:

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

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 local, state and federal life safety codes.

Items that are not of direct or remedial benefit to the individual 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 individual or his/her family must own any equipment that is repaired.
Covered Modifications may include, but are not limited to:

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
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
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; Fences; 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.
Items utilized as restraints are not coverable under the waiver.

Equipment or supplies purchased for exclusive use at the school/home school are not covered.
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.
Items that would normally be available to any child, and are ordinarily provided by the family, are not covered.
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 $50,000 of supports (ATES, Home Modifications) over the duration of the waiver.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	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 providers are not subject to licensure but substantial equivalency. Tribal Providers 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 providers are not subject to licensure but substantial equivalency. Tribal Providers 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: 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:

Individual Goods and Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
17 Other Services	17010 goods and 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):*

Individual goods and services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid state plan that address an identified need in the ISP (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements:

(1) The item or service would decrease the need for other Medicaid services
AND/OR
(2) Promote inclusion in the community
AND/OR
(3) Increase the person's safety in the home environment
AND
(4) The individual does not have the funds to purchase the item or service

Exclusions

Individual Goods and Services do not include experimental goods and services inclusive of items which may be defined as restrictive under NC G.S. 122C-60. This service is available only to beneficiaries who self-direct at least one of their services. The purchase, rental, or leasing of cars/vans/trucks is not permissible under this definition. The purchase of animals, food, nutritional supplements, alcohol, and tobacco are not coverable under this definition

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

The cost of individual directed goods and services for each individual cannot exceed $2,000.00 per participant plan year annually.

The ISP must outline how each of the applicable requirements are met, including the beneficiary does not have the funds to purchase the item or service.

Beneficiaries under the age of 21 will access Durable Medical Equipment though the State Plan Durable Medicaid Equipment benefit through EPSDT to access equipment or supplies that are not otherwise provided through this waiver or through the Medicaid State Plan.

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

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

☐ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency with Choice
Agency	Commercial/Retail Businesses
Individual	Employee in a self directed arrangement
Agency	Financial Support Services Agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Agency with Choice

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

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

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

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

Certificate *(specify):*

Other Standard *(specify):*

Meets applicable state and local requirements for type of item 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: Individual Goods and Services

Provider Category:

Individual

Provider Type:

Employee in a self directed arrangement

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Staff that work with participants are approved by employer of record OR recommended by Managing Employer and approved by Agency with Choice 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 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
- Supervised by the employer of record or managing employer
- For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director
- Agencies with Choice follow the NC State Nursing Board regulation
- Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies. The Agency with Choice must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record or Agency with Choice

PIHP

Frequency of Verification:

Prior to hiring

Employer of Record Annually
Agency with Choice as specified for a provider agency

Appendix C: Participant Services

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

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

Provider Category:

Agency

Provider Type:

Financial Support Services Agency

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency.

Certificate *(specify):*

Other Standard *(specify):*

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

Verification of Provider Qualifications

Entity Responsible for Verification:

PIHP

Frequency of Verification:

Annually

Appendix C: Participant Services

C-1/C-3: Service Specification

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

Service Type:

Other Service

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

Service Title:

Natural Supports Education

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 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 and the individual's natural support network in order to enhance the decision making capacity of the natural support network. Natural Supports Education may provide orientation regarding the nature and impact of the intellectual and other developmental disabilities upon the individual, provide education and training on intervention/strategies, and provide education and training in the use of specialized equipment and supplies. The requested education and training must have outcomes directly related to the needs of the individual, be of direct or remedial benefit to the individual, or have an impact the natural support network's ability to provide care and support to the individual. 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 individual's natural support network. The expected outcome of this training is to develop and support greater access to the community by the beneficiary by strengthening his or her natural support network.

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

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

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

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.

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

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

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

- [ ] **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agencies
Individual	Employee in a self-directed arrangement

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 providers are not subject to licensure but substantial equivalency. Tribal Providers 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 beneficiaries:

Criminal background check presents no health and safety risk to beneficiary

Not listed in the North Carolina Health Care Abuse Registry.

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

Qualified professional as specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.
Qualified in CPR and First Aid

Has expertise as appropriate in the field in which the training is provided in the ISP.

Qualified in the customized needs of the 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.

Are at least 18 years oldThe organization must be established as a legally constituted entity capable of meeting all of the requirements of the PIHP.

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agencies
PIHP

Frequency of Verification:

Verifies employee qualifications at the time employee is hired
Credentialing by the State.
Upon initial review
PIHP 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: Natural Supports Education

Provider Category:

Individual

Provider Type:

Employee in a self-directed arrangement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

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

Are at least 18 years old

The Criminal Background Check presents no risk to the beneficiary

Not listed in the North Carolina Health Care Abuse Registry.

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

Qualified in CPR and First Aid

Has expertise as appropriate in the field in which the training is provided as identified in the Individual Support Plan

Qualified Professional as specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.

Supervised by the employer of record or Managing Employer

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

Agencies with Choice follow the NC State Nursing Board regulations.

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

Upon enrollment with the PIHP, the Agency with Choice must have achieved national accreditation with at least one of the designated accrediting agencies.

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record or Agency with Choice
PIHP

Frequency of Verification:

Prior to hiring
Employer of Record annually
Agency with Choice as specified for Provider Agencies

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	11100 speech, hearing, and language therapy
Category 3:	**Sub-Category 3:**
11 Other Health and Therapeutic Services	11090 physical therapy
Category 4:	**Sub-Category 4:**
11 Other Health and Therapeutic Services	11080 occupational 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 (psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy, physical therapy, nutrition, and other licensed professionals who possess experience with individuals with Intellectual / Developmental Disabilities) to assist family members, support staff and other natural supports in assisting individuals with developmental disabilities. Under this model, family members and other paid/unpaid caregivers are trained by a certified, licensed, and/or registered professional, or qualified assistive technology professional to carry out therapeutic interventions, consistent with the Individual Support Plan.

Activities covered are:
- 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 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:

Specialized Consultative Services may not duplicate services provided through Natural Supports Education and Crisis Supports. Specialized Consultative Service does not cover Applied Behavioral Analysis. Specialized Consultative Services does not cover one-on-one therapy.

Beneficiaries under the age of 21 will access Specialized Consultative Services though EPSDT. Specialized Consultative Service is only provided to individuals aged 21 and over. All medically necessary 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**

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	Independent Practitioner

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Specialized Consultation

Provider Category:

Agency

Provider Type:

Provider Agencies

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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 or appropriate License for other licensed professionals who possess experience with individuals with Intellectual / Developmental Disabilities); state certification for recreational therapy; board certified behavior analyst-MA; master's degree and expertise in augmentative communication; state certification in assistive technology
-Criminal background check presents no health or safety risk to participant
-Not listed in the North Carolina Health Care Abuse Registry
-Qualified in the customized need of the participants 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: Other Service
Service Name: Specialized Consultation

Provider Category:

Individual

Provider Type:

Independent Practitioner

Provider Qualifications

License *(specify):*

Licensure specific to discipline, if applicable

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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; state certification in assistive technology and state certification in recreation therapy
- Criminal background check presents no health or safety risk to participant
- Not listed in the North Carolina Health Care Abuse Registry
- Qualified in the customized need of the participants 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 - Periodic

HCBS Taxonomy:

Category 1: **Sub-Category 1:**

08 Home-Based Services	08010 home-based 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 individuals who use 4 or less hours of Supported Living per day.

Supported Living provides a flexible partnership that enables a person/s 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 person/s. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the individual/s, budget management, attending appointments, and interpersonal and social skills building to enable the individual to live in a home in the community. Training activities, supervision, and assistance may be provided to allow the person 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. Transportation to and from the individuals and points of travel in the community is included to the degree that they are not reimbursed by another funding source.

This service is distinct from Residential Supports in that it provides for a variety of living arrangements for individuals who choose to live in their own home versus the home of a provider. A person'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. Persons living in a Supported Living arrangement shall choose who lives with him/her, are involved in the selection of direct care staff, and participate in the development of roles and responsibilities of staff. Persons receiving Supported Living have 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 person/s to move if the person/s changes service providers.
b. Own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person if such entity requires, as a condition of renting or leasing, the person 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 persons 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 must have staffing available in the case of emergency or crisis. Requirements for the person/s safety in the absence of a staff person shall be addressed and may include use of tele care options. When assessed to be appropriate Assistive Technology elements may be utilized in lieu of direct care staff.

To ensure the intent of the definition to support 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, person's 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. In addition, it also includes step-parents, non-minor step-children and step-siblings and non-minor adoptive relationships. All persons 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 includes payment for services provided by the spouse of a person or to family members as defined in this service definition or legal guardian. When Supported Livings is provided through self-direction an Employer of Record shall not provide direct supports to the member.

A Supported Living home must have no more than three (3) residents including any live-in caregiver providing supports per SL2011-202/HB509. A live-in caregiver is defined as an individual unrelated to the person and who provides services in the person's home through the Supported Living provider agency and is not on the lease.

The provider must develop an individualized staffing plan and schedule. The staffing plan is based on the person/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 person 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.

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 person and who provides services in the person's home. Reimbursement shall not include the cost of maintenance of the dwelling. Residential expenses, e.g. phone, cable, food, rent) shall 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 must develop an individualized staffing plan and schedule. The staffing plan is based on the person/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 person 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.

Special Needs Adjustment: A special adjustment is available for Levels 1-3. The adjustment does not change the Level designated for the person, but adjusts the Level to meet one or more of the following circumstances. There is not a limit on the number of times Special Adjustment payments can be used. Each request for an adjustment is based on the person's unique circumstance, needs and care planning review process:
a. The individual 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 person 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 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 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. Persons who require a continued Special Needs Adjustment due to medical or behavioral health issues may be reassessed for appropriateness of Level.

This service is not available at the same time of day as Community Living and Support, Community Networking, Day Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the person. The following exception applies:• Respite may be used by individuals living in a Residential or Supported Living setting when the individual is accessing a non-integrated community setting like a summer camp.

Remote monitoring:
Monitoring systems using video, web-cameras, or other technology are available on an individual basis, when the individual and the support team agrees it is appropriate and meets the health and safety needs of the individual. Remote support technology may only be used with full consent of the individual and his/her guardian and that consent is indicated in the individual's plan of care (including if the individual has a reference for the location of any monitoring equipment; such as where they are comfortable with a camera being located in their home). The individual/ guardian can revoke consent if they are no longer interested in monitoring systems.
Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required, virtual support may not be provide.

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:

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.
B. Supported Living Periodic is for individuals who use 4 or less hours of Supported Living per day.
Remote Monitoring Vendor 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 30 minutes. 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. Application for 1915(c) HCBS Waiver: NC.0423.R04.00 - Jul 01, 2024 Page 115 of 318 05/20/2024 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 30 minutes) when a request for beneficiary assistance is made.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency
Individual	Employee in a self-directed arrangement

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living - Periodic

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Staff or live-in caregiver 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 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
Upon enrollment as a provider, the Agency With Choice must have achieved national accreditation with at least one of the designated accrediting agencies.
Employers of Record have an arrangement with an enrolled crisis services provider to respond to person/s crisis situations.

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 flexibility in responding to the needs of an 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: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Living - Periodic

Provider Category:

Individual

Provider Type:

Employee in a self-directed arrangement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Staff that work with participants are approved by employer of record OR recommended by Managing Employer and approved by Agency with Choice that work with participants:

- 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
- Supervised by the employer of record or managing employer
- For service directed by the Agency with Choice, paraprofessionals providing this service must be supervised by a qualified professional. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 (b) (c) (f) and according to licensure or certification requirements of the appropriate discipline.
- State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director
- Agencies with Choice follow the NC State Nursing Board regulations
- Has an arrangement with an enrolled crisis services provider to respond to participant crisis situations

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record
Agency with Choice
PIHP

Frequency of Verification:

Prior to hiring
Employer of record annually
Agency with Choice as specified for provider agencies

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 - Transition

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):*

Supported Living provides a flexible partnership that enables a person/s 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 person/s. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the individual/s, budget management, attending appointments, and interpersonal and social skills building to enable the individual to live in a home in the community. Training activities, supervision, and assistance may be provided to allow the person 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.
The purpose of Supported Living Transition is to provide members with the support that they need to facilitate their transition to Supported Living. Supported Living transition is for individuals transitioning from any living arrangement to a living arrangement where the individual is directly responsible for his or her own living expenses. Supported Living Transition will be billed at the Supported Living Periodic Modifier.

Covered transition services are:
– a. Meeting the person who is preparing to transition in an effort to get to know them and assess their support needs for Supported Living; (can the person cook meals to have a healthy diet, how will they handle basic household maintenance tasks like vacuuming, cleaning appliances, bathroom- do they know how and who to call for help, are there types of technology that would support success. Does the person need help to make appointments with doctors? Do they know how to access transportation? What is the plan for their free time? Have they ever been alone overnight or will they?
– b. Meeting with treatment team members in an effort to gather, review, and discuss information that will help to better understand that person and their support needs; assistance with finding an apartment and signing a lease, determining transportation services, gathering needed household items like furniture and supplies, learning about the surround community, developing a home safety plan for fire, setting up services like phone, water, sewer, electric, cable etc., practicing skills needed to be safe, interviewing roommates, developing a emergency plan for disasters like hurricanes, etc.

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

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

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

Relatives who own provider agencies may not provide Supportive Living services to family members. Other staff employed by the provider agency may provide services to the individual.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider Agency

Appendix C: Participant Services

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

Service Type: Other Service
Service Name: Supported Living - Transition

Provider Category:

Agency

Provider Type:

Provider Agency

Provider Qualifications

License *(specify):*

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers may demonstrate substantial equivalency to tribal code or law.

Certificate *(specify):*

Other Standard *(specify):*

Provider verifies employee qualifications at the time employee is hired 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

Verification of Provider Qualifications

Entity Responsible for Verification:

Provider Agency
PIHP

Frequency of Verification:

Provider verifies employee qualifications at the time employee is hired.
Credentialing at 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:

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):*

Supported Living provides a flexible partnership that enables a person/s 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 person/s. The service includes direct assistance as needed with activities of daily living, household chores essential to the health and safety of the individual/s, budget management, attending appointments, and interpersonal and social skills building to enable the individual to live in a home in the community. Training activities, supervision, and assistance may be provided to allow the person 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. Transportation to and from the individuals and points of travel in the community is included to the degree that they are not reimbursed by another funding source.

This service is distinct from Residential Supports in that it provides for a variety of living arrangements for individuals who choose to live in their own home versus the home of a provider. A person'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. Persons living in a Supported Living arrangement shall choose who lives with him/her, are involved in the selection of direct care staff, and participate in the development of roles and responsibilities of staff. Persons receiving Supported Living have 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 person/s to move if the person/s changes service providers.
b.Own, be owned by, or be affiliated with any entity that leases or rents a place of residence to a person if such entity requires, as a condition of renting or leasing, the person 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 persons 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 must have staffing available in the case of emergency or crisis. Requirements for the person/s safety in the absence of a staff person shall be addressed and may include use of tele care options. When assessed to be appropriate Assistive Technology elements may be utilized in lieu of direct care staff.

To ensure the intent of the definition to support 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, person's 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. In addition, it also includes step-parents, non-minor step-children and step-siblings and non-minor adoptive relationships. All persons 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 shall not include payment for services provided by the spouse of a person or to family members as defined in this service definition or legal guardian. When Supported Livings is provided through self- direction an Employer of Record shall not provide direct supports to the member.

A Supported Living home must have no more than three (3) residents including any live-in caregiver providing supports per SL2011-202/HB509. A live-in caregiver is defined as an individual unrelated to the person and who provides services in the person's home through the Supported Living provider agency and is not on the lease.

The provider must develop an individualized staffing plan and schedule. The staffing plan is based on the person/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 person 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.

Reimbursement for Supported Living shall 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 person and who provides services in the person's home. Reimbursement shall not include the cost of maintenance of the dwelling. Residential expenses, e.g. phone, cable, food, rent) shall 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 must develop an individualized staffing plan and schedule. The staffing plan is based on the person/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 person 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 the Individual Budget Tool and other evidence of support need. The SIS Level is only one piece of evidence that may be considered.

Level One: Level A and B
• Level one is intended to serve persons who require 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 person but typically 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 person/s 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 person/s. Typically, the live-in caregiver or staff must be onsite but not awake at night or appropriate technology may be used to ensure supervision.
Level Three: Levels E, F and G

• Level 3: The beneficiary requires continuous supervision including awake overnight staff in order to remain safe and healthy. Typically, Person/s receiving Level Three supports include arrangements in which a person/s is living in his/her own home with overnight and awake staff or appropriate technology may be used to ensure supervision as identified in the ISP.

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

Special Needs Adjustment
A special adjustment is available for Levels 1-3. The adjustment does not change the Level designated for the person, but adjusts the Level to meet one or more of the following circumstances. There is not a limit on the number of times Special Adjustment payments can be used. Each request for an adjustment is based on the person's unique circumstance, needs and care planning review process:
a. The individual 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 person 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 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 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. Persons who require a continued Special Needs Adjustment due to medical or behavioral health issues may be reassessed for appropriateness of Level.

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

person. The following exception applies:

Respite may be used by individuals living in a Residential or Supported Living setting when the individual is accessing a 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.

Remote monitoring:
Monitoring systems using video, web-cameras, or other technology are available on an individual basis, when the individual and the support team agrees it is appropriate and meets the health and safety needs of the individual. Remote support technology may only be used with full consent of the individual and his/her guardian and that consent is indicated in the individual's plan of care (including if the individual has a reference for the location of any monitoring equipment, such as where they are comfortable with a camera being located in their home). The individual/ guardian can revoke consent if they are no longer interested in monitoring systems.
Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required to ensure health and safety, virtual support may not be provided.

Reimbursement for Supported Living shall 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 person and who provides services in the person's home. Reimbursement shall not include the cost of maintenance of the dwelling. Residential expenses, e.g. phone, cable, food, rent) shall 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 must develop an individualized staffing plan and schedule. The staffing plan is based on the person/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 person 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 the Individual Budget Tool and other evidence of support need. The SIS Level is only one piece of evidence that may be considered.

Level One: Level A and B
• Level one is intended to serve persons who require 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 person but typically 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 person/s 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 person/s. Typically, the live-in caregiver or staff must be onsite but not awake at night or appropriate technology may be used to ensure supervision.
Level Three: Levels E, F and G

• Level 3: The beneficiary requires continuous supervision including awake overnight staff in order to remain safe and healthy. Typically, Person/s receiving Level Three supports include arrangements in which a person/s is living in his/her own home with overnight and awake staff or appropriate technology may be used to ensure supervision as identified in the ISP.

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

Special Needs Adjustment
A special adjustment is available for Levels 1-3. The adjustment does not change the Level designated for the person, but adjusts the Level to meet one or more of the following circumstances. There is not a limit on the number of times Special Adjustment payments can be used. Each request for an adjustment is based on the person's unique circumstance, needs and care planning review process:
a. The individual 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 person 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 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 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. Persons who require a continued Special Needs Adjustment due to medical or behavioral health issues may be reassessed for appropriateness of Level.

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

person. The following exception applies:

Respite may be used by individuals living in a Residential or Supported Living setting when the individual is accessing a 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.

Remote monitoring:
Monitoring systems using video, web-cameras, or other technology are available on an individual basis, when the individual and the support team agrees it is appropriate and meets the health and safety needs of the individual. Remote support technology may only be used with full consent of the individual and his/her guardian and that consent is indicated in the individual's plan of care (including if the individual has a reference for the location of any monitoring equipment, such as where they are comfortable with a camera being located in their home). The individual/ guardian can revoke consent if they are no longer interested in monitoring systems.
Participants will be provided initial and ongoing training, support, and assistance using the technology necessary for the remote delivery of this service. The participant will have full control of virtual support devices and have the ability to turn on and off the device and end services any time they wish. In order to ensure the health and safety of the participant, the plan of care team must assess and monitor the appropriateness and effectiveness of virtual support with the participant. The Individual Service Plan (ISP) must include a justification statement explaining how remote support assures health and safety If it is determined that in-person assistance is required to ensure health and safety, virtual support may not be provided.

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

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.

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

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

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

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

Provider Specifications:

Provider Category	Provider Type Title
Individual	Employee in a self-directed arrangement
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:
Individual
Provider Type:

Employee in a self-directed arrangement

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Staff that work with participants are approved by employer of record OR recommended by Managing Employer and approved by Agency with Choice that work with participants:

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

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

- Agencies with Choice follow the NC State Nursing Board regulations
- Has an arrangement with an enrolled crisis services provider to respond to participant crisis situations

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

Verification of Provider Qualifications

Entity Responsible for Verification:

Employer of Record
Agency with Choice
PIHP

Frequency of Verification:

Prior to hiring
Employer of record annually
Agency with Choice as specified for provider agencies

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 Providers 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 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
Upon enrollment as a provider, the Agency With Choice must have achieved national accreditation with at least one of the designated accrediting agencies.
Employers of Record have an arrangement with an enrolled crisis services provider to respond to person/s crisis situations.

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 flexibility in responding to the needs of an 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. 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. Evaluation by an adapted vehicle supplier with 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:
2. Door handle replacements
3. Door modifications
4. Installation of raised roof or related alterations to existing raised roof system to approve head clearance
5. Lifting and/or lowering devices
6. Devices for securing wheelchairs or scooters
7. 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
8. Handrails and grab bars
9. Seating modifications
10. Lowering of the floor of the vehicle
11. Modifications for accessibility

• Member who live in Residential Supports or who live in licensed facilities, and use a vehicle that belongs to them and can transition to other settings with the member may access Vehicle modification service.
• 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.
• 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.

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

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

☒ **Provider managed**

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

☐ **Legally Responsible Person**

☐ **Relative**

☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Commercial/Retail Businesses
Individual	Specialized Vendors

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):*

Applicable state/local business license

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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:

Individual

Provider Type:

Specialized Vendors

Provider Qualifications

License *(specify):*

Applicable state/local business license

Tribal providers are not subject to licensure but substantial equivalency. Tribal Providers 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 §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*
- ☐ **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- ☒ **As an administrative activity.** *Complete item C-1-c.*
- ☐ **As a primary care case management system service under a concurrent managed care authority.** *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:

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, community based provider or Tribal Care Coordination.

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 Tailored Plan/PIHP 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 Tailored Plan/PIHP must report such disclosures to DHB within 20 working days from the date the Tailored Plan/PIHP 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 Tailored Plan/PIHP.

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 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 Innovations service provider qualifications, unlicensed provider agencies who contract to provide North Carolina Innovations services must also conduct criminal background checks on all prospective employees who may have direct access to individuals served. The PIHP 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.

When beneficiaries elect the Individual and Family Directed Services Option, criminal background checks must be obtained for all prospective employees for the Employer of Record Model submitted to the Financial Support Services agency. If the employee has a conviction listed in § 108C-4 but not on the Convictions Barring Employment list below, the EOR may elect to hire the employee if the EOR feels the employee can perform the duties of their job while also maintaining the beneficiary’s health and safety.

Criminal background checks are provided without charge as a component part of Financial Supports Services in the employer of record model. In the Agency with Choice Model, the agency obtains a criminal background check prior to hiring any employee referred for hire by a Managing Employer.

The PIHP reviews the provider agency (including agencies offering self-direction under Agencies with Choice options) 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 PIHP, no less than every three years. Annually, the PIHP reviews employer of record personnel practices to ensure that there is documentation of the criminal background check for each employee hired.

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

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

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been

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

G.S. 131E-256, 10 A NCAC, requires the Tailored Plan/PIHP 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 Tailored Plan/PIHP must report such disclosures to DHB within 20 working days from the date the Tailored Plan/PIHP receives such disclosures. DHB will report such disclosures to the HHS-OIG within 20 working days of notification by the Tailored Plan/PIHP.

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 IDD who contract with the PIHP 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 http://www.ncdhhs.gov/dhsr/hcpr/index.html.

When beneficiaries elect the Individual and Family Directed Services Option, abuse registry screenings must be conducted for any job applicant under serious consideration. Abuse registry screenings are provided without charge as a component part of Financial Supports Services in the employer of record model. In the Agency with Choice Model, the agency obtains an Abuse Registry Screening prior to hiring any employee referred for hire by a managing employer.

The PIHP reviews the provider agency (including Agencies with Choice) 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, no less than every three years. The PIHP 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 to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

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

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure

that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

☐ **Self-directed**

☐ **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○ **The state does not make payment to relatives/legal guardians for furnishing waiver services.**

◉ **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

This policy applies to waiver beneficiaries ages 18 and older who live with a relative who is employed by a waiver provider agency. Waiver beneficiaries under the age of 18 may receive services provided by a relative who is residing in their home, as consistent with Community Living and Support definition.

Relatives are defined as individuals related by blood or marriage to the waiver beneficiary who resides in and out of their home. Providers hiring the guardian to provide direct supports must verify the guardian meets criteria as stated in N.C G.S 35A 1213 subsection (f) 1-3: (f) An individual who contracts with or is employed by an entity that contracts with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services may not serve as a guardian for a ward for whom the individual or entity is providing these services, unless the individual is one of the following:
(1) A parent of that ward. (2) A member of the ward's immediate family, a licensed family foster care provider, or a licensed therapeutic foster care provider who is under contract with a local management entity (LME) for the delivery of mental health, developmental disabilities, and substance abuse services and is serving as a guardian as of January 1, 2013. For the purposes of this subsection, the term "immediate family" is defined as a spouse, child, sibling, parent, grandparent, or grandchild. The term also includes stepparents, stepchildren, stepsiblings, and adoptive relationships. (3) A biologically unrelated individual who was serving on March 1, 2013, as a guardian without compensation for guardianship services. (1987, c. 550, s. 1; 2004-203, s. 31(a); 2012-151, s. 12(c); 2013-258, ss. 1, 2.)

Community living and Support is the only waiver service that may be provided by a relative who resides in the home of the Waiver individual

It is recommended that a relative residing in the home of the beneficiary provide no more 40 hours per week of service to the person. This must be reported to the PIHP, but does not require approval by the PIHP.
If more than 40 hours are requested to be provided by relatives residing in the home of the beneficiary, approval must be obtained from the PIHP. The ISP should include justification as to why there is no other qualified provider to provide Community living and Support. Assurances must be documented of provider choice, and that the individual will not be isolated from their community. In exceptional situations, up to 84 hours per week may be approved. This is the total number of hours that one relative may provide regardless of the number of beneficiaries residing in the home. Exceptional Situations may include Individuals living in a remote area unserved or underserved by other providers. Individuals with documented complex medical or behavioral needs, where having a family member (chosen by the member) would be the most appropriate provider of care. These members may experience documented difficulty in identifying staff. In these situations, there is documented evidence that numerous providers have been unsuccessful at appropriately supporting the individual.

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 Coordinators monitor through on-site monitoring and documentation review to ensure that payment is made only for services rendered and that the services are furnished in the best interest of the 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.

Employers of Record and Managing Employers participating in the Individual Family Directed option may not be employed to provide waiver services.
Provider agencies, Employers of Record and Agency with Choice in conjunction with the Managing Employer must monitor the relative or legal guardian’s provision of the service on site and at a minimum of one time per month.

○ **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. The PIHP must 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 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. 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.

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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 and percent of providers determined to be continually compliant with licensing, certification, contract and waiver standards according to PIHP monitoring schedule. Numerator: Number of 1915 C waiver providers who had a review

completed and were found to be compliant Denominator: Total number of 1915 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 =
☒ **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:
Number and percent of 1915 (c) waiver providers with a plan of correction.
Numerator: Number of 1915(c) waiver providers with a plan of correction.
Denominator: Total number of 1915 (c) waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Profile Investigation DATA

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:

Performance Measure:
Number and percent of new licensed providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services Numerator: Number of new licensed providers who meet the requirements of licensure, certification, and/or other standards prior to furnishing 1915 c waiver services Denominator: Total number of new licensed 1915 c Waiver 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 =
☒ **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:

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:
Number and percent of monitored non-licensed and non-certified providers, who have been found to be out of compliance and have a plan of correction. Numerator: Total number of monitored non-license and noncertified found to out of compliance and required a plan of correction. Denominator: total number of monitored providers non-licensed and noncertified providers.

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:

Performance Measure:
Number and percent of monitored non-licensed, non-certified providers that are compliant with 1915 c waiver requirements. Numerator: Number of monitored non-

licensed, non- certified providers that are compliant with 1915 c waiver requirements.
Denominator: Number of non-licensed, non-certified providers reviewed.

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**

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:

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:
Number and percent of monitored provider agencies wherein all staff completed all mandated training for 1915(c) Waiver. Numerator: Number of provider agencies monitored wherein all staff have completed all mandated training. 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 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):*

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

The 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 Tailored Plan/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 Tailored Plan/PIHP reporting during the annual EQRO.

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:
(1) Adult beneficiaries (Age 22 and over) who receive Residential Supports or Supported Living: No more than 40 hours per week is authorized for any combination of Community Networking, Community Living and Support, Day Supports and/or Supported Employment services.
(2) Child beneficiaries (Through Age 21) who receive Residential Supports: During the school year, no more than 20 hours per week is authorized for any combination of Community Networking, Day Supports and/or Supported Employment services. When school is not in session, up to 40 hours per week is authorized for any combination of Community Networking, Community Living and Support, Day Supports and/or Supported Employment services.
(3) Adult beneficiaries (Age 22 and over) who live in private homes: No more than 84 hours per week is authorized for any combination of Community Living and Support, Community Networking, Day Supports and/or Supported Employment services.
(4) Child beneficiaries (Through age 21) who live in private homes: During the school year, no more than 54 hours per week is authorized for any combination of Community Living and Support, Community Networking, Day Supports and/or Supported Employment services. When school is not in session, up to 84 hours per week is authorized for any combination of Community Living and Support, Community Networking, Day Supports and/or Supported Employment services.

Adult and child beneficiaries who live in private homes with intensive support needs may receive up to 12 additional hours of Community Living and Supports per day based on the authorization guidelines outlined in the definition. For all services in the above sets of services in 1–4, if a person is getting only one service out of the set of services subject to a limit, the limit is applied to the one service received.

Assistive Technology, Equipment and Supports and Home Modifications are limited to a combined total of $50,000 over the life of the waiver.

☐ **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.

Budget Guidelines by Level of Support:
The only individual budget limit is $184,000 per year in Innovations waiver services. An individual may exceed the $184,000 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.

This individual may live with family members if the family member is receiving Supported Living, other disability specific services, a spouse, or a minor child.
However, there is a budget guideline used in the planning process. Based on an assessment process and/or other factors, beneficiaries are assigned to individual budget guidelines. These Individual Budget Guidelines are not a limit on what may be requested/authorized for the beneficiary. The only budget limit is the $184,000 per year waiver limit.

Basis of the Individualized Budget:

The Individualized Budget Tool is designed to estimate the amount of services a person would typically need and provides a guideline to be used in the planning process. The Budget Guideline categories are based on SIS score, age, and residential situation.

The assessment instrument used to measure individual support needs is the Supports Intensity Scale (SIS) assessment tool developed by the American Association on Intellectual Disabilities and Developmental Disabilities (AAIDD). The SIS is a valid, reliable instrument for assessing the level of an individual's support needs in major domains of daily living as well as behavioral and medical needs. The SIS has been in use by the original demonstration PIHP, Cardinal Innovations, for 6 years. Cardinal was a national norming site for the child version (for children below the age of 16) of the SIS. The SIS assessment is a requirement for continued participation in the waiver.

SIS Assessors are trained by AAIDD or by AAIDD certified trainers.

The SIS has been enhanced by supplemental questions that include four topics: community safety risk (convicted and not convicted), extreme self-injury risk, and extraordinary medical care (risk) for individuals whose supervision for those concerns requires 24 hour eyes on supervision. Individuals who are at high need/risk in these categories receive services within the top two budget categories.

The categories of need (Categories A-G) were adopted from work performed by other jurisdictions employing the SIS as the assessment instrument in resource allocation models. These categories were derived based on the SIS assessments, additional information concerning the participants' living arrangement (e.g., lives with family or resides in a community residential setting) and the amount of service expenditures for the individuals assessed.

The specific categories of need were derived in other jurisdictions by employing statistical techniques to identify SIS elements that were statistically significant in explaining differences in service expenditures. All waiver participants are assigned to an Individualized Budgeting category on either the Residential Support Individualized Budgeting Tool (for those individuals that require residential services) or the Non-Residential Individualized Budgeting Tool (for those individuals that do not require residential services).

The Individualized Budgeting Category divides the population by age into adults and children. Children are defined as less than 22 years of age and adults are defined as 22 years of age or over. Individuals under the age of 22 who have graduated from high school are considered as adults for the purpose of budgeting. As the SIS is not utilized for children under the age of five, children under 5 and their teams will plan for services utilizing the traditional person centered planning process.

The budget amount for each cell of the Individualized Budget Categories was developed based on an analysis of historical expenditures of the "Base Budget Services" for individuals participating in NC Innovations and the previous IDD waiver, guideline service packages, and the average rates paid by the PIHPs to providers.

The SIS tool is administered to all waiver participants (five years of age and older) at least every three years for adults and every two years for children.

Services Included in the Individualized Budgeting Categories:
Waiver services defined as “Base Budget Services” are included in the Individualized Budgeting Categories. “Base Budget Services” are:
1. Community Networking Services
2. Day Supports
3. Community Living and Support
4. Respite
5. Supported Employment

Not Base Budget Services:
1. Residential Supports
2. Supported Living
3. Assistive Technology Equipment and Supplies
2. Community Navigator (previously named Community Guide)
3. Community Transition Services
4. Crisis Services
5. Financial Support Services
6. Individual Goods and Services
7. Home Modifications
8. Natural Supports Education
9. Specialized Consultation Services
10. Vehicle Modifications

The services in “Base Budget” and the services not included in the “Base Budget” together may not total more than the waiver cost limit of $184,000. This individual budget limit of $184,000 per year in Innovations waiver services may be exceeded based on the criteria listed in Appendix B.

Individual Budget Guidelines:
The budget amounts in the Individualized Budgeting Categories are guidelines for the Base Budget services in a member’s Individual Support Plan.

The Individualized Budgeting Tool and the SIS are tools that are used in the planning process. The individual has an assigned Base Budget Guideline, which is not a limit on the amount of services that can be requested/approved, but along with the SIS is used as information and as a guideline for base budget services. Services will be approved above the assigned Base Budget Guideline if the PIHP determines that services are medically necessary. If any of the services that are requested by the beneficiary are denied, then due process will be applied.

In developing the Individual Support Plan, the planning team will be guided by the person’s support needs as identified in the SIS assessment, their age and their selection of living arrangement along with all other evidence. The planning team will include in the plan all services the individual/family/team believes to be medically necessary regardless of the individual budget guideline or SIS. All Individual Support Plans are reviewed by the PIHP Utilization Management Department for final determination and authorization of funding.

Adjustments to the Budget Limits:
The Budget amounts will be adjusted in future years to reflect the service component of the approved capitation rate paid for this waiver. In the event that the service component of the approved capitation rate paid for this waiver is less than or more than the weighted average of budget amounts (plus an allowance for services that are not included in “Base Budget Services”), all budget amounts will be uniformly adjusted on a percentage basis to meet the capitation rate. However, the level of services approved for any individual may not be reduced because of a change in capitation payments. The level services are approved, reduced or denied solely based on the needs of the beneficiary, based on all of the evidence in that case. The service component of the approved capitation rate is the total capitation rate less amounts for administration, risk, and services not included in the

1915(c) waiver.

In addition, the overall Individualized Budgeting Tool will be periodically evaluated to confirm that the underlying elements upon which they are based continue to be reliable predictors of necessary resources based on assessed support needs. In the event that the categories of need are modified as a result of this evaluation or based on experience, the State will submit a waiver amendment to CMS before implementation.

Availability of Methodology:
A description of the methodology used by the other jurisdictions to develop the categories of need algorithm is available to CMS upon request. The methodology for determining the Individualized Budgeting Tool is available for public review and inspection upon request from DHB.

Adjustments for Individual Circumstances:
The Tailored Care Manager/ Care Coordinator can call an ISP review meeting in the event of an increased need for service by a waiver beneficiary. If the interdisciplinary team review determines a need for increased intensity of services, the PIHP Utilization Management Department or designee may approve an increase in intensity of services. Changes in services (within service definition limits) will not be time limited or temporary unless based on an expected change in the individual's needs. Temporary increases are for unplanned/unexpected circumstances that change the participant's support needs for a time-limited period.

If the interdisciplinary team determines that a waiver beneficiary has an extended need for an increased intensity of supports needs (beyond six months), this will be considered a permanent support needs change. If the individual changes living arrangement (from home to a community based residential facility or from a community based residential facility to home), this will move the beneficiary between the Non-Residential Individualized Budgeting Tool and the Individualized Budgeting Tool. Also, the participant with a change in needs may be re-assessed and, if supported by the results of a new SIS assessment, moved to a higher category of support need. However, no change in the budget category or living arrangement can be required in order to approve medically necessary increases in services. Services in excess of the Individual Budget will be approved if medically necessary without moving to a higher category of support need.

Whenever services are requested in the Individual Support Plan, the will indicate in the ISP why the individual needs those services and supports. This justification should include information related to the behavioral, safety, health and/or welfare support needs of the individual. If a plan is submitted in excess of the individual's budget guideline, Utilization review will approve if the service is medically necessary for that individual and the request is otherwise approvable under the waiver.

Beneficiary Safeguards:
Medically necessary services in excess of the Individual Budget will be approved without moving to a higher category of support need.

Regardless of the base budget amount, Tailored Care Manager/ Care Coordinator will prepare justification for why the individual needs services and supports are necessary for the individual.

This justification may include information related to behavioral, safety, health and/or welfare support needs specific to the individual. As reported in Appendix B-2 Individual Cost Limit, the participant will be referred to an ICF-IID if their care cannot be met within the $184,000 waiver cost limit.

Waiver beneficiaries are notified of their Individual Budget Guidelines through standardized letters issued by the applicable PIHP.

☐ **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 and how they meet federal HCB Settings requirements, at the time of submission and in the future.

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 ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

The Home and Community Based Services (HCBS) final rule directed the Department of Health and Human Services (DHHS) to ensure individuals receiving services through its 1915(c) waivers have full access to the benefit of community living and the opportunity to receive services in the most integrated setting possible. North Carolina conducted an internal review of its state statutes and regulations governing Medicaid HCBS waiver services and assessed that the HCBS Final Rule applies to three 1915(c) waivers and select services offered under the 1915(b)(3) benefit operated by North Carolina. Services under the Innovations wavier were provided in the following settings type: Services offered at the setting type: -individuals may receive services in their home or in the home of their family, in facilities licensed under 10A NCAC 27G.5601(c)(2) and (3) (referred to as 5600(b) and (c) group homes) and licensed under 10A NCAC 27G.5601(c)(6) (referred to as Alternative Family Living arrangements (or licensed AFLs) (5600(f))/unlicensed residential settings serving one adult (referred to as unlicensed AFLs), in the community, Adult Day Health/Adult Day Care facilities certified under NC GS 131 D), Day Support facilities licensed under 10A NCAC 27G.2301(referred to as 2300 facilities) and 10A NCAC 27G.5400, Institutional Respite may be provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) facility.

North Carolina assessed waiver services to identify settings that were presumed to have institutional characteristics, including qualities that would isolate HCBS beneficiaries, and determined which services would be impacted by the HCBS Final Rule. Services were separated into two categories, Impacted and Non-Impacted services. Impacted Services were services identified to be provided in a setting that was presumed to have institutional characteristics. Non-Impacted services were services identified to be provided in a setting not presumed to have institutional characteristics. Therefore, the North Carolina HCBS State transition plan was developed to ensure compliance for Impacted services. The following services were considered to be impacted by the final regulation that specifically addressed the HCBS settings requirements of the HCBS regulations: NC Innovations Waiver services include Residential Supports (provided in 5600 b and c group homes, licensed 5600(f) AFLs, and unlicensed AFLs), Day Supports (provided in 2300 licensed day programs and adult day health/care programs certified under 131D), and Supported Employment.

Initial compliance and ongoing monitoring for continued HCBS compliance continues through Provider Self-Assessments (PSA) submitted through the NC HCBS database. The Provider Self-Assessment allows providers to read and respond to questions that ensure settings are integrated in the community and beneficiary rights are met. Providers were required to included HCBS settings rules requirements in their policies and procedures. The PSA allowed providers to discuss and explain settings rules were included in their policies and procedures. Providers who did not fully address questions submitted their policies for review. Through onsite monitoring All settings where residential supports, day supports, and adult day health, and support employment corporate settings are fully compliant and were not included in the State's Settings Transition Plan..

North Carolina's ongoing monitoring activities and functions will ensure continuous, long-term compliance to the HCBS settings regulation in Impacted and Non-Impacted Services. HCBS Efforts have been incorporated into existing monitoring and performance improvement policies as evidence of compliance and integration with HCBS Final Rule. Through on-site monitoring completed by Care managers/Care coordinator processes. To ensure long-term compliance to HCBS settings regulation for all HCBS settings (Impacted and non-Impacted services) beyond the transition period. The NC DHHS via the Tailored plan will continue to review HCBS Provider Self-Assessments for 100% compliance of new sites (before service delivery) through utilizing the HCBS Provider Self-Assessment that NC DHHS created during the transition period.
It is important to note that New HCBS settings related to Residential Supports, Day Supports, Adult Day Health, and Supported Employment Corporate setting, which were not part of the transition period must be in full compliance prior to the provision of HCBS waiver services. The DHHS, in collaboration with Tailored plans will: 1) determine if individual provider assessments and provider policies and procedures are compliant with all aspects of the HCBS Final Rule, 2) identify providers that need technical assistance to ensure compliance, and 3) identify providers out of compliance and assess their intent and capacity with technical assistance to comply. Like the assessment process during the transition period, this will be accomplished using a unified process using a standardized e-Review tool and companion document for evaluation of
provider compliance. Additional evidence may be requested, or subsequent reviews conducted, as needed, to further assess compliance with all aspects of the HCBS. settings rule. Assurance of compliance with HCBS settings rules will be identified through, monthly HCBS service monitoring completed by Care manager/Care coordinators, My Individual Experience surveys (MIE), NC DHHS quality assurance monitoring. NC Medicaid is in the process of implementing an annual or biannual attestation Provider Self-Assessment process. Providers will be required to attest their sites continue to meet HCBS settings final rule, through a review and attestation of each PSA question in the HCBS database. Validation of this attestation will be completed through a Care manager/Care Coordinator on site monitoring visit.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (1 of 8)

State Participant-Centered Service Plan Title:

06/28/2024

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 *(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 as defined in North Carolina Administrative Code at 10A NCAC 27G .0104 A Qualified professional is equivalent to the federally defined qualified developmental disabilities professional.

☐ **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. *Select one:*

◉ **Entities and/or individuals that have responsibility for service plan development may not provide other direct waiver services to the participant.**

○ **Entities and/or individuals that have responsibility for service plan development may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify:*

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 toolkits are available to gather information and enable the beneficiaries to share information with the ISP team. The participant can complete the toolkit with the assistance of the Tailored Care Manager / Care Coordinator or support providers as needed. Based on the unique needs of the beneficiary, a decision can be made to use one toolkit, multiple toolkits or none at all.
(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/Care Coordinator will ensure that the person is invited to the ISP meeting as well. For Tribal members, the Tribal provider / care managers in required with the beneficiary's approval.

For members in the Tribal Options, the TCM will complete the Individual Support Plan in conjunction with the EBCI Tribal Option Care Manager and/or the tribal medical home and Cherokee Central Schools (if applicable) and not in isolation.

Appendix D: Participant-Centered Planning and Service Delivery

D-1: Service Plan Development (4 of 8)

d. Service Plan Development Process. In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Individual Support Plan (ISP):

ISP Essential Elements:

All current Individual Service Plans include the following Essential Elements and all Future individual Plans must include the following elements:

A. My Choices and Supports: Where I choose to live, How I choose to spend my day, Supports I Need, My Preferences
B. My Support Needs: Medical Support Needs and Behavioral Health Support Needs
C. When I may need Extra Help: Things that may start a Crisis, What you can do to help me avoid the Crisis, What to do to get me out of a Crisis
D. Crisis Planning: What A Crisis Looks Like for Me, Who to call, and How to Support Me Best
E. My Action Plan (goals): Who Helps me, How and How Often (Service/frequency), Where I Am Now, Where, Target Date *Every Service must have a goal.
F. Demographic Information and Data Elements
G. Risk Support Needs Assessment
H. ISP Approved Signature Page

Not all ISPs will look the same as beneficiaries on the Innovations Waiver have different needs, wants, and methods to tell their person centered story. 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 Innovations 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 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. The Tailored Care Manager/Care Coordinator must send the completed ISP and all required documentation so that it is received by the PIHP no later than 60 days after the Level of Care approval date (the date that it is approved by the PIHP). If the ISP is not received within the time limit, a new PIHP Level of Care Eligibility Determination Form will have to be obtained and the approval process reinitiated. Individuals are moved onto the waiver and into services as quickly as possible. The dates outline in the waiver are the maximum allowable. If an interim plan is utilized, the plan must be updated as more information is gathered. This interim plan allows for services to begin immediately, if needed for emergency situations.

Annual Updates – Annual updates are due during the birth date month of the beneficiary. For example, the annual update for a participant 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 participant'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 participant 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 participant 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 participant 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/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 participant, 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 Manager/Care Coordinator:

Each NC Innovations Waiver participant is assigned a Tailored Care Manager/Care Coordinator. Tailored Care Managers/Care Coordinators are Qualified Professionals under the North Carolina credentialing system and are competent in the person centered planning process. 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. Care Coordinators will perform the person centered planning when the individual declines Tailored Care Management. Wherever Tailored Care Manager is noted, this may be a Care Coordinator if the individual declines Tailored Care Management. Through the NC Innovations Risk/Support needs assessment the Tailored Care Manager/Care Coordinator will identify if individual is linked to a primary care professional. If the person is not linked to primary care, the Tailored Care Manager/Care Coordinator will assist the individual in obtaining a primary care provider. 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/location that is desired by the beneficiary. Each team member receives a written invitation to the meeting.

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. Person-centered planning (and as a result the person centered plan) should address whole person care- physical and behavioral health needs as well as other needs such as housing, food stability, etc. to improve health/life outcomes. It is a process of building effective/collaborative partnerships with participants and working in partnership with them to create a road map for reaching the beneficiary's goals. The planning process is directed by the beneficiary and identifies strengths and capabilities, desires and support needs. 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. The member may also choose to access the Community Navigator service to prepare for his/her ISP or develop a Person Centered Plan to inform the ISP.

At the time the beneficiary enters the waiver, information is shared with them regarding the NC Innovations waiver. The beneficiary's Tailored Care Manager/Care Coordinator is available to answer any questions that the beneficiary/family may have regarding available services. The Tailored Care Manager works with the beneficiary/family to develop the ISP. That 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/Care Coordinator, other 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 Innovations Level of Care tool. 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 toolkits 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 Innovations 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 Supports Intensity Scale (SIS), 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, developmental testing, physician recommendations, psychological testing, adaptive behavior scales or other evaluations as needed.

Self-Direction Assessment: This is an assessment to determine what types of support the participant or legally responsible person needs to self-direct wavier services if self-directed services are requested.

Prior to the Person Centered Planning Meeting: The Tailored Care Manager/Care Coordinator offers the beneficiary/legally responsible person information about Individual Family Supports and arranges for training if the beneficiary/legally responsible person is interested in learning more about individual/family directed supports. The Tailored Care Manager/Care Coordinator informs the beneficiary/legally responsible person of the beneficiary's individual budget amount and answers any questions regarding the budget. The Tailored Care Manager also provides the amount of the self-directed budget if the beneficiary/legally responsible person desires to self-direct one or more services. The Tailored Care Manager/Care Coordinator 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 disabilities 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 family of the minor or adult beneficiary, who are able to serve as important contributors. The person centered planning process enables and assists the beneficiary to identify and access a personalized mix of non-paid and paid services that 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 participant 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/Care Coordinator reassesses each beneficiary's needs at least annually and develops an updated ISP 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 TTailored 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 will inform the beneficiary of the right to request a fair hearing. The Tailored Care Manager/Care Coordinator 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 "When I May Need Extra Help"(Crisis Prevention Plan) is incorporated within the ISP. The "When I May Need Extra Help" 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 "When I May Need Extra Help" Plan should include what positive skills the participant 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 "When I May Need Extra Help" Plan is an active and living document that is to be used in the event of a crisis. After crisis, the participant 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 school based services, generic community resources and Medicaid state plan services. The Tailored Care Manager/Care Coordinator is responsible for linking the beneficiary to primary care. The Tailored Care Manager makes sure that the ISP contains a plan for coordinating services, including the Tailored Care Manager/Care Coordinator's responsibility for overall plan coordination of waiver and other services.

The ISP planning team will regularly discuss employment of relatives/guardians to provide waiver services when they live in the home of the waiver beneficiary to ensure that the waiver beneficiary has requested this staffing choice, that no barriers to full community membership and relationship building with non-family members occurs, that the staff qualifications needed and unique training needs of the waiver beneficiary are met and that the role of relative/ legal guardian clearly encourages autonomy and skill building for independence in the community. Agreement of the participant in this arrangement if approved by the PIHP and any identified barriers that need to be addressed will be documented in the ISP.

The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. Tailored Care Manager will work with participants 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 providers who are providing services per the ISP.

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 Tailored Care Manager/Care Coordinator developing the plan are employees of the PIHP in a separate unit from the individuals authorizing the plan. The Tailored Care Manager/Care Coordinator 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. or the individual's service budget.

Updates/Changes to the ISP:

The Tailored Care Manager/Care Coordinator works with the participant 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/Care Coordinator is ultimately responsible for monitoring and overseeing the implementation of the ISP. The Tailored Care Manager/Care Coordinator monitors the provision of services through observation of service provision, review of documentation and verbal reports. The Tailored Care Manager/Care Coordinator maintains close contact with members of the person centered planning team to ensure that the ISP is implemented as intended.

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 Innovations Risk/ Support Needs Assessment or other DHHS approved 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 works with the beneficiary, family and other team members to complete the assessment.

1. The NC Innovations 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, participants and their family and the Tailored Care Manager.

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 Manager/Care Coordinator , 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 participant. Tribal Members will also be education on Tribal Providers that are available for service provision. 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 are employed by the PIHP in a separate unit from the individuals authorizing the plan. ISP approval occurs locally at the PIHP. DHB authorizes the PIHP to approve ISPs through routine monitoring of the plan of care approval process. A percentage of child and adult ISP’s are reviewed by DHB staff during the External Quality Review (EQR) process. The EQR vendor selects 10 files from members on the NC Innovations waiver during each review. The EQR vender also completes interviews with the Tailored Care Manager/Care Coordinator Teams. On a routine basis, DHB staff review performance measures related to ISPs. 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 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 and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The Tailored Care Manager/Care Coordinator is responsible for monitoring the implementation of the ISP. Services are implemented within 45 days of ISP approval. The PIHP Tailored Care Manager 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 whose services are provided by guardians and relatives living in the home of the beneficiary receive monthly face-to-face monitoring visits.
(3) Beneficiaries who live in residential programs receive face-to-face monitoring visits monthly.
(4) Beneficiaries who choose the individual family directed service option receive face-to-face monitoring visits monthly.
(5) For months that beneficiaries do not receive face-to-face monitoring, the Tailored Care Manager has telephone contact to ensure that there are no issues that need to be addressed.
(6) 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 should ensure that enrollee 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.

Follow-Up and Remediation is addressed by the state through:

Service Plan monitoring occurs through the collection and review of performance measures. The External Quality Review process also looks at a sample of service plans to ensure that service plans are being revised as needed and members needs are being addressed. Furthermore, the EQR validates the following performance measures:
Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals
Proportion of Individual Support Plans that address identified health and safety risk factors
Percentage of participants reporting that their Individual Support Plan has the services that they need Proportion of individuals for whom an annual plan and/or needed update took place
Proportion of new waiver participants who are receiving services according to their ISP within 45 days of ISP approval.
Proportion of participants who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan
Proportion of PCPs that are completed in accordance with DHB requirements.
Proportion of records that contain a signed freedom of choice statement
Proportion of participants reporting their Tailored Care Manager helps them to know what waiver services are available

b. Monitoring Safeguards. *Select one:*

- ○ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may not provide other direct waiver services to the participant.**
- ◉ **Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare may provide other direct waiver services to the participant.**

The state has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify:*

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 Tailored Care Management and services will not work in the same unit.

Individuals providing Tailored Care Manager/Care Coordinator 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

For beneficiaries that are not members of Federally Recognized Tribes, the Tailored Care Manager or Care Coordinator may not provide other direct waiver services to the beneficiary and may not be affiliated with a service

Appendix D: Participant-Centered Planning and Service Delivery

Quality Improvement: Service Plan

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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:
The number and percent of beneficiaries reporting that their Individual Support Plan has the services that they need. Numerator: Number of 1915 C Waiver beneficiaries who indicate that the ISP contains the services and supports they need Denominator: Total number of reviewed Individual Support Plans for 1915 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 = 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**	☒ **Annually**

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

Performance Measure:
Number and percent of Individual Support Plans that address identified health and safety risk factors Numerator: Number of Individual Support Plans for 1915 C waiver beneficiaries that address strategies to address health and safety risks factors. Denominator: Total number of reviewed Individual Support Plans for 1915 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 = 95% confidence level with +/- 5% margin of error
☒ **Other** Specify:	☐ **Annually**	☐ **Stratified** Describe Group:

PIHPs		
	☐ **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

Performance Measure:
Number and percent of Individual Support Plans in which the services and supports reflect beneficiary assessed needs and life goals Numerator: Number of Individual Support Plans for 1915 C waiver beneficiaries in which services and supports reflect assessed needs and life goals Denominator: Total number of reviewed Individual Support Plans for 1915 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 = 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**	☒ **Annually**

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

b. ***Sub-assurance: The State monitors service plan development in accordance with its policies and procedures.***

Performance Measures

For each performance measure 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.

c. ***Sub-assurance: Service plans are updated/revised at least annually or when warranted by changes in the waiver participants needs.***

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 1915 c waiver beneficiaries whose Individual Support Plans were revised, as applicable, by the Tailored Care Manager to address their changing needs. Denominator: total number of 1915 c waiver beneficiaries who required a revised Individual Support Plan due to changing needs and plan was reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Individual Record Review

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: 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**	☐ **Annually**

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

Performance Measure:
Number and percent of 1915c waiver beneficiaries for whom an annual Individual Support Plan took place. Numerator: Number of 1915(c) waiver beneficiaries for whom an annual individual support plan took place Denominator: Total number of reviewed 1915 c waiver beneficiaries requiring an annual individual support plan.

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:	☐ **Annually**	☐ **Stratified** Describe Group:

PIHP		
	☐ **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

Performance Measure:
Number and percent of 1915 c waiver beneficiaries whose annual Individual Support Plan was revised or updated. Numerator: Number of 1915 c waiver beneficiaries whose Individual Support Plans were revised or updated Denominator: The total number of reviewed 1915 c waiver beneficiaries in the sample.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Case Record Review Spreadsheets

Responsible Party for	**Frequency of data**	**Sampling Approach**

data collection/generation *(check each that applies):*	**collection/generation** *(check each that applies):*	*(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: 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:	☐ **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: Semi-annually

d. ***Sub-assurance: Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.***

Performance Measures

For each performance measure 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 1915 c Waiver beneficiaries who are receiving services as specified in the Individual Support Plan Numerator: Number of 1915 C waiver beneficiaries who received services in the type, scope, amount, duration, and frequency listed in the Individual Support Plan Denominator: Total number of 1915 C waiver beneficiaries individual support plans 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 =

☒ **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: PIHP	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of new 1915 c waiver beneficiaries receiving services according to their individual support plan within 45 days of Individual Support Plan Approvals

Numerator: Number of new 1915 C waiver beneficiaries who get services within 45 days of approval of the Individual Support Plan Denominator: Total number of new 1915 C 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**

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:

e. ***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:
Number and percent of records that contain a signed freedom of choice statement Numerator: Total number of Individual Support Plans for 1915 C waiver beneficiaries where freedom of choice statement is signed Denominator: Total number of Individual Support Plans for 1915 C waiver beneficiaries reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Freedom of Choice signature on the ISP

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**

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:
Number and percent of beneficiaries reporting Tailored Care Manager helps them to know what waiver services are available. Numerator: Number of Individual Support Plans for 1915 C waiver beneficiaries that indicate the Tailored Care Manager helps the beneficiary know what services are available Denominator: Total number of Individual Support Plans for 1915 C waiver beneficiaries reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Signature on the 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:
Number and percent of 1915 C beneficiaries reporting they have a choice between providers. Numerator: Number of Individual Support Plans for 1915 C waiver beneficiaries that indicate the beneficiaries were given a choice of providers Denominator: Total number of Individual Support Plans for 1915 C waiver beneficiaries reviewed.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Freedom of Choice signature on ISP

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):*

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 Tailored Plan/PIHP reviews service plan development via Tailored Care Management and in Utilization Management (UM). Utilization Management ensures that all service plan elements are present. During the annual EQRO review, which consists of CCME as well as DHB and DMH staff, state Subject Matter Experts in I/DD services utilize a standard review tool to review the PIHP's monitoring process to ensure that the Tailored Plan/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 States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

The PIHPs will address and correct problems identified on a case-by-case basis and include the information in reports to DHB and the Intra-departmental Monitoring Team. 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:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design

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

- (●) **No**
- ( ) **Yes**

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

Appendix E: Participant Direction of Services

Applicability *(from Application Section 3, Components of the Waiver Request)*:

- (●) **Yes. This waiver provides participant direction opportunities.** Complete the remainder of the Appendix.
- ( ) **No. This waiver does not provide participant direction opportunities.** Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction.

Indicate whether Independence Plus designation is requested *(select one):*

- ( ) **Yes. The state requests that this waiver be considered for Independence Plus designation.**
- (●) **No. Independence Plus designation is not requested.**

Appendix E: Participant Direction of Services

E-1: Overview (1 of 13)

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The NC Innovations waiver offers beneficiaries both agency directed and participant directed supports options. Participant directed services are known as individual and family directed services. The NC Innovations waiver provides the opportunity for beneficiaries, or the legally responsible person for that beneficiary, to be the employer of record. The Tailored Plan/PIHP also covers Agency with Choice models of participant directed services.

An FSA may bill for Community Transition and Individual Goods and Services to the same participant. Community Transition Services and Individual Goods and Services are not directly provided to the member by the FSA. For example, if the individual needs a deposit to turn on their electricity to move into their own home and it is authorized by the PIHP, then the FMS would issue payment to the utility company on behalf of the beneficiary. The participant may direct one or all of these services, and may receive additional provider directed services that the beneficiary does not choose to self-direct.
Beneficiaries are offered an opportunity to receive an orientation to individual and family directed supports meeting from the Community Navigator at the time of the initial or annual plan. The orientation consists of information presented by the Community Navigator. The community navigator is a provider that assists beneficiaries in locating and coordinating community resources and with direct assistance in participant direction activities.

The Tailored Care Manager includes Community Navigator services in the ISP as directed by beneficiaries. When a beneficiary and/or legally responsible person expresses interest in directing services, they receive training from a Community Navigator. The Community Navigator also provides the beneficiary/legally responsible person with a copy of an employer handbook and other educational materials. The training and educational materials provide sufficient information to ensure that the beneficiary and/or legally responsible person make informed choices about the degree they wish to self-direct services.

After the training, the beneficiary and/or legally responsible person meets with a Tailored Care Manager. The employer of record or managing employer is identified. The employer of record or managing employer is the beneficiary, the parent of a minor beneficiary or the guardian of the beneficiary. If a representative is desired or needed to assist in directing services, the Tailored Care Manager/Care Coordinator assists in the appointment of the representative. The Tailored Care Manager/Care Coordinator assesses the employer of record, managing employer, and representative, if applicable, to determine the areas of support needed to self-direct services.
Standard assessment tools are used with each employer, managing employer and/or representative. The Employer of Record may not be an LLC.

The beneficiary and/or legally responsible person direct the Tailored Care Manager to add the requested model of individual and family directed supports, either employer of record or agency with choice, to the ISP and select the services that are to be self-directed. Services are directed to the extent that the beneficiary and/or legally responsible person desire.

The beneficiary, legally responsible person, and Tailored Care Manager/Care Coordinator work collaboratively to include supports for self-direction in the ISP that may include additional community navigator services. The beneficiary and legally responsible person also choose either a financial supports agency or agency with choice, depending on the model of individual and family directed supports elected. The completed ISP is submitted to the Tailored Plan/PIHP for approval. Emergency and back-up staffing plans are included.

Once the ISP is approved, a referral is made to a financial supports agency for beneficiaries who have elected the employer of record model. The financial supports agency assists by assuring that services are managed and funds distributed as needed. The financial supports agency also assists with required paperwork that is submitted to the Internal and State Revenue Services, and facilitates the employment of support staff. The employer of record screens, hires, and trains staff. The employer of record manages the individual and family directed (participant-directed) budget by setting employee pay rates and benefits through the use of a computer based auto calculator. Community Navigators are able to assist employers who do not have access to computers with the auto calculator and other web-based resources. The employer of record provides the supervision of the staff in lieu of supervision that would normally be provided by a qualified professional in a provider directed employment arrangement. If necessary, the employer dismisses employees. The Community Navigator will be mandated until the Employer of Record can demonstrate competency in all employer functions.

For beneficiaries who elect the agency with choice model, a referral is made to an agency with choice. The agency with choice serves as the common law employer for employees providing services to the beneficiary. The managing employer

screens, interviews and recommends applicants for hire. Managing employers and the agency with choice jointly ensure that employees are trained. The managing employer provides supervision of staff with oversight by a qualified professional employed by the agency with choice. If necessary, the managing employer dismisses or recommends dismissal of employees.

In both models, agreements with the Tailored Plan/PIHP, the financial supports agency, agency with choice and employees outline responsibilities of all parties in the individual and family directed support option. Community Navigator assist the employer or managing employer with employer duties and responsibilities as requested or needed. Beneficiaries in either model of individual and family directed supports have access to individual goods and services when employees begin to provide at least one service to the beneficiary.

The Tailored Plan/PIHP provides ongoing support for individual and family directed supports by maintaining a website with information about individual and family directed supports. The Tailored Plan/PIHP also arrange periodic meetings for employers and managing employers that provide opportunities for meetings with key support agencies, including Tailored Care Managers, community navigators, agencies with choice and financial supports agencies.

The Tailored Plan/PIHP monitors Employers of Record annually and provides any needed technical assistance to comply with Individual Family Directed policies and processes. Community Navigator agencies, Financial Supports Agencies, and Agencies with Choice are monitored at least once every three years at a frequency determined by The Tailored plan/PIHP. Beneficiaries in individual and family directed supports may elect to return to provider directed services at any time by informing the Tailored Care Manager/Care Coordinator . The Tailored Plan/PIHP may remove a beneficiary from individual and family supports, after consultation with the DHB, in instances when the participant’s health and safety are compromised, or after an employer or managing employer has made the same major mistake three different times in one year. The two major mistake includes the inability to implement the Individual Support Plan and/or the inability to comply with NC Innovations requirements. The LME-MCO must make reasonable efforts to provide the beneficiary with technical assistance and/or support prior to terminating the Participant Directed Option. The rationale is that each beneficiary should be given every opportunity to be successful in the Participant Directed Service option should he/she desire to participate.

Termination of the Participant Directed Option will occur immediately in the following circumstances: the individual’s health and/or safety are compromised, misuse of Innovations Waiver funds, suspected fraud or abuse of funds, no approved representative when one is required, refusal to accept required Community Navigator services, refusal to allow Tailored Care Manager monitoring, and refusal to participate in Tailored Plan/PIHP, State, or federal monitoring.

Appendix E: Participant Direction of Services

E-1: Overview (2 of 13)

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one*:

- ○ **Participant: Employer Authority.** As specified in ***Appendix E-2, Item a***, the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
- ○ **Participant: Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
- ◉ **Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies*:

- ☒ **Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.**
- ☒ **Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.**

☒ **The participant direction opportunities are available to persons in the following other living arrangements**

Specify these living arrangements:

Beneficiaries that live in facilities larger than three beds have the option to direct their community networking and supported employment services.

Appendix E: Participant Direction of Services

E-1: Overview (3 of 13)

d. Election of Participant Direction. Election of participant direction is subject to the following policy *(select one):*

- ○ **Waiver is designed to support only individuals who want to direct their services.**
- ◉ **The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.**
- ○ **The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the state. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria.**

Specify the criteria

Appendix E: Participant Direction of Services

E-1: Overview (4 of 13)

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

General orientation on the two models of the individual/family directed supports option, employer of record and agency with choice is provided to all waiver beneficiaries when they enter the waiver and annually as part of the development of their ISP by the TTailored Care Manager/Care Coordinator.

If the beneficiary/legally responsible person is interested in electing one of the individual/family directed models, they will receive training on the roles and responsibilities, and the advantages and potential liabilities of participation in the option and each model. The Community Navigator Agency is responsible for training and provision of educational materials to include the employer handbook and resource materials at the time of training. If the participant has chosen one of the two models of individual/family directed supports, they will receive ongoing training per specified areas in their ISP.

Appendix E: Participant Direction of Services

E-1: Overview (5 of 13)

f. Participant Direction by a Representative. Specify the state's policy concerning the direction of waiver services by a representative *(select one):*

○ **The state does not provide for the direction of waiver services by a representative.**

◉ **The state provides for the direction of waiver services by representatives.**

Specify the representatives who may direct waiver services: *(check each that applies)*:

☒ **Waiver services may be directed by a legal representative of the participant.**

☒ **Waiver services may be directed by a non-legal representative freely chosen by an adult participant.**
Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

In the Participant Directed Services option, called Individual and Family Directed Supports, the parent of minor beneficiary or legal guardian is designated as the Managing Employer. If the Managing Employer desires assistance, a representative is chosen. If the Managing Employer requires assistance, a representative is appointed. In either scenario, the representative must meet certain guidelines to ensure that the representative functions in the best interests of the beneficiary. The representative may be a family member, friend, someone who has power of attorney, income payee, or another person who willingly accepts responsibility for performing tasks that the Managing Employer is unable to perform and must be at least 18 years old. The representative must be committed to follow the beneficiary's needs and preferences while using sound judgment to act on the beneficiary's behalf. The representative may not be paid to be the representative or to provide any other service to the participant, with the exception of guardianship services.

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

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

Additionally, the Managing Employer cannot be employed to provide services to the beneficiary.

The representative must meet the following requirements:
1. Demonstrate knowledge and understanding of the beneficiary's needs and preferences and respect these preferences
2. Demonstrate evidence of a personal commitment to the beneficiary and be willing to follow the individual's wishes while using sound judgment to act on the beneficiary's behalf
3. Agree to a predetermined level of contact with the beneficiary
4. Be at least 18 years of age
5. Be willing and able to comply with program requirements and be approved by the participant or his/her legal representative to act in this capacity

The representative may not:
1. Be paid for being the representative
2. Provide paid services to the beneficiary, including employees of agencies providing services, with the exception of guardianship services
3. Have a history of physical, mental or financial abuse

Appendix E: Participant Direction of Services

E-1: Overview (6 of 13)

g. Participant-Directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver

service that is specified as participant-directed in Appendix C-1/C-3.

Waiver Service	Employer Authority	Budget Authority
Supported Living - Periodic	☒	☒
Community Living and Support	☒	☒
Community Networking	☒	☒
Supported Employment	☒	☒
Supported Living	☒	☒
Natural Supports Education	☒	☒
Community Transition	☒	☒
Respite	☒	☒
Individual Goods and Services	☒	☒

Appendix E: Participant Direction of Services

E-1: Overview (7 of 13)

h. Financial Management Services. Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one*:

◉ **Yes. Financial Management Services are furnished through a third party entity.** *(Complete item E-1-i).*

Specify whether governmental and/or private entities furnish these services. *Check each that applies*:

☐ **Governmental entities**

☒ **Private entities**

○ **No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used.** *Do not complete Item E-1-i.*

Appendix E: Participant Direction of Services

E-1: Overview (8 of 13)

i. Provision of Financial Management Services. Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one*:

◉ **FMS are covered as the waiver service specified in Appendix C-1/C-3**

The waiver service entitled:

Financial Support Services

○ **FMS are provided as an administrative activity.**

Provide the following information

i. Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services:

Agencies under contract with and approved by the PIHP who meet the qualifications for Financial Supports listed in Appendix C. The PIHP uses a standardized process to request information or proposals from provider agencies within the provider network who may have interest or expertise in providing these services.

ii. Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform:

The PIHP sets rates for the Financial Supports Service by analyzing the cost of the tasks the Financial Supports Agency is required to perform and the frequency these activities are performed. A monthly rate is established with the Financial Supports Agency billing the actual cost of start-up costs (initial employee training, initial supplies, etc.).

iii. Scope of FMS. Specify the scope of the supports that FMS entities provide *(check each that applies)*:

Supports furnished when the participant is the employer of direct support workers:

- ☒ **Assist participant in verifying support worker citizenship status**
- ☒ **Collect and process timesheets of support workers**
- ☒ **Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance**
- ☒ **Other**

Specify:

Requests criminal background, drivers checks and healthcare registry checks on behalf of the Employer of Record

Supports furnished when the participant exercises budget authority:

- ☒ **Maintain a separate account for each participant's participant-directed budget**
- ☒ **Track and report participant funds, disbursements and the balance of participant funds**
- ☒ **Process and pay invoices for goods and services approved in the service plan**
- ☒ **Provide participant with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other services and supports**

Specify:

Additional functions/activities:

- ☐ **Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency**
- ☒ **Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency**
- ☒ **Provide other entities specified by the state with periodic reports of expenditures and the status of the participant-directed budget**
- ☐ **Other**

Specify:

iv. Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of

FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.

The Financial Supports Agencies are monitored at least annually by the PIHP. An instrument developed by the PIHP is used to review all financial supports agency responsibilities and systems. In addition, the PIHP monitors incidents and complaints that are submitted. The Financial Supports Agency is required to maintain a complaint log and conduct satisfaction surveys. The results of the complaint logs and satisfaction surveys are submitted to the PIHP.

Appendix E: Participant Direction of Services

E-1: Overview (9 of 13)

j. Information and Assistance in Support of Participant Direction. In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☒ **Case Management Activity.** Information and assistance in support of participant direction are furnished as an element of Medicaid case management services.

Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:

Tailored Care Manager/Care Coordinator provide basic support to all individuals receiving participant-directed services. Beneficiaries are offered the opportunity to receive an orientation regarding self directed care at the time of the initial ISP development. The Tailored Care Manager informs beneficiaries that training on individual and family directed services is available from a Community Navigator. The Tailored Care Manager/Care Coordinator assists with the development of the ISP, including any self-directed services. Finally, the Tailored Care Manager/Care Coordinator monitors the implementation of the ISP.

☒ **Waiver Service Coverage.**

Information and assistance in support of participant direction are provided through the following waiver service coverage(s) specified in Appendix C-1/C-3 (check each that applies):

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Home Modifications	☐
Day Supports	☐
Supported Living - Periodic	☐
Community Living and Support	☐
Community Networking	☐
Vehicle Modifications	☐
Assistive Technology	☐
Supported Living - Transition	☐
Community Navigator	☒

Participant-Directed Waiver Service	Information and Assistance Provided through this Waiver Service Coverage
Benefits Counseling	☐
Supported Employment	☐
Supported Living	☒
Home Delivered Meal	☐
Crisis Services	☐
Specialized Consultation	☐
Natural Supports Education	☐
Community Transition	☐
Respite	☐
Individual Goods and Services	☐
Residential Supports	☐
Financial Support Services	☒

☐ **Administrative Activity.** Information and assistance in support of participant direction are furnished as an administrative activity.

Specify (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:

Appendix E: Participant Direction of Services

E-1: Overview (10 of 13)

k. Independent Advocacy *(select one).*

○ **No. Arrangements have not been made for independent advocacy.**

◉ **Yes. Independent advocacy is available to participants who direct their services.**

Describe the nature of this independent advocacy and how participants may access this advocacy:

Independent Advocacy is available through advocacy organizations. Beneficiaries are notified upon entry to the waiver of the availability of self-referral to an advocacy organization, and how to contact the PIHP. Tailored Care Manager/Care Coordinator and community Navigators are also able to assist beneficiaries and families in obtaining independent advocacy services.

Appendix E: Participant Direction of Services

E-1: Overview (11 of 13)

l. Voluntary Termination of Participant Direction. Describe how the state accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the state assures continuity of services and participant health and welfare during the transition from participant direction:

A beneficiary in individual and family directed supports may withdraw from the option at any time by notifying the Tailored Care Manager/Care Coordinator. The Manager prepares a revision to the ISP, and submits the revision to the PIHP, so that provider directed services are authorized for the beneficiary with no service lapse. The following steps are followed:
(1) Employer or managing employer requests that the Tailored Care Manager terminate individual and family directed services option, and return the beneficiary to provider-directed services.
(2) Tailored Care Manager/Care Coordinator asks the employer or managing employer to select a provider and updates the ISP to reflect termination of individual and family directed services and the provider agency selected by the employer or managing employer to provide provider-directed services.
(3) The legally responsible person signs the ISP, and the Tailored Care Manager/Care Coordinator submits it to the PIHP for approval.
(4) The PIHP approves the ISP, authorizes provider-directed services and terminates Financial Supports Services.
(5) The PIHP sends a letter to the legally responsible person, Financial Supports Agency, Community Navigator and Agency with Choice notifying them of the termination of individual and family directed services per the legally responsible person’s request the date of the termination of payroll to employees. The letter is copied to the TTailored Care Manager/Care Coordinator and DHB.
(6) The Employer of Record or Agency with Choice notifies staff that they are no longer employed under the individual and family directed services option.
(7) The finance department reconciles the individual budget with the Financial Supports Agency. Any non-used funds are returned to the PIHP by the Financial Supports Agency.

Appendix E: Participant Direction of Services

E-1: Overview (12 of 13)

m. Involuntary Termination of Participant Direction. Specify the circumstances when the state will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A beneficiary in individual and family directed supports may be removed from individual and family directed services involuntarily under the following circumstances:
(1) Immediate health and safety concern, including maltreatment of the beneficiary
(2) Repeated unapproved expenditures/misuse of NC Innovations funds
(3) No approved representative available when the employer of record/managing employer in the Agency with Choice Option is determined to need one
(4) Refusal to accept the necessary Community Navigator services
(5) Refusal to allow Tailored Care Manager to monitor services
(6) Refusal to participate in PIHP, state or federal monitoring
(7) Non-compliance with individual and family supports, Financial Supports Agency, Agency with Choice and/or employee support agreements
(8) Inability to implement the approved ISP or comply with NC Innovations requirements, despite reasonable efforts to provide additional technical assistance and support (for event requiring additional technical assistance/corrective action plan in twelve months).

Normally, employers or managing employers in individual and family directed supports are terminated from the individual and family directed services option if the same major mistake occurs more than three times in a twelve month period. However, the recommendation can occur at any point when the beneficiaries' health and safety are at risk or misuse of funds is suspected. For example, an incident of substantiated abuse by a paid employee could lead to termination if a plan cannot be implemented to ensure health and safety. If it is determined at any point in the PIHP investigation that the person immediately needs to be returned to the provider directed option to ensure their health and safety, this can be recommended. The following steps are followed:

(1) Concerns and/or allegations of major problems with the implementation of individual and family directed supports are reported to each PIHP.
(2) The PIHP consultant investigates the concerns or allegations of major problems. The consultant will review all available plans of correction and documentation.
(3) Depending on results of the investigation, the consultant may recommend termination of individual and family directed services If the removal is an emergency, the PIHP contacts their Office of the Medical Director and obtains a decision regarding removal. This decision is reported to DHB the first working day following the removal.
(4) Termination from the individual and family directed services option is normally at the end of a month; however, when the termination is due to a threat to the beneficiaries' health and safety, such as physical abuse, termination occurs immediately, and provider-directed services resumes immediately.
(5) If the employer/Agency with Choice disagrees with the decision of the PIHP/DHB, the employer/Agency with Choice may file a reconsideration request or a grievance.
(6) Steps 2 through 6 of the voluntary termination procedure are followed to return the participant to the provider-directed supports option.

Appendix E: Participant Direction of Services

E-1: Overview (13 of 13)

n. Goals for Participant Direction. In the following table, provide the state's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the state will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		100
Year 2		125
Year 3		150
Year 4		175

	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 5		200

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant Direction (1 of 6)

a. Participant - Employer Authority *Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b:*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Select one or both*:

☒ **Participant/Co-Employer.** The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

Specify the types of agencies (a.k.a., agencies with choice) that serve as co-employers of participant-selected staff:

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

☒ **Participant/Common Law Employer.** The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. *Select one or more decision making authorities that participants exercise*:

☒ **Recruit staff**

☒ **Refer staff to agency for hiring (co-employer)**

☐ **Select staff from worker registry**

☒ **Hire staff common law employer**

☒ **Verify staff qualifications**

☒ **Obtain criminal history and/or background investigation of staff**

Specify how the costs of such investigations are compensated:

Component part of Financial Supports Services; conducted by Agency with Choice for all applicants referred by the Managing Employer and compensated by service rate

☐ **Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-1/C-3.**

Specify the state's method to conduct background checks if it varies from Appendix C-2-a:

☒ **Determine staff duties consistent with the service specifications in Appendix C-1/C-3.**

☒ **Determine staff wages and benefits subject to state limits**

☒ **Schedule staff**

☒ **Orient and instruct staff in duties**

☒ **Supervise staff**

☒ **Evaluate staff performance**

☒ **Verify time worked by staff and approve time sheets**

☒ **Discharge staff (common law employer)**

☒ **Discharge staff from providing services (co-employer)**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (2 of 6)

b. Participant - Budget Authority *Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b:*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Select one or more*:

☒ **Reallocate funds among services included in the budget**

☒ **Determine the amount paid for services within the state's established limits**

☒ **Substitute service providers**

☒ **Schedule the provision of services**

☒ **Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-1/C-3**

☒ **Specify how services are provided, consistent with the service specifications contained in Appendix C-1/C-3**

☒ **Identify service providers and refer for provider enrollment**

☒ **Authorize payment for waiver goods and services**

☒ **Review and approve provider invoices for services rendered**

☐ **Other**

Specify:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (3 of 6)

b. Participant - Budget Authority

ii. Participant-Directed Budget Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Each beneficiary in this waiver has an individual budget guideline. The budgeting methodology is described in Appendix C-4. The budget guideline amounts in the individualized budgeting categories are guidelines. Individuals may request budget modifications based on new or one time needs as described in the individual budgeting methodology. In addition the employer or managing employer may set aside up to $2,000 per year to purchase individual goods and services. Individual budget modifications require the prior approval of the PIHP. Information about the individual and family directed budget is provided in the employer handbook and in additional handouts provided during individual and family directed supports training.
The participant-directed budget is known as the individual and family directed supports budget and is a component of the individual budget. It consists of the total dollar amount of individual and family directed services, at the individual and family directed supports rate.

In the employer of record model, the individual and family directed services rates are set by the PIHP and are the established hourly service rates for provider directed services rates minus an administrative rate established to cover the costs of Financial Support Services, forms and supplies provided to employers of record and start-up costs for employers (blood-borne pathogen supplies, first aid kits, employment ads, background checks, initial employee training, etc.). The employer is provided with an auto-calculator that assists in managing the individual and family directed budget. The employer has the authority to establish employee pay rates and benefits. Additionally, the employer budgets and directs payment for workers compensation insurance, employment taxes, additional employee training, habilitation training supplies, back-up staffing and other items that are directly related to the cost of providing services. The Community Navigator trains the employer in the use of the auto-calculator and provides alternative methods for budgeting if the employer does not have access to a computer. The financial supports agency establishes procedures for managing participant funds and provides the employer of record with a monthly report of revenues (service billing) and expenditures (services provided). The procedures and format for the monthly report are subject to the approval of the PIHP.

In the agency with choice model, the established hourly service rate is the same as the rate paid to the provider agency to deliver NC Innovations waiver services. The service rate includes the cost of employee pay rates, employment taxes, workers compensation insurance, employee benefits, forms, supplies, start-up costs to include first aid kits, employment ads, initial and on-going employee training, criminal and other background checks, first aid supplies, employment ads, habilitation training supplies, qualified professional oversight, maintenance of records, back-up staffing and other items directly related to the cost of providing services. The agency with choice establishes procedures for managing beneficiary funds and assists managing employers in budgeting the individual and family directed budget. The agency with choice also provides a quarterly report of revenue (service billing) and expenditures to the managing employer. The procedures and format for the quarterly report are subject to the approval of the PIHP.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (4 of 6)

b. Participant - Budget Authority

iii. Informing Participant of Budget Amount. Describe how the state informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The beneficiary, employer and/or managing employer are informed of the participant directed (individual and family directed) budget amount by the Tailored Care Manager/Care Coordinator. A budget adjustment may be requested at any time by directing the Tailored Care Manager/Care Coordinator to prepare an ISP revision that includes the reason for the need for the adjustment. The Tailored Care Manager/Care Coordinator has a standard form that is used in requesting budget adjustments that is attached to the plan revision.

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (5 of 6)

b. Participant - Budget Authority

iv. Participant Exercise of Budget Flexibility. *Select one*:

- (●) **Modifications to the participant directed budget must be preceded by a change in the service plan.**
- ( ) **The participant has the authority to modify the services included in the participant directed budget without prior approval.**

Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:

Appendix E: Participant Direction of Services

E-2: Opportunities for Participant-Direction (6 of 6)

b. Participant - Budget Authority

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The financial supports agency and agency with choice track the individual and family directed supports budget per a standard reporting format developed with and approved by the PIHP. The report is completed monthly by the Financial Supports Agency and Quarterly by the Agency with Choice and is provided to the employer or Agency with Choice, the PIHP and Tailored Care Manager/Care Coordinator. “Red Flags” that are indicators of potential problems in revenues (under utilization) or spending (over utilization) are identified. The Financial Supports Agency, or any other entity that receives the report, are alert to these red flags so that the Tailored Care Manager/Care Coordinator and/or PIHP may address the issue immediately with the employer or managing employer. The employer or managing employer may be required to develop a corrective action plan. Continued under or over utilization of the budget may result in removal from individual and family directed supports and a return to agency directed supports.

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 Innovations waiver operates concurrently with a 1915(b) waiver through prepaid inpatient health plans (PIHP). All waiver applicants/participants are notified of their right to request a fair hearing by the Tailored Plan/PIHP in accordance with 42 CFR 431
Subpart E and 42 CFR 438 Subpart F. Participants are required to access the Tailored Plan/PIHP's internal appeal process before requesting a
hearing with the State, as required under the concurrent 1915(b) waiver, NC Mental Health, Developmental Disabilities and Substance Abuse Services Health Plan.

Upon enrollment in the Tailored Plan/PIHP, the Tailored Plan/PIHP 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 Tailored Plan/PIHP 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 Tailored Plan/PIHP before accessing the
state fair hearing process. This requirement can be found in the concurrent 1915(b) waiver (#NC 02.RO3), section A, Part IV-E, "Grievance System". If the applicant/beneficiary requests a hearing, the Tailored Plan/PIHP gathers information on the case and schedules the appeal with an independent reviewer who had no prior involvement in making the adverse decision. the Tailored Plan/PIHP 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 participant 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 Tailored Plan/PIHP
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**

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the state agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The Tailored Plan/PIHP has an internal dispute resolution system as required by 42 CFR 438 Subpart F. For beneficiaries that elect to make use of the grievance process are informed that the grievance process is not a pre-requisite or substitute 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 Tailored Plan/PIHP's internal appeal and grievance processes are outlined in the contract between the State and Tailored Plan/PIHP. The requirements cover the types of information that the Tailored Plan/PIHP 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 timeframes for addressing grievances and appeals.

The Tailored Plan/PIHP 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**

b. Operational Responsibility. Specify the state agency that is responsible for the operation of the grievance/complaint system:

DMH/DD/SUS

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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/SUS 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/SUS. 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 Client Rights Committee and the PIHP 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, LME-MCO or MH/DD/SUS 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 complaint database for analysis. Action taken by the PIHP 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. 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 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. 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 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 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 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 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 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 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. Providers of publicly funded services licensed under North Carolina General Statute 122C, with the exception of hospitals, and providers of publicly funded non- licensed periodic or community based mental health, developmental disability or substance misuse services are required to report critical events or incidents involving consumers receiving mental health, developmental disability or substance misuse services. Tribal Members may also report to the Tribal Family Safety program and applicable accrediting bodies based on equivalent tribal code / rules and laws. 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 participant must be recorded in the progress note of the participant 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: consumer 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, managing employer or employer of record 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 Tailored Plan/PIHP during routine monitoring which occurs annually for Alternative Family Living providers and every two years for other providers. .

Level II Incidents include any incident that involves a threat to a consumer's health or safety or a threat to the health and safety of others due to consumer behavior. Level II incidents are reported immediately to the employee's supervisor, employer of record, or managing employer. The managing employer immediately notifies the agency with choice. A written report is prepared that is submitted to and reviewed by the employee's supervisor, employer of record, or managing employer. The managing employer forwards the report to the agency with choice. A written report is prepared that is submitted to and reviewed by the employee's supervisor, employer of record, or managing employer. The written report is forwarded to the Tailored Plan/PIHP 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 consumer, 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, employer of record or managing employer. The managing employer immediately notifies the agency with choice. The supervisor (including the financial support service provider in the Agency with Choice model) or Employer of Record immediately notifies the Tailored Plan/PIHP, who notifies DMH/DD/SAS. The Tailored Plan/PIHP 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 (including the Agency with Choice) or Employer of Record. The written report is forwarded to the Tailored Plan/PIHP within 72 hours of the incident's occurrence. All providers (including the Agency with Choice) and Employers of Record are required to conduct a peer review of Level III incidents, beginning within 24 hours of the incident.
Reporting requirements apply to children and adults, Allegations of Abuse, Neglect or Exploitation Report all suspected or alleged cases of abuse, neglect or exploitation of a child (age 17 or under) or disabled adult to the local DSS, pursuant to G.S. 108A Article 6, G.S. 7B Article 3 and 10A NCAC 27G .0610. per NC General Statue 122C Providers of publicly funded services licensed under NC General Statutes 122C (8)(b) "Provider category" means the type of facility in which a client receives services or resides. The provider category determines the extent of monitoring that a provider receives and is determined as follows: Category B – G.S. 122C, Article 2, community-based providers not requiring State licensure.

Providers must follow IRIS reporting requirements, by reporting Level II incident reports are required to be reported to the host LME within 72 hours Level III require an immediate verbal report and IRIS report within 72 hours. Where a provider's individual policies are more restrictive (i.e. timelines), then the provider must also be compliant with their own

policies.

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 Tailored Plan/PIHP, beneficiary are provided a consumer 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/Care Coordinator discusses the rights and protections, inclusive of agencies, to contact with the participant/legally responsible person as a component of the admissions process to the NC Innovations waiver. Opportunities for information training occur during routine monitoring and annually during the Person-centered planning process.

Providers within the Tailored Plan/PIHP network are required to inform the beneficiaries of rights and protections through individual agency procedure. When a beneficiary elects the individual/family directed supports option, employers, managing employers, representatives and/or managing employers receive the employer handbook that details their rights, protections and agencies available to assist them in a self-directed services model.

The Tailored Plan/PIHP and the NC DHHS operate toll-free care lines where beneficiaries can receive additional information or assistance in reporting Abuse, Neglect, and exploitation. Tailored Care managers are also responsible to report or assist a member to report ANE. 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. NC Incident Reporting System is managed by NC DHHS DMH/DD/SUS, follow up of investigations are monitored by NC DMH/DD/SUS. DMH/DD/SUS has a customer service and Community Rights team, who work closely with the Tailored Plans/PIHP to address complaints, concerns, and appeals. The Customer Services and Community rights team receive and review Incident reports submitted to the States Incident reporting system. The questions and responses can be submitted to the Tailored Plans/PIHPs and Providers through the IRIS system. Events are evaluated and follow- up is completed if the following items are involved in the incident: death, physical/psychological impairment, media coverage, abuse, neglect, exploitation, lack of information in report, and injury.

Incidents are categorized into different levels based on severity; Level I, II, or III. Level III incidents are reviewed by the Customer Service and Community Rights Team within 24 hours of receipt. Investigations into all incidents includes a review to ensure the provider completed the following: attended to the health and safety needs of the individual involved in the incident; developed and implemented a corrective active plan within 45 days, assigned an individual responsible for implementing the corrective action plan, maintain documentation, and adhere to confidentiality requirements. These methods vary for Level III incidents in that Level III incidents are reviewed to ensure the provider secured the client's record, conducted an internal team review within 24 hours of the incident, complete preliminary findings of the incident within 5 working days, complete a final written report of the incident within 3 months of the incident, and immediately notify the LME, provider agency (if different from reporting agency) the client's guardian, Department of Social Service (if applicable) pharmacy or physician(if incident involves a medication error) and law enforcement (if applicable)
Level 1 Incidents are maintained by the provider agency (including the Agency with Choice) and Employer of Record. Each provider agency (including the Agency with Choice) or Employer of Record is required to maintain copies of these reports for review by the PIHP during routine monitoring.
Written reports of Level II incidents are forwarded to the PIHP within 72 hours of the incident's occurrence. The provider agency (including the Agency with Choice) and Employer of Record are 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 to review the provider's clinical care and practices and the PIHP's management processes, including service coordination, service oversight and technical assistance for providers. These incidents require communication between the provider and the PIHP, 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 who notifies DMH/DD/SAS. The PIHP 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 PIHP within 72 hours of the incident's occurrence. Providers (including the Agency with Choice) and Employers of Record 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 reoccurrence 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 timeframes
(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, 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 and DHHS, documentation of the incident, and report to the PIHP, DHHS and other authorities as required by law. The PIHP reviews provider handling of the Level III incident:
(1) To ensure that consumers 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/SUS reviews the PIHP oversight of providers and follows up, as warranted, to ensure problems are corrected. The PIHP also analyzes and responds to patterns of incidents as part of quality improvement and monitoring processes. DMH/DD/SUS analyzes and responds to statewide patterns of incidents as part of quality improvement and monitoring. DMH/DD/SUS 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) The Disability Rights, 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 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 participant 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 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 and the PIHP 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 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, the PIHP 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 must report Level III Incidents to the North Carolina Division of Mental Health, Developmental Disabilities and Substance Misuse 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.
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/SUS.
The DMH/DD/SUS is responsible for analyzing and responding to statewide patterns of incidents as part of QI and monitoring PIHP oversight of response processes, produce statewide quarterly incident trend reports, review PIHP 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.

The Local Management Entity shall complete the complaint investigation within 30 calendar days of the date of the receipt of the complaint.(3) Upon completion of the complaint investigation, the Local Management Entity shall submit a report of investigation findings to the complainant, the provider and client's home Local
Management Entity, if different. The report shall be submitted within 15 calendar days of the date of completion of the investigation. The complaint investigation report shall include:
(A) statements of the allegations or complaints lodged;
(B) steps taken and information reviewed to reach conclusions about each allegation or
complaint;
(C) conclusions reached regarding each allegation or complaint;
(D) citations of statutes and rules pertinent to each allegation or complaint; and
(E) required action regarding each allegation or complaint.

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/SUS. DHB tracks performance measures and receives all incident reports quarterly. The DMH/DD/SUS also assists in the oversight of critical incidents and events.

Aggregate data for all incidents is collected by the provider and submitted to the PIP 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/SUS reviews all data and monitors the PIHPS oversight of providers and follows up as warranted to ensure that problems are corrected. The DMH/DD/SUS 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 during routine monitoring. Level II and Level III incidents are reported by the provider within 72 hours of the incident occurring. The PIHP and the DMH/DD/SUS reviews all Level III incidents within 72 hours of receiving the report. In cases of consumer death within 7 days of restrictive intervention, the PIHP 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. Tribe is not subject to all rules referenced in NC 122C and have their own version of 122C or rules established by the MH/IDD/SU Commission.

Employers of record are required to provide or arrange for employee 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 adheres to 42 CFR 482.13 and interpretative guidelines issued by CMS, the Joint Commission Requirements for Seclusion/Restraint and applicable EBCI Tribal Code such as 122-305, 122-403 and Tribal Rules 10A CHR 70E-1103.

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/SUS. A list of approved curriculums can be found at https://files.nc.gov/ncdhhs/documents/files/Approved-NCI-Curriculum--October-2018-.pdf. 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;
- 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 disabilities 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 wellbeing 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/habilitation 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/SUS. 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 LME-MCO. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP. The Tailored Care Manager 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. Physical restraint is the application or use of any manual method of restraint that restricts freedom of movement or the application or use of any physical or mechanical device the restricts freedom of movement or normal access to one’s body, including material or equipment attached or adjacent to the beneficiary that he or she cannot easily remove. Holding a beneficiary in a therapeutic hold or any other manner that restricts his or her movement constitutes manual restraint for that beneficiary. 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.

Protective devices are devices such as posy vests, geri-chairs or table top chairs to provide support and safety for clients with physical disabilities; devices such as helmet and mittens for self-injurious behaviors, or devices such as soft ties used to prevent medically ill clients from removing intravenous tubes, indwelling catheters, cardiac monitor electrodes or similar medical devices. Protective devices for behavioral control must follow the processes outlined in General Statute including approval by the provider's Human Rights Community and must be outlined in the beneficiary's person centered plan.
Restrictive interventions are to only be provided by staff who have been trained in prevention strategies and have demonstrated competence in these strategies through the completion of a program approved by DMH/DD/SUS. The approved DMH / DD / SUS programs includes prevention techniques, non-restraining physical interventions and optional restraining physical interventions. Restraints which result in the person being in a face-down or prone position are not part of the approved programs. The programs emphasizes building positive relationships, decision making and problem solving, assessing risk for escalating behavior, and early crisis intervention. If agencies choose to use another program, it must be approved by DMH/DD/SUS.
It is expected that restraint/seclusion are an intervention of last resort. Functional assessments, relationship building, positive behavioral support plans, and crisis plans are some of the alternatives to restrictive interventions.

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 are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. The PIHPs 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 participant behavior issues. The PIHPs provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the PIHP. 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.

If the agency is licensed through the Division of Health Service Regulation, the PIHP, DHB, or the DMH/DD/SUS may contact the Division of Health Service Regulation regarding any concerns. Providers report aggregate data to the PIHP quarterly. The PIHP 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.
Employers of record are required to provide or arrange for employee 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/SUS. 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;
• 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 disabilities 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 wellbeing 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/habilitation 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/SUS. 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 LME-MCO - PIHP. Any reports of unauthorized use or misapplication of restraints will be investigated by the PIHP. 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 Tailored Plan/PIHP are regularly informed on the use of restraints, restrictive interventions and
rights restrictions through incident reporting and data reports. The Tailored Plan/PIHP 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 participant behavior issues. The Tailored Plan/PIHPs provide oversight to the use of
restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the Tailored Plan/PIHP. 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 Tailored Plan/PIHP.
Unauthorized use of restrictive interventions 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 Manager/Care Coordination monitoring tool is to be determine of 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 Tailored Plan/PIHP. Any reports of unauthorized use or misapplication of restraints will be investigated by the Tailored Plan/PIHP. 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, the Tailored Plan/PIHP, DHB, or the
DMH/DD/SUS may contact the Division of Health Service Regulation regarding any concerns. Providers report aggregate data to theTailored Plan/PIHP quarterly. The Tailored Plan/PIHP collects this data for DHB.

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 includes seclusion. Seclusion is included in this section.
Employers of record are required to provide or arrange for employee training on alternatives to restrictive interventions.

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/SUS. 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;
• 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 disabilities 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 wellbeing 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/habilitation 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/SUS. 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 Tailored Plan/ PIHP. Any reports of unauthorized use or misapplication of restraints will be investigated by the Tailored Plan/PIHP. 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.

It is expected that restraint/seclusion are an intervention of last resort. Functional assessments, relationship building, positive behavioral support plans, and crisis plans are some of the alternatives to restrictive interventions.

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 Tailored Plan/PIHP are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. The Tailored Plan/PIHPs 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 participant behavior issues. The Tailored Plan/PIHPs provide oversight to the use of restrictive behavioral interventions. These incidents are reviewed during provider monitoring reviews by the Tailored Plan/PIHP. 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 Tailored Plan/PIHP.

Unauthorized use of seclusion 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 be determine of 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 Tailored Plan/PIHP. Any reports of unauthorized use or misapplication of restraints will be investigated by the Tailored Plan/PIHP. 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, the Tailored Plan/PIHP, DHB, or the DMH/DD/SUS may contact the Division of Health Service Regulation regarding any concerns. Providers report aggregate data to the Tailored Plan/PIHP quarterly. The Tailored Plan/PIHP 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)*

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

North Carolina Administrative Code at 10A NCAC 27G.0209 outlines medication requirements for individuals in 24-hour facilities. Provider agencies, including agencies with choice, 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 Tailored Plan/PIHP with the provider agency. Employers of record are required to train or arrange for training of their employees in medication administration if applicable.

An independent peer review by a pharmacist or physician is conducted at least once every six months for service recipients receiving antipsychotic medications and at least once every three months for individuals receiving opioids.

Tailored Plan/PIHPs conduct monitoring of providers on an annual basis in addition to the quarterly review completed by the pharmacist and physician.

Tailored Plan/PIHPs 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 within 72 hours 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 Tailored Plan/PIHPs 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 DHB 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/SUS Customer Services. The contract managers work with the IMT to determine harmful trends and identify quality improvement strategies. Depending on the nature of the strategy, the Tailored Plan/PIHP quality strategy may be amended or the strategy may be used by the Tailored Plan/PIHP 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)*

ii. State Policy. Summarize the state policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Consumers 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 clients only when authorized in writing by the client'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.

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 and substance misuse providers do not supersede those that govern licensed home care or hospice providers.

iii. Medication Error Reporting. *Select one of the following:*

◉ **Providers that are responsible for medication administration are required to both record and report medication errors to a state agency (or agencies).**
Complete the following three items:

(a) Specify state agency (or agencies) to which errors are reported:

Provider agencies, agencies with choice and employers of record report medication errors to the PIHP who, in turn, reports the errors to the Division of MH/DD/SUS through incident reporting described in Appendix G-1.

(b) Specify the types of medication errors that providers are required to *record:*

Errors reported include: wrong or missed dosage, wrong medication, wrong time (over 1 hour from prescribed time) or medication refusals by the beneficiary.

(c) Specify the types of medication errors that providers must *report* to the state:

Any error that results in permanent physical or psychological impairment is reported to the Division of MH/DD/SUS 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:

iv. State Oversight Responsibility. Specify the state agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The PIHP reports medication errors via incident reporting described in Appendix G-1. This includes Quarterly Reporting to the Division of DMH/DD/SUS.

Unlicensed personnel who administer medications are required to be trained by registered nurses, pharmacists, or physicians as outlined in 10A NCAC 27E.0107. Medication Administration Records (MARs) must be maintained. Any errors are immediately reported to a physician or pharmacist who determine what follow up is needed. The Division of Mental Health, Developmental Disabilities and substance Abuse Services endorses the instructor training offered at Area Health Educations Centers and maintains a list of instructors on their website.

Incidents on medication errors are reported to DHB on quarterly basis, as well as timeliness of follow up by the PIHP. This is captured in the waiver assurances regarding medication errors resulting in medical treatment and actions taken to protect the beneficiary where indicated. Additionally, the training of staff in medication administration is reviewed by the PIHP during routine monitoring and is captured in the Appendix C performance measures.

Appendix G: Participant Safeguards

Quality Improvement: Health and Welfare

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.")*

i. Sub-Assurances:

a. ***Sub-assurance: The state demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instancesof abuse, neglect, exploitation and unexplained death.*** *(Performance measures in this sub-assurance include all Appendix G performance measures for waiver actions submitted before June 1, 2014.)*

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 1915 c beneficiaries not requiring medical treatment or hospitalization due to medication error. Numerator: Number of 1915 c beneficiaries not requiring emergency medical treatment or hospitalization due to medication error. Denominator: Number of 1915 c beneficiaries with medication errors reported.

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**

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

Performance Measure:
Number and percent of deaths reviewed and determined to be of unexplained or suspicious cause. Numerator: number of deaths of unexplained or suspicious cause total number of deaths. Denominator: Total number of deaths reported.

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** Specify:

Performance Measure:
Number and percent of deaths where required PIHP follow-up interventions were completed as required. Numerator: Number of deaths where follow up intervention was completed by the LME-MCO. Denominator: All deaths where follow up intervention was required.

Data Source (Select one):
Other
If 'Other' is selected, specify:
NC Incident and Reporting System

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

collection/generation *(check each that applies):*	*(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**

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

Performance Measure:
Number and Percent of Actions Taken to Protect the Beneficiary, where indicated. Numerator: Number of actions taken to protect the Beneficiary from additional harm, where indicated. Denominator: All actions where protective actions were 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: PIHPs	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of 1915 c survey respondents who reported being given information on how to identify and report incidents. Numerator: Total number of survey respondents who reported being given information how to identify and report of abuse, neglect, exploitation, and unexplained death. Denominator: Total number of 1915 c waiver participants who responded to this survey question.

Data Source (Select one):
Other
If 'Other' is selected, specify:
PIHP Provider Satisfaction Survey

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:

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

Performance Measure:
Number and percent of incidents referred to the Division of Social Services or the Division of Health Service Regulation as required. Numerator: Number of incidents that were not critical that were reported to DHSR. Denominator: Total number of incidents reported to DHSR

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 percent 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:

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:
Number and percent of level 2 or 3 incidents that required PIHP/TP follow-up interventions were completed as required. Numerator: number of Level 2 or 3 incident reports that required PIHP/TP follow-up intervention. Denominator: total number of level 2 or 3

Data Source (Select one):
Critical events and incident reports
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** Specify:

Performance Measure:
Number and percent 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, with cause of incidents and what can be done to prevent future occurrence. Denominator: Total number of level 2 or 3 incidents.

Data Source (Select one):
Critical events and incident reports
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** Specify:

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

Performance Measure:
Number and percent of level 2 and 3 incidents reported within required state policy timeframes. Numerator: Number of level 2 and 3 incidents address with required timeframes as specified in State policy. Denominator: Total number of level 2 and 3 incidents reported.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☐ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☒ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☒ **Other** Specify: 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:
Number and percent of incidents referred to the Division of Social Services (DSS) or the Division of Health Service Regulation (DHSR) as required. Numerator: Number of incidents referred to DSS or DHSR. Denominator: Total number of incidents.

Data Source (Select one):
Critical events and incident reports
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** 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:
Number and percent 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 conducted in accordance with all waiver policies and guidelines. Denominator: All restrictive interventions .

Data Source (Select one):
Critical events and incident reports
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: DMH/DD/SAS	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Performance Measure:
Number and percent of restrictive interventions (both restraint and seclusion) that did not result in medical treatment. Numerator: Number of restrictive interventions that did not result in medical treatment. Denominator: All restrictive interventions.

Data Source (Select one):
Critical events and incident reports
If 'Other' is selected, specify:
NC Incident 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: DMH/DD/SAS	☐ **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:
Number and percent of 1915 c waiver beneficiaries age 21 and older who had a primary care or preventative care visit during the waiver year. Numerator: Number of 1915 c waiver beneficiaries age 21 and older who had a primary care or preventative care visit during the waiver year. Denominator: Number of 1915c waiver beneficiaries age 21 and older during the waiver year.

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:

Performance Measure:
Number and percent of 1915 c beneficiaries under the age of 21 who had a primary care or preventative care visit during the waiver year. Numerator: Number of 1915 c waiver beneficiaries under the age of 21 who had a primary care or preventative care visit during the waiver year. Denominator: Number of 1915 c waiver beneficiaries under the age of 21 during the waiver year.

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:

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

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

The Tailored Plan/PIHP will analyze and address problems identified and include the analysis in the report to NC Medicaid. In situations where providers are involved, the Tailored Plan/PIHP 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. 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 participant health and welfare. DHB and the Tailored Plan/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**
	☐ **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 §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the 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 Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the 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 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). The strategy encompasses an interdisciplinary collaborative approach through partnerships with enrollees and their families, stakeholders, governmental departments and divisions, contractors, the Tailored Plan/PIHPs, 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 DHB-PIHP 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.

Oversight of the Tailored Plan/PIHP is led by DHB and consists of the DHB contract manager and other staff from the State Medicaid Agency, the Division of MH/DD/SUS, other divisions within the NC DHHS as needed and the Tailored Plan/PIHP. Collectively, the individuals reviewing the Tailored Plan/PIHP 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 DWAC, and recommendations are made to DHB for system improvements.

Discovery Activities:

Performance Measures and Performance Improvement Projects:
DHB, in conjunction with the PIHPs and system stakeholders, identified the performance measures outlined in the Innovations waiver document and in the DHB-PIHP 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 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/care coordination, utilization management, network management, quality management) consists of a documentation review and onsite interviews. A review of MH/DD/SUS tailored care management/care coordination 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 PIHPs 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 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.
- Validation of performance measures and performance improvement projects

- Recommendations for improving the quality of healthcare services furnished by the PIHP
- An assessment of the degree to which the PIHP 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 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 PIHPs 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 PIHPs 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 administers a consumer survey annually designed to measure adult and child consumer experience and satisfaction with the PIHP. The survey contains questions designed to measure at least the following dimensions of client satisfaction with PIHP providers, services, delivery and quality:
– Overall satisfaction with PIHP 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 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 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:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the state's targeted standards for systems improvement.

The need for system design changes is identified through the NC Quality Strategy and through State Holder engagement which make recommendations to DHB. DHB prioritizes and implements the needed changes. NC Quality and Clinical staff use the discovery activities 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 Tailored Plan/PIHP 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):*

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 Innovations waiver operates in conjunction with a 1915(b) waiver and all services are provided through prepaid inpatient health plans (PIHP). The Division of Health Benefits (DHB) makes a capitated payment monthly to the Tailored Plan/PIHPs for each enrollee and the Tailored Plan/PIHPs provide all needed MH/DD/SUS services to Medicaid recipients through their provider networks. The Tailored Plan/PIHPs are required through their contracts with DHB to implement a compliance plan to guard against fraud and abuse, to conduct provider and self-direction audits to verify that services authorized and paid for by the Tailored Plan/PIHP are actually provided and to take disciplinary action when needed. The Tailored Plan/PIHPs must report any incidents of fraud and abuse to DHB. Provider agencies and individuals in self-directed arrangements are monitored at a frequency set by the PIHPs but no less than every three years.

The Tailored Plan/PIHPs 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 participants appropriately and as needed through several required activities described in the contract, such as routine financial and clinical reports by the Tailored Plan/PIHP, administration of consumer and provider surveys by the Tailored Plan/IHP or an external entity, on site reviews of operational processes and procedures, record reviews and external quality review activities through an independent entity. Participant Directed and non-participant directed services are monitored on a quarterly basis by the Care Coordinator / Tailored Care Manager through the use of the Tailored Care Management/Care Coordination Monitoring Tool. The Tailored Care Management/Care Coordination Monitoring Tool reviews the following items related to self direction: Employer Related Responsibilities, Monthly Review w/ Employer, Satisfaction with Services and Progress, Review of Monthly Financial Report, Health and Safety Review, Emergency Plan, and Involvement in Staff Selection. 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.

The EVV is not a part of the Prepayment Review program, refer to I-2-b on the state's EVV plan.

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Appendix I: Financial Accountability

Quality Improvement: Financial Accountability

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States 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. *(For waiver actions submitted before June 1, 2014, this assurance read "State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.")*

i. 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 in this sub-assurance include all Appendix I performance measures for waiver actions submitted before June 1, 2014.)

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 claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered. Numerator: Number of claims that are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for service rendered. Denominator: Total number of claims.

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 =* *95% confidence level with +/- 5% margin of error*
☒ ***Other*** *Specify:* *PIHPs*	☐ ***Annually***	☒ ***Stratified*** *Describe Group:* *Reviewed quarterly sample of claims*
	☐ ***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 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 and percent of capitation payments to the Tailored Plans that are made in accordance with the CMS approved actuarially sound rate methodology. Numerator: # of capitation payments to the Tailored Plans that are made in accordance with the CMS approved actuarially sound rate methodology; Denominator: # of capitation payments to the Tailored Plan.

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:* *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.*

Medicaid capitated payments to the PIHP 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 Tailored Plan/PIHP encounter data to set the rates and take into consideration any program or policy changes that might impact the waiver program.

b. Methods for Remediation/Fixing Individual Problems

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

The Tailored Plan/PIHP 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 Tailored Plan/PIHP 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 Tailored Plan/PIHP reports to the State immediately. The State assists with remediation as appropriate and may require corrective actions by the Tailored Plan/PIHP.

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 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 TP/PIHPs are responsible for setting all provider rates for waiver services. The TP/PIHPs set rates based on demand for services, availability of qualified providers, clinical priority or best clinical practices and estimated provider service cost. The TP/PIHPs use the State's Medicaid rates for the same or similar services as a guide in setting rates. Billing codes and Services rates are available on each PIHP/TP webpage for wavier participants to review.

All proposed changes to existing rates or for implementing new rates are reviewed internally by the PIHPs and externally by their respective PIHP provider advisory committee. The provider council is comprised of a cross section of the PIHP'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'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.

Innovations service rates are paid in capitation under the concurrent authorities; NC Mental Health, Intellectual and Developmental Disabilities and Substance Misuse Services Health Plan waiver, #NC-02 and North Carolina Medicaid Reform Demonstration # 11-W-00313/4 and 21-W-00070/4. As such, the Tailored Plans/PIHPs are responsible for setting all provider rates for waiver services. The Tailored Plan/PIHPs set rates based on demand for services, availability of qualified providers, clinical priority or best clinical practices and estimated provider service cost. The TPs/PIHPs use the State's Medicaid rates for the same or similar services as a guide in setting rates.
For services provided through the individual and family directed option (employer of record model), the administrative portion of the service rate is set aside to cover charges for other administrative costs. The direct service portion of the rate is made available to the employer of record for wages and benefits.

Stakeholders were able to provide public comment on this section: The 1915 (c) Innovations Waiver was posted for public comment on February 5, 2024 - March 8, 2024. Access to the document was provided on the NC Medicaid Website designated for public posting, with the opportunity to provide feedback through Medicaid.publicfeedback.gov and postal mail. The department provided a mailing address for submission of public comment through mail to North Carolina Department of Health and Human Services NC Medicaid HCBS 1915(c) Innovations Waiver Team 1950 Mail Service Center Raleigh, NC 27699-1950. The Department did not receive any feedback through postal mail.

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 TP/PIHPs monthly for each waiver beneficiary through the State's Medicaid Management Information System (MMIS), in accordance with Section A.I.B of the concurrent 1915(b) waiver, "Delivery Systems" and the risk contract between the state Medicaid agency and the TP/PIHP. The capitated payments are considered payment in full for all services covered under the waiver program.

Individual providers bill the TP/PIHPs according to the terms of their respective contracts with the TP/PIHP. The contract between DHB and the TP/PIHPs outline requirements for subcontracting and timeliness of payment to providers by the TP/PIHP. The TP/PIHP may not contract with a subcontractor who is not eligible for participation in the Medicaid program.

EVV: The State uses an open vendor model for EVV and has implemented EVV requirements for Innovations Waiver service subject to EVV. Providers generate the elements for EVV visits for Innovations Waiver services subject to EVV; Community Living and Supports, Individual and Group, and Supported Living, Periodic, as required by the 21st Century Cures Act which is captured by the providers selected EVV vendor. Capitation payments are based on historical data generated as part of rate setting process approved by CMS. Once rates are approved, state and health plans agree to a rate. In order to validate services that are provided, the state receives claims from the health plans that reflect EVV services provided. EVV claims were submitted to the states new encounter processing system. This is where all EVV claims are submitted from the plans. EVV is structured to serve as a aggregator to collect information in order to make sure information is correct before it is submitted to the states from the intermediary entities.

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 Innovations 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 PIHPs 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 PIHPs at the beginning of the following month for each waiver participant identified through this process. DHB requires the PIHPs to review a representative sample of records and encounter data using 95% confidence level and +/- 5% margin of error. periodically to determine whether assurances as to service plans and service delivery are met and report findings to DHB.

At the PIHP/Local Levels:
Level of Care for waiver participation is determined by the PIHPs and eligibility for Medicaid is determined by the local departments of social services (DSS). Initial level of care determinations are made by the PIHPs. The PIHPs notify the DSS when Level of Care 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 participants for whom payment will be made at the beginning of the next month. The PIHPs use this report to verify that waiver eligibility has been entered into the system and to identify any waiver participants 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's claims payment system, which prevents payment for unauthorized services. The PIHPs monitor service delivery through Tailored Care Management/Care Coordination contact with waiver participants 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 TP/PIHP 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 monthly for each waiver participant. Capitated payments continue until one of the following occurs: the individual loses Medicaid eligibility; or, the DSS, upon instruction from the PIHP, removes the individual from the waiver. For waiver beneficiary 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 PIHPs 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 §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may voluntarily elect to receive waiver and other services***

through such MCOs or prepaid health plans. Contracts with these health plans are on file at the state Medicaid agency.

Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.

◉ ***This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain waiver and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.***

○ ***This waiver is a part of a concurrent ?1115/?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 ?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 textbox below, indicate the contract authorities. In addition, if the state contracts with MCOs, PIHPs, or PAHPs under the provisions of §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 §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 TP/PIHPs are based on cost and utilization data submitted by the PIHPs for waiver services. Any costs of room and board for participants 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:

Per the service definition, and individual accessing Supported Living has the ability to opt for a live in caregiver at all levels. As such, the service definition outlines that reimbursement for the portion of Room and Board attributable to the live in caregiver will be covered under Supported Living.
Mercer and the State discussed reasonable Room and Board expectation in the State of North Carolina. Since the service definition dictates a minimum of two participants and no more than three residents, including any live in caregiver providing supports, a live in caregiver would only be possible in a three bedroom housing setting. Mercer has include information regarding Room and Board costs applicable to residents in North Carolina in the development of the unit cost. Mercer relied on statistics for the U.S. Department of Housing and Urban Development, Federal Communications Commission, and the United states Department of Agriculture to develop the Room and Board cost assumptions.
The unit cost development includes expected Room and Board costs of a three bedroom housing setting to be $ 992.27 (inclusive of rent, utilities, cable) in total and food costs to be $226.39 in total. Mercer developed the unit cost such that $557.14 of Room and Board expenses was allocated to the live-in caregiver per month. Note that the Room and Board costs were subsequently allocated across the two participants in the Supported Living setting.
Additionally, since the live in caregiver is an optional arrangement available to the participant, the State put forth that on average approximately 25% of the participants would utilized this portion of the service offering. this may be viewed as an add-on to the base per diem for the Supported Living service. This assumption was incorporated in the development of the overall average unit cost per diem.

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: ICF/IID

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	88822.75	11158.00	99980.75	188660.00	8975.00	197635.00	97654.25
2	91401.08	11552.00	102953.08	189603.00	9020.00	198623.00	95669.92
3	93969.51	11959.00	105928.51	190551.00	9065.00	199616.00	93687.49
4	96622.15	12381.00	109003.15	191504.00	9111.00	200615.00	91611.85

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)
5	99359.54	12817.00	112176.54	192462.00	9156.00	201618.00	89441.46

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:
		ICF/IID
Year 1	14752	14752
Year 2	14736	14736
Year 3	14736	14736
Year 4	14736	14736
Year 5	14736	14736

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 estimated average length of stay for the waiver is 346.3 days. This figure is based on average user months observed in PIHP claims data for the Innovations waiver during the July 1, 2022 to June 30, 2023 (SFY 2023) time period. Average length of stay was compared for multiple years and was relatively consistent year over year. Ultimately the decision to use a single year (SFY 2023) was to align time periods with that used for the base data in developing factor D, D', G, and G' estimates.

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:*

The basis for Factor D was PIHP managed care data for the SFY 2023 period, as collected for rate-setting purposes. This data, which included cost and utilization information, was also reviewed to develop trend assumptions to project future service-level utilization and unit costs for waiver renewal years 1-5.

The unit costs for each service are based on the rates paid to providers by the PIHPs during SFY 2023 under managed care adjusted for required uniform dollar increases discussed below. The State established the unit cost for year 1 of the waiver by trending adjusted unit costs reflected in SFY 2023 under managed care at 1.0% annually for two years.
Effective July 1, 2023, the State is implemented provider rate increases for select Innovations services to support wage increases for direct care workers. The unit add-on was a level $1.13 15-minute unit equivalent. The waiver Year 1 average cost per unit projections were updated to reflect these increases. Impacted services include:

- *Community Networking*
- *Day Supports*
- *Residential Supports*
- *Respite*
- *Supported Employment*
- *Community Living and Supports*
- *Supported Living*
- *Supported Living – Periodic*
- *Supported Living - Transition*

For years 2-5, the unit cost is calculated to reflect moderate annual inflation.

User projections are developed for each service based on the total number of approved waiver slots and the proportion of total clients expected to utilize each waiver service based on SFY 2023 experience. Effective October 1, 2023, there was a decrease to the projected number of users for Community Navigator Services. The decrease can be attributed to users transitioning to Tailored Care Management, the State's Health Home program.
Projections for all waiver years incorporate considerations for utilization and unit cost trends of approximately 2.5% and 1.0% annually, respectively. Monthly cost, utilization, and enrollment data from SFY 2022 and SFY 2023 historical LME/MCO claims were reviewed on a rolling basis for the Innovations waiver services. Additionally, the analysis for trends developed for the Innovations waiver services in the SFY 2025 capitation rate-setting for the Tailored Plan program was leveraged. For this analysis, data was analyzed on a rolling basis to evaluate changes in historical cost and utilization patterns while smoothing the influence of historical program changes, significant outliers, and seasonality. Regression models were also created to fit the historical data to linear equation. The slope of the fitted line from the historical data informed prospective trend assumptions.

Benefits counseling is a new service being added to the waiver to provide assistance to Innovations users utilizing Supported Employment. It is assumed that 5% of Supported Employment users will access this service when similar services are not available within 30 days. It is assumed that these users will utilize Benefits Counseling at an average of 10 hours per year. The unit cost was set equal to Specialized Consultation as it has similar delivery and provider requirements.

The most recent available 372 report, SFY 2018, was reviewed as a part of the waiver development. Managed care claims data was used as the basis for the waiver development given it reflected more recent experience including emerging utilization and unit cost levels.

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' was the combination of PIHP managed care data for behavioral health services and Medicaid FFS data for the SFY 2023 period for individuals covered under the Innovations waiver. The summarization for Factor D' captured only Medicaid payments and excluded managed care Innovations waiver service expenditures included in Factor D development. This data was projected to each renewal year utilizing the same service level trend information used to develop factor D (3.5% overall trend). Monthly cost, utilization, and enrollment data from SFY 2022 and SFY 2023 historical LME/MCO and FFS claims were reviewed on a rolling basis for the Innovations population non-waiver services. Additionally, the analysis for trends developed for the Innovations population non-waiver services in the SFY 2025 capitation rate-setting for the Tailored Plan program was leveraged. For this analysis, data was analyzed on a rolling basis to evaluate changes in historical cost and utilization patterns while smoothing the influence of historical program changes, significant outliers, and seasonality. Regression models were also created to fit the historical data to linear equation. The slope of the fitted line from the historical data informed prospective trend assumptions.

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 PIHP managed care data for individuals actively utilizing ICF-MR services under the 1915(b) waiver managed care program. This data represented services rendered during the SFY 2023 period.

Factor G data was projected to each renewal year with trend assumptions developed from reviewing of the detailed managed care data consistent with rate-setting processes. Trends were developed to project future ICF-MR utilization and unit costs for waiver renewal years 1-5 (average annual trend of 0.5%). Monthly cost, utilization, and enrollment data from SFY 2022 and SFY 2023 historical LME/MCO claims were reviewed on a rolling basis for the ICF services. Additionally, the analysis for trends developed for the ICF services in the SFY 2025 rate-setting for Tailored Plan and Medicaid Direct BH programs was leveraged. For this analysis, data was analyzed on a rolling basis to evaluate changes in historical cost and utilization patterns while smoothing the influence of historical program changes, significant outliers, and seasonality. Regression models were also created to fit the historical data to linear equation. The slope of the fitted line from the historical data informed prospective trend assumptions

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:*

TThe basis for Factor G' was the combination of PIHP managed care data for behavioral health services and Medicaid FFS data for the SFY 2023 period for individuals actively utilizing ICF-MR services under the 1915(b)waiver managed care program. The summarization for Factor D' captured only Medicaid payments and excluded managed care ICF-MR expenditures included in Factor G development.

Factor G' data was projected to each renewal year with trend assumptions developed from reviewing of the detailed managed care data consistent with rate-setting processes. Trends were developed to project future utilization and unit costs for waiver renewal years 1-5 (average annual trend of 0.5%). Monthly cost, utilization, and enrollment data from SFY 2022 and SFY 2023 historical LME/MCO and FFS claims were reviewed on a rolling basis for the non-ICF services for ICF beneficiaries. Additionally, the analysis for trends developed for the non-ICF services of ICF beneficiaries in the SFY 2025 rate-setting for Tailored Plan and Medicaid Direct BH programs was leveraged. For this analysis, data was analyzed on a rolling basis to evaluate changes in historical cost and utilization patterns while smoothing the influence of historical program changes, significant outliers, and seasonality. Regression models were also created to fit the historical data to linear equation. The slope of the fitted line from the historical data informed prospective trend assumptions.

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	
Community Navigator	
Community Networking	
Day Supports	
Residential Supports	
Respite	
Supported Employment	
Financial Support Services	
Assistive Technology	
Benefits Counseling	
Community Living and Support	
Community Transition	
Crisis Services	
Home Delivered Meal	
Home Modifications	
Individual Goods and Services	
Natural Supports Education	
Specialized Consultation	
Supported Living - Periodic	
Supported Living - Transition	
Supported Living	
Vehicle Modifications	

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (5 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Community Navigator Total:							376152.00
Community Navigator	☒	15-Minute	400	6.00	156.73	376152.00	
Community Networking Total:							89675090.55

GRAND TOTAL:		1310313229.44
Total: Services included in capitation:		1310313229.44
Total: Services not included in capitation:		
Total Estimated Unduplicated Participants:		14752
Factor D (Divide total by number of participants):		88822.75
Services included in capitation:		88822.75
Services not included in capitation:		
Average Length of Stay on the Waiver:	346	

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Community Networking	☒	15-minute	5601	2115.00	7.57	89675090.55	
Day Supports Total:							195817917.96
Day Supports	☒	Hourly	5922	1141.00	28.98	195817917.96	
Residential Supports Total:							345776376.64
Residential Supports	☒	day	4868	316.00	224.78	345776376.64	
Respite Total:							41104514.88
Respite	☒	15-minute	5253	1248.00	6.27	41104514.88	
Supported Employment Total:							24840421.76
Supported Employment	☒	15-minute	1639	1592.00	9.52	24840421.76	
Financial Support Services Total:							1035414.00
Financial Support Services	☒	Event	414	122.00	20.50	1035414.00	
Assistive Technology Total:							1551241.32
Assistive Technology	☒	Event	1102	29.00	48.54	1551241.32	
Benefits Counseling Total:							152520.00
Benefits Counseling	☒	15-minute	82	40.00	46.50	152520.00	
Community Living and Support Total:							554642905.20
Community Living and Support	☒	15-minute	8705	8264.00	7.71	554642905.20	
Community Transition Total:							127811.60
Community Transition	☒	Event	28	2.00	2282.35	127811.60	
Crisis Services Total:							334912.50
Crisis Services	☒	15-minute	130	75.00	34.35	334912.50	

GRAND TOTAL:	**1310313229.44**
Total: Services included in capitation:	1310313229.44
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**14752**
Factor D (Divide total by number of participants):	**88822.75**
Services included in capitation:	88822.75
Services not included in capitation:	
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Delivered Meal Total:							**5375545.56**
Home Delivered Meal	☒	Event	1566	462.00	7.43	**5375545.56**	
Home Modifications Total:							**3143727.40**
Home Modifications	☒	Event	230	2.00	6834.19	**3143727.40**	
Individual Goods and Services Total:							**14244.12**
Individual Goods and Services	☒	Event	27	44.00	11.99	**14244.12**	
Natural Supports Education Total:							**23357.16**
Natural Supports Education	☒	Event	27	81.00	10.68	**23357.16**	
Specialized Consultation Total:							**8368791.00**
Specialized Consultation	☒	15-minute	3103	58.00	46.50	**8368791.00**	
Supported Living - Periodic Total:							**31284.00**
Supported Living - Periodic	☒	Hourly	3	1185.00	8.80	**31284.00**	
Supported Living - Transition Total:							**3329.48**
Supported Living - Transition	☒	Hourly	4	77.00	10.81	**3329.48**	
Supported Living Total:							**37584346.38**
Supported Living	☒	Day	438	263.00	326.27	**37584346.38**	
Vehicle Modifications Total:							**333325.93**
Vehicle Modifications	☒	Event	49	1.00	6802.57	**333325.93**	

GRAND TOTAL:	**1310313229.44**
Total: Services included in capitation:	1310313229.44
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**14752**
Factor D (Divide total by number of participants):	**88822.75**
Services included in capitation:	88822.75
Services not included in capitation:	
Average Length of Stay on the Waiver:	346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (6 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Community Navigator Total:							**379920.00**
Community Navigator	☒	15-Minute	400	6.00	158.30	**379920.00**	
Community Networking Total:							**92893705.20**
Community Networking	☒	15-minute	5601	2168.00	7.65	**92893705.20**	
Day Supports Total:							**202804219.80**
Day Supports	☒	Hourly	5922	1170.00	29.27	**202804219.80**	
Residential Supports Total:							**349237524.64**
Residential Supports	☒	Day	4868	316.00	227.03	**349237524.64**	
Respite Total:							**42528655.71**
Respite	☒	15-minute	5253	1279.00	6.33	**42528655.71**	
Supported Employment Total:							**25571546.88**
Supported Employment	☒	15-minute	1639	1632.00	9.56	**25571546.88**	
Financial Support Services Total:							**1071742.50**
Financial Support Services	☒	Event	414	125.00	20.71	**1071742.50**	
Assistive Technology Total:							**1620931.80**
Assistive Technology	☒	Event	1102	30.00	49.03	**1620931.80**	
Benefits Counseling Total:							**154061.60**

GRAND TOTAL:	**1346886380.52**
Total: Services included in capitation:	1346886380.52
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**91401.08**
Services included in capitation:	91401.08
Services not included in capitation:	
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Benefits Counseling	☒	15-minute	82	40.00	46.97	154061.60	
Community Living and Support Total:							574435028.45
Community Living and Support	☒	15-minute	8705	8471.00	7.79	574435028.45	
Community Transition Total:							129089.52
Community Transition	☒	Event	28	2.00	2305.17	129089.52	
Crisis Services Total:							347246.90
Crisis Services	☒	15-minute	130	77.00	34.69	347246.90	
Home Delivered Meal Total:							5567130.00
Home Delivered Meal	☒	Event	1566	474.00	7.50	5567130.00	
Home Modifications Total:							3175163.80
Home Modifications	☒	Event	230	2.00	6902.53	3175163.80	
Individual Goods and Services Total:							14713.65
Individual Goods and Services	☒	Event	27	45.00	12.11	14713.65	
Natural Supports Education Total:							24180.39
Natural Supports Education	☒	Event	27	83.00	10.79	24180.39	
Specialized Consultation Total:							8599126.69
Specialized Consultation	☒	15-minute	3103	59.00	46.97	8599126.69	
Supported Living - Periodic Total:							32404.05
Supported Living - Periodic	☒	Hourly	3	1215.00	8.89	32404.05	
Supported Living -							3450.72

	GRAND TOTAL:	***1346886380.52***
	Total: Services included in capitation:	*1346886380.52*
	Total: Services not included in capitation:	
	Total Estimated Unduplicated Participants:	***14736***
	Factor D (Divide total by number of participants):	***91401.08***
	Services included in capitation:	*91401.08*
	Services not included in capitation:	
	Average Length of Stay on the Waiver:	*346*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition Total:							
Supported Living - Transition	☒	Hourly	4	79.00	10.92	**3450.72**	
Supported Living Total:							**37959878.82**
Supported Living	☒	Day	438	263.00	329.53	**37959878.82**	
Vehicle Modifications Total:							**336659.40**
Vehicle Modifications	☒	Event	49	1.00	6870.60	**336659.40**	

GRAND TOTAL:	**1346886380.52**
Total: Services included in capitation:	1346886380.52
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**91401.08**
Services included in capitation:	91401.08
Services not included in capitation:	
Average Length of Stay on the Waiver:	346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (7 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Community Navigator Total:							**383712.00**
Community Navigator	☒	15-minute	400	6.00	159.88	**383712.00**	
Community Networking Total:							**96203112.06**
Community Networking	☒	15-minute	5601	2222.00	7.73	**96203112.06**	
Day Supports Total:							**209890129.68**

GRAND TOTAL:	**1384734758.47**
Total: Services included in capitation:	1384579155.27
Total: Services not included in capitation:	155603.20
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**93969.51**
Services included in capitation:	93958.95
Services not included in capitation:	10.56
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Day Supports	☒	hour	5922	1199.00	29.56	209890129.68	
Residential Supports Total:							352729438.40
Residential Supports	☒	day	4868	316.00	229.30	352729438.40	
Respite Total:							44005904.37
Respite	☒	15-minute	5253	1311.00	6.39	44005904.37	
Supported Employment Total:							26652696.84
Supported Employment	☒	15-minute	1639	1673.00	9.72	26652696.84	
Financial Support Services Total:							1108592.64
Financial Support Services	☒	Event	414	128.00	20.92	1108592.64	
Assistive Technology Total:							1691702.24
Assistive Technology	☒	Event	1102	31.00	49.52	1691702.24	
Benefits Counseling Total:							155603.20
Benefits Counseling	☐	15-minute	82	40.00	47.44	155603.20	
Community Living and Support Total:							594858003.05
Community Living and Support	☒	15-minute	8705	8683.00	7.87	594858003.05	
Community Transition Total:							130385.92
Community Transition	☒	Event	28	2.00	2328.32	130385.92	
Crisis Services Total:							359860.80
Crisis Services	☒	15-minute	130	79.00	35.04	359860.80	
Home Delivered Meal Total:							5768956.08
Home Delivered Meal	☒	Event	1566	486.00	7.58	5768956.08	

GRAND TOTAL:	**1384734758.47**
Total: Services included in capitation:	1384579155.27
Total: Services not included in capitation:	155603.20
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**93969.51**
Services included in capitation:	93958.95
Services not included in capitation:	10.56
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Home Modifications Total:							**3206917.60**
Home Modifications	☒	Event	230	2.00	6971.56	**3206917.60**	
Individual Goods and Services Total:							**15189.66**
Individual Goods and Services	☒	Event	27	46.00	12.23	**15189.66**	
Natural Supports Education Total:							**25015.50**
Natural Supports Education	☒	Event	27	85.00	10.90	**25015.50**	
Specialized Consultation Total:							**8832379.20**
Specialized Consultation	☒	15-minute	3103	60.00	47.44	**8832379.20**	
Supported Living - Periodic Total:							**33540.30**
Supported Living - Periodic	☒	Hourly	3	1245.00	8.98	**33540.30**	
Supported Living - Transition Total:							**3573.72**
Supported Living - Transition	☒	Hourly	4	81.00	11.03	**3573.72**	
Supported Living Total:							**38340019.02**
Supported Living	☒	Day	438	263.00	332.83	**38340019.02**	
Vehicle Modifications Total:							**340026.19**
Vehicle Modifications	☒	Event	49	1.00	6939.31	**340026.19**	

GRAND TOTAL:	**1384734758.47**
Total: Services included in capitation:	1384579155.27
Total: Services not included in capitation:	155603.20
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**93969.51**
Services included in capitation:	93958.95
Services not included in capitation:	10.56
Average Length of Stay on the Waiver:	346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (8 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Community Navigator Total:							**387552.00**
Community Navigator	☒	15-minute	400	6.00	161.48	**387552.00**	
Community Networking Total:							**99648399.18**
Community Networking	☒	15-minute	5601	2278.00	7.81	**99648399.18**	
Day Supports Total:							**217325200.68**
Day Supports	☒	hour	5922	1229.00	29.86	**217325200.68**	
Residential Supports Total:							**356252117.92**
Residential Supports	☒	day	4868	316.00	231.59	**356252117.92**	
Respite Total:							**45537206.40**
Respite	☒	15-minute	5253	1344.00	6.45	**45537206.40**	
Supported Employment Total:							**27602890.70**
Supported Employment	☒	15-minute	1639	1715.00	9.82	**27602890.70**	
Financial Support Services Total:							**1145964.42**
Financial Support Services	☒	Event	414	131.00	21.13	**1145964.42**	
Assistive Technology Total:							**1763905.28**
Assistive Technology	☒	Event	1102	32.00	50.02	**1763905.28**	
Benefits Counseling Total:							**157144.80**
Benefits Counseling	☒	15-minute	82	40.00	47.91	**157144.80**	
Community							**615922275.00**

GRAND TOTAL:	***1423823982.44***
Total: Services included in capitation:	*1423823982.44*
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	***14736***
Factor D (Divide total by number of participants):	***96622.15***
Services included in capitation:	*96622.15*
Services not included in capitation:	
Average Length of Stay on the Waiver:	*346*

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Living and Support Total:							
Community Living and Support	☒	15-minute	8705	8900.00	7.95	**615922275.00**	
Community Transition Total:							**131684.00**
Community Transition	☒	Event	28	2.00	2351.50	**131684.00**	
Crisis Services Total:							**372656.70**
Crisis Services	☒	15-minute	130	81.00	35.39	**372656.70**	
Home Delivered Meal Total:							**5973788.88**
Home Delivered Meal	☒	Event	1566	498.00	7.66	**5973788.88**	
Home Modifications Total:							**3238988.80**
Home Modifications	☒	Event	230	2.00	7041.28	**3238988.80**	
Individual Goods and Services Total:							**15672.15**
Individual Goods and Services	☒	Event	27	47.00	12.35	**15672.15**	
Natural Supports Education Total:							**25862.49**
Natural Supports Education	☒	Event	27	87.00	11.01	**25862.49**	
Specialized Consultation Total:							**9217213.26**
Specialized Consultation	☒	15-minute	3103	62.00	47.91	**9217213.26**	
Supported Living - Periodic Total:							**34719.96**
Supported Living - Periodic	☒	Hourly	3	1276.00	9.07	**34719.96**	
Supported Living - Transition Total:							**3698.48**
Supported Living -	☒	Hourly				**3698.48**	

GRAND TOTAL:	**1423823982.44**
Total: Services included in capitation:	1423823982.44
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**96622.15**
Services included in capitation:	96622.15
Services not included in capitation:	
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Transition			4	83.00	11.14		
Supported Living Total:							**38723615.04**
Supported Living	☒	Day	438	263.00	336.16	**38723615.04**	
Vehicle Modifications Total:							**343426.30**
Vehicle Modifications	☒	Event	49	1.00	7008.70	**343426.30**	

GRAND TOTAL:	**1423823982.44**
Total: Services included in capitation:	1423823982.44
Total: Services not included in capitation:	
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**96622.15**
Services included in capitation:	96622.15
Services not included in capitation:	
Average Length of Stay on the Waiver:	346

Appendix J: Cost Neutrality Demonstration

J-2: Derivation of Estimates (9 of 9)

d. Estimate of Factor D.

ii. Concurrent §1915(b)/§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
Community Navigator Total:							**391416.00**
Community Navigator	☒	15-minute	400	6.00	163.09	**391416.00**	
Community Networking Total:							**103188063.15**
Community Networking	☒	15-minute	5601	2335.00	7.89	**103188063.15**	
Day Supports Total:							**225045475.20**
Day Supports	☒	hour	5922	1260.00	30.16	**225045475.20**	

GRAND TOTAL:	**1464162184.93**
Total: Services included in capitation:	1464003465.73
Total: Services not included in capitation:	158719.20
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**99359.54**
Services included in capitation:	99348.77
Services not included in capitation:	10.77
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Residential Supports Total:							**359820946.08**
Residential Supports	☒	day	4868	316.00	233.91	**359820946.08**	
Respite Total:							**47123507.34**
Respite	☒	15-minute	5253	1378.00	6.51	**47123507.34**	
Supported Employment Total:							**28583111.04**
Supported Employment	☒	15-minute	1639	1758.00	9.92	**28583111.04**	
Financial Support Services Total:							**1183857.84**
Financial Support Services	☒	Event	414	134.00	21.34	**1183857.84**	
Assistive Technology Total:							**1837210.32**
Assistive Technology	☒	Event	1102	33.00	50.52	**1837210.32**	
Benefits Counseling Total:							**158719.20**
Benefits Counseling	☐	15-minute	82	40.00	48.39	**158719.20**	
Community Living and Support Total:							**637708191.45**
Community Living and Support	☒	15-minute	8705	9123.00	8.03	**637708191.45**	
Community Transition Total:							**133001.12**
Community Transition	☒	Event	28	2.00	2375.02	**133001.12**	
Crisis Services Total:							**385634.60**
Crisis Services	☒	15-minute	130	83.00	35.74	**385634.60**	
Home Delivered Meal Total:							**6181628.40**
Home Delivered Meal	☒	Event	1566	510.00	7.74	**6181628.40**	
Home Modifications							**3271377.40**

GRAND TOTAL:	**1464162184.93**
Total: Services included in capitation:	1464003465.73
Total: Services not included in capitation:	158719.20
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**99359.54**
Services included in capitation:	99348.77
Services not included in capitation:	10.77
Average Length of Stay on the Waiver:	346

Waiver Service/ Component	Capi-tation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Component Cost	Total Cost
Total:							
Home Modifications	☒	Event	230	2.00	7111.69	**3271377.40**	
Individual Goods and Services Total:							**16161.12**
Individual Goods and Services	☒	Event	27	48.00	12.47	**16161.12**	
Natural Supports Education Total:							**26721.36**
Natural Supports Education	☒	Event	27	89.00	11.12	**26721.36**	
Specialized Consultation Total:							**9609866.88**
Specialized Consultation	☒	15-minute	3103	64.00	48.39	**9609866.88**	
Supported Living - Periodic Total:							**35943.84**
Supported Living - Periodic	☒	Hourly	3	1308.00	9.16	**35943.84**	
Supported Living - Transition Total:							**3825.00**
Supported Living - Transition	☒	Hourly	4	85.00	11.25	**3825.00**	
Supported Living Total:							**39110666.88**
Supported Living	☒	Day	438	263.00	339.52	**39110666.88**	
Vehicle Modifications Total:							**346860.71**
Vehicle Modifications	☒	Event	49	1.00	7078.79	**346860.71**	

GRAND TOTAL:	**1464162184.93**
Total: Services included in capitation:	1464003465.73
Total: Services not included in capitation:	158719.20
Total Estimated Unduplicated Participants:	**14736**
Factor D (Divide total by number of participants):	**99359.54**
Services included in capitation:	99348.77
Services not included in capitation:	10.77
Average Length of Stay on the Waiver:	346